DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS
Title 20, Chapter 4, Article 14

Amend: R20-4-1401, R20-4-1403, R20-4-1405

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: **Aug 1, 2023**

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

FROM: Council Staff

DATE: **July 6, 2023**

SUBJECT: **DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS**
Title 20, Chapter 4

Amend: R20-4-1401, R20-4-1403, R20-4-1405

Summary:

This regular rulemaking for the Arizona Department of Insurance and Financial Institutions seeks to amend three (3) rules in Title 20, Chapter 4, Article 14, Investigations. The purpose of the Department is to execute laws of this state relating to financial institutions and enterprises.

On July 1, 2020, the Department of Financial Institutions merged with the Department of Insurance to form the Department of Insurance and Financial Institutions. The proposed changes in this rulemaking reflect the structural changes of that merger, updates and modernizes terminology, and makes changes identified in the 2020 Five Year Review Report.

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

The Department cites both general and specific statutory authority for these rules

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

The Department indicates that the rules do 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?

The Department did not review or rely on any study relevant to the proposed amended rules.

4. Summary of the agency's economic impact analysis:

The rulemaking pertains to examinations and investigations conducted by the Department. The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimum financial impact, including no anticipated effect on the revenues or payroll expenditures, to persons being examined or investigated.

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 believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of examining and investigating persons or entities.

6. What are the economic impacts on stakeholders?

The Department does not anticipate any significant costs or benefits to persons or entities being examined or investigated by the Department.

The changes being proposed by the Department are modest. For all the Sections, the Department is replacing the obsolete title of "Superintendent" with "Director." Section R20-4-1401 clarifies the definition of "licensee." Section R20-4-1403 modernized the delivery of a subpoena to use any means intended to effectuate delivery of the subpoena. And Section R20-4-1405 eliminates references to fingerprints because the Department already has statutory authority to obtain fingerprints from a wide variety of persons and entities.

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

The Department states that there are no changes between the proposed rulemaking and the final rulemaking.

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

The Department did not receive any public or stakeholder comments.

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 that this is not applicable as these rules do not require 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?

The Department states that no federal law is applicable to the subject of this rulemaking.

11. Conclusion

This regular rulemaking for the Arizona Department of Insurance and Financial Institutions seeks to amend three rules in Title 20, Chapter 4, Article 14, Investigations. As mentioned above, the amendments will reflect the structural changes of the Department, update and modernize terminology, and make changes identified in the 2020 Five Year Review Report.

The Department is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A). Council staff recommends approval of this rulemaking.

Arizona Department of Insurance and Financial Institutions
100 N 15th Avenue, Suite 261, Phoenix, Arizona 85007
(602) 364-3100 | difi.az.gov

Katie M. Hobbs, Governor
Barbara D. Richardson, Director

DATE: June 8, 2023

VIA EMAIL: grrc@azdoa.gov
Nicole Sornsin, Chair
Governor's Regulatory Review Council
100 North 15th Ave., Suite 305
Phoenix, AZ 85007

RE: Arizona Department of Insurance and Financial Institutions
Financial Institutions Division
A.A.C. Title 20, Chapter 4, Article 14 – Investigations

Dear Chairperson Sornsin:

Please find enclosed the Final Rulemaking for A.A.C. Title 20, Chapter 4, Article 14 – Investigations, being submitted by the Arizona Department of Insurance and Financial Institutions ("Department").

Pursuant to A.A.C. R1-6-201(A)(1), the Department responds as follows:

a. The Department closed the record on this rulemaking on February 12, 2023.
b. This rulemaking relates to the five-year review report submitted by the Arizona Department of Insurance and Financial Institutions to the Council for Section R20-4-1401 and approved at the Council's January 5, 2021 Council Meeting.
c. The rulemaking does not establish a new fee.
d. The rulemaking does not contain a fee increase.
e. The rulemaking does not request an immediate effective date under A.R.S. § 41-1032.
f. The Department certifies that the preamble discloses a reference to any study relevant to the rule that it reviewed and either did or did not rely on in its evaluation of or justification for the rulemaking. The Department did not review or rely on any study relevant to the rulemaking.
g. No new full-time employees are necessary to implement and enforce the rule.
h. The following documents are also submitted to the Council with this cover letter:
    i. The Notice of Final Rulemaking;
    ii. An economic, small business, and consumer impact statement that contains the information required by A.R.S. § 41-1055;
    iii. The general and specific statutes authorizing the rulemaking.

By this submission, the Department is requesting approval of this rulemaking from the Council.

For questions about this rulemaking, please contact Mary Kosinski at (602) 364-3476 or mary.kosinski@difi.az.gov.

Sincerely,

Barbara D. Richardson

Barbara D. Richardson
Director

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS

– financial institutions

PREAMBLE

1. Articles, Parts, or Sections Affected (as applicable) **Rulemaking Action**

R20-4-1401	Amend
R20-4-1403	Amend
R20-4-1405	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. § 6-123(2)

Implementing statute: A.R.S. §§ 6-123.01, 6-124, and 12-2212

3. The effective date of the rule:

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the

agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening:	29 A.A.R. 201, January 13, 2023
Notice of Proposed Rulemaking:	28 A.A.R. 138, January 13, 2023

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

Name: Mary E. Kosinski

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

Telephone: (602)364-3476

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

Web site: https://difi.az.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:

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 14 – Investigations. The changes the Department is proposing will reflect the structural change

to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions (the "new agency"), on July 1, 2020. The former Department of Financial Institutions became a division of the new agency.

As a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article.

When reviewing the rules in the Article, the Department also endeavored to modernize the current rules since the most recent rulemaking for this Article was in 2003. In addition, the change made to Section R20-4-1401 is being made to fulfill a commitment made by the Department in a Five-Year Review in 2020.

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 and does not propose to rely on any study relevant to 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:

The rulemaking replaces the obsolete title of "Superintendent" with "Director," clarifies that a "licensee" must be a licensee of the Department and updates the method for delivering a subpoena. The rulemaking does not diminish a previous grant of authority

granted to the Department.

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

Pursuant to A.R.S. § 41-1055(A)(1):

- The rulemaking is not designed to change any conduct because of a perceived harm. Instead, the rulemaking pertains to examinations and investigations conducted by the Department.

Pursuant to A.R.S. § 41-1055(A)(2):

- The Department does not anticipate any probable costs or benefits to persons being examined or investigated by the Department.

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to persons being examined or investigated.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The Department has not made any 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:

The Department published the Notice of Proposed Rulemaking for the Investigations Article on January 13, 2023. (29 A.A.R. 138, January 13, 2023) At that time it also opened a 30-day Comment Period. During the Comment Period, no one submitted a comment to the Department or requested an Oral Proceeding.

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

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

Not applicable. The rulemaking pertains to examinations and investigations conducted by the Department.

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:

No federal law is 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 formal analysis has been submitted to the Department that compares the rule's impact of the competitiveness of business in this state to the impact of business in other states.

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

No materials are incorporated by reference.

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. The rule was not previously made, amended or repealed as an emergency rule.

15. The full text of the rules follows:

Title 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

ARTICLE 14. INVESTIGATIONS

Section

ARTICLE 14. INVESTIGATIONS

R20-4-1401. Definitions

In this Article, unless the context otherwise requires:

1. "Examination" means reviewing an applicant's or licensee's operations, books, and records for any lawful purpose, including those listed in A.R.S. § 6-124(A).
2. "Investigation" means an inquiry, other than an examination, into the affairs of a licensed or unlicensed entity including a review of the entity's operations, books, and records, conducted by the ~~Superintendent~~ Director for any lawful purpose, including those listed in A.R.S. § 6-124(A).
3. "Licensee" means a financial institution or enterprise~~.~~ licensed with the Department.

R20-4-1403. Subpoenas: Service; Amendment; Investigation or Examination not a Condition of the ~~Superintendent's~~ Director's Subpoena Power

The ~~Superintendent~~ Director may serve a subpoena ~~either by personal delivery or by first class, certified, or express mail, or by facsimile transmission.~~ using any means intended to effectuate delivery of the subpoena. A Department employee, or an attorney or agent of the Attorney

General's office, may accomplish service for the ~~Superintendent.~~ Director. The ~~Superintendent~~ Director may amend a subpoena at any time, and may serve the amended subpoena as provided in this Section. Under A.R.S. §§ 6-123(3), 6-124(B), and 12-2212, the ~~Superintendent~~ Director may compel testimony or document production, by subpoena or other means, regardless of whether an examination or investigation is in progress.

R20-4-1405. ~~Fingerprints;~~ Background Information

A. In connection with an examination or investigation, the ~~Superintendent~~ Director may investigate the following persons' background:

1. An applicant or a licensee, or a person whom the ~~Superintendent~~ Director reasonably believes may be violating any statute or rule administered by the ~~Superintendent;~~ Director; and
2. An officer, director, agent, employee, partner, joint venturer, affiliate, or other person associated with a person described in subsection (A)(1), if the other person has or had any involvement in or control over the activities of the person described in subsection (A)(1).

B. In connection with an examination or investigation, the ~~Superintendent~~ Director may require a person described in A.R.S. § 6-123.01(A) or (E) to submit a statement of personal history ~~and fingerprints~~ to the Department.

A.R.S. § 41-1055(B) Economic, Small Business, And Consumer Impact Statement

Title 20. Commerce, Financial Institutions and Insurance

Chapter 4. Department of Insurance and Financial Institutions – Financial Institutions

Article 14. Investigations

A.R.S. § 41-1055(B)(1): An identification of the proposed rulemaking.

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 14 – Investigations.

The changes the Department is proposing will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions (the "new agency"), on July 1, 2020. The former Department of Financial Institutions became a division of the new agency.

As a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article.

When reviewing the rules in the Article, the Department also endeavored to modernize the current rules, specifically for delivery of a subpoena, since the most recent rulemaking for this Article was in 2003. In addition, the change made to Section R20-4-1401 is being made to fulfill a commitment made by the Department in a Five-Year Review in 2020.

Questions about this Economic Impact Statement can be directed to: Mary E. Kosinski (mary.kosinski@difi.az.gov).

A.R.S. § 41-1055(B)(2): An identification of the persons who will be directly affected by, bear the costs of or directly benefit from the proposed rulemaking.

This Article applies to any person or entity subject to investigation or examination by the Department pursuant to A.R.S. § 6-124.

A.R.S. § 41-1055(B)(3): A cost benefit analysis of the following:

(a) The probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking. The probable costs to the implementing agency shall include the number of new full-time employees necessary to implement and enforce the proposed rule. The preparer of the economic, small business and consumer impact statement shall notify the joint legislative budget committee of the number of new full-time employees necessary to implement and enforce the rule before the rule is approved by the council.

The Department does not anticipate any costs or benefits in implementing and enforcing the proposed rulemaking. No new full-time employees will be necessary to implement and enforce the proposed rulemaking.

(b) The probable costs and benefits to a political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.

No political subdivision of this state is directly affected by the implementation and enforcement of the proposed rulemaking.

(c) The probable costs and benefits to businesses directly affected by the proposed rulemaking, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the proposed rulemaking.

The Department does not anticipate any significant probable costs or benefits to persons or entities being examined or investigated by the Department. The changes being proposed by the Department are modest. For all the Sections, the Department is replacing the obsolete title of "Superintendent" with "Director." Section R20-4-1401 clarifies the definition of "licensee." Section R20-4-1403 modernizes the delivery of a subpoena to use any means intended to effectuate delivery of the subpoena. And Section R20-4-1405 eliminates references to fingerprints because the Department already has statutory authority to obtain

fingerprints from a wide variety of persons and entities. (*See,* A.R.S. §§ 6-123 and 6-123.01).

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to persons or entities being examined or investigated.

A.R.S. § 41-1055(B)(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 proposed rulemaking.

The Department does not anticipate any impact of this rulemaking on private and public employment because this Article governs examinations and investigations conducted by the Department.

A.R.S. § 41-1055(B)(5): A statement of the probable impact of the proposed rulemaking on small businesses. The statement shall include:

(a) An identification of the small businesses subject to the proposed rulemaking.

"Small business" is defined as a concern, including its affiliates, which is:

a. Independently owned and operated,

b. Not dominant in its field,

c. Employs fewer than 100 full-time employees, and

d. Had gross annual receipts of less than $4 million in its last fiscal year. A.R.S. § 41-1001(23).

The Department presumes that some of the businesses that it may investigate or examine may qualify as a small business. However, the rulemaking applies to the Department's authority to conduct an examination or investigation, not to the entity or person being examined or investigated.

(b) The administrative and other costs required for compliance with the proposed rulemaking.

The Department does not anticipate any administrative or other costs required for compliance with the proposed rulemaking.

(c) A description of the methods prescribed in section 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 to use each method.

A.R.S. § 41-1035 lists the following methods to reduce the impact on small businesses:

1. Establish less stringent compliance or reporting requirements in the rule for small businesses.

The Department did not establish a less stringent compliance or reporting requirements for small businesses because the rulemaking does not pertain to reporting requirements.

2. Establish less stringent schedules or deadlines in the rule for compliance or reporting requirements for small businesses.

The Department did not establish a less stringent schedules or deadlines for small businesses because the rulemaking does not pertain to schedules or deadlines for compliance or reporting requirements.

3. Consolidate or simplify the rule's compliance or reporting requirements for small businesses.

The Department did not consolidate or simplify the rule's compliance or reporting requirements for small businesses because the rulemaking does not pertain to compliance or reporting requirements.

4. Establish performance standards for small businesses to replace design or operational standards in the rule.

The Department did not establish performance standards for small businesses to replace design or operational standards in the rule because the rulemaking does not pertain to performance standards.

5. Exempt small businesses from any or all requirements of the rule.

The Department made no exemptions for small businesses in the rulemaking because it examines and investigates licensees without consideration of whether the entity or person being examined or investigated is a small business.

(d) The probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.

The Department does not anticipate any cost or benefit to private persons and consumers.

A.R.S. § 41-1055(B)(6): A statement of the probable effect on state revenues.

No impact on state revenues is anticipated.

A.R.S. § 41-1055(B)(7): A 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 Department believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of examining and investigating persons or entities.

A.R.S. § 41-1055(B)(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. An agency advocating that any data is acceptable data has the burden of proving that the data is acceptable. For the purposes of this paragraph, "acceptable data" means empirical, replicable and testable data as evidenced in supporting documentation, statistics, reports, studies or research.

The rule is not based on any data.

Authorizing Statute: A.R.S. § 6-123(2)

6-123. Deputy director; powers

In addition to the other powers, express or implied, the deputy director may:

1. Exercise all powers that are necessary for the administration and enforcement of the laws and rules relating to financial institutions and enterprises.

2. In accordance with title 41, chapter 6, adopt rules that are necessary or appropriate to administer, enforce and accomplish the purposes of this title and adopt rules and issue orders that limit transactions between financial institutions or enterprises and the directors, officers or employees of the financial institutions or enterprises.

3. Require appropriate records, documents, information and reports from any financial institution or enterprise.

4. Submit to the department of public safety, or the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor, the name and fingerprints of any applicant, licensee, active manager or responsible individual or the name and fingerprints of any organizer, director or officer of any corporate applicant or licensee for:

(a) A banking permit.

(b) Permission to organize a savings and loan association or credit union.

(c) Any license.

(d) Any certificate.

(e) Authority to engage in interstate banking and branching in this state.

The department of public safety shall report the criminal record, if any, of such applicant, licensee or organizer, director or officer of such corporate applicant or licensee within ninety days after receipt of the deputy director's request.

5. Employ appraisers to appraise any property that is owned or held as security by any financial institution or enterprise. The reasonable expenses and compensation of such appraisers shall be paid by the financial institution or enterprise.

6. Hold membership in, pay dues to and attend the convention of the national and regional organizations of state officials occupying like offices or performing similar functions.

7. Cooperate with other regulatory agencies and professional associations to promote the efficient, safe and sound operation and regulation of interstate banking and branching activities, including the formulation of interstate examination policies and procedures and the drafting of model rules and agreements.

8. Participate in the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor. The deputy director may allow the system to collect licensing fees on behalf of the deputy director, to collect a processing fee for the services of the system directly from each applicant for a license or licensee and to process and maintain records on behalf of the deputy director, including information collected pursuant to this section and section 6-123.01. This paragraph does not affect the records disclosure requirements and limitations prescribed in section 6-129.01.

Implementing Statutes: A.R.S. §§ 6-123.01, 6-124, 12-2212

6-123.01. Fingerprint requirements; fees

A. Before receiving and holding a license, permit, certificate or permission to organize a bank, savings and loan association or credit union, the deputy director may require an applicant, licensee, active manager or responsible individual, an organizer, director or officer of any corporate applicant or licensee, any individual in control of a licensee or applicant, any individual who seeks to acquire control of a licensee or each key individual to submit a full set of fingerprints and fees to the department. The department of insurance and financial institutions shall submit the fingerprints and fees to the department of public safety, or the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor, 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.

B. The fees that the department collects under subsection A of this section shall be credited pursuant to section 35-148.

C. The applicant is responsible for providing the department with readable fingerprints. The applicant shall pay any costs that are attributable to refingerprinting due to the unreadability of any fingerprints and any fees that are required for the resubmission of fingerprints.

D. The department may issue a temporary license or certificate or grant temporary permission to organize to an original applicant before the department receives the results of a criminal records check if there is not evidence or reasonable suspicion that the applicant has a criminal history background that would be cause for denial of a license, certificate or permission to organize. The department may terminate the temporary license or certificate or permission to organize if a fingerprint card is returned as unreadable and the applicant fails to submit new fingerprints within ten days after being notified by the department that the original card was unreadable or if the results of the criminal records check reveal grounds for the denial of the license or certificate or permission to organize. The temporary license or certificate or permission to organize shall not be effective longer than one hundred eighty days.

E. The deputy director may require a current licensee, organizer, director, active manager, responsible individual or officer of any corporate licensee to submit a full set of fingerprints to the department. The department of insurance and financial institutions shall submit the fingerprints and fees to the department of public safety 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.

F. This section does not affect the department's authority to otherwise issue, deny, cancel, terminate, suspend or revoke a license.

6-124. Investigations; compelling testimony and the production of documents; self-incrimination

A. The deputy director may conduct examinations and investigations within or outside this state to determine whether any person has engaged, is engaging or is about to engage in any act, practice or transaction which constitutes an unsafe or unsound practice or a violation of any law or rule applicable to persons subject to the jurisdiction of the deputy director or any order of the deputy director or to aid in the enforcement of this title or to aid in adopting rules.

B. The deputy director and any examiner or administrative law judge, in the performance of the deputy director's, examiner's or administrative law judge's duties, may take evidence, examine on oath any person and compel the attendance of witnesses and the production of documents, books and papers. On refusal to appear or produce, the deputy director may apply to the superior court in Maricopa county to compel appearance or production.

C. All financial institutions and enterprises shall, on request of the deputy director, make their books and records available for inspection and examination by the deputy director or the deputy director's examiners.

12-2212. Subpoena by public officer; contempt

A. When a public officer is authorized by law to take evidence, he may issue subpoenas, compel attendance of witnesses and production of documentary evidence, administer oaths to witnesses, and cause depositions to be taken, in like manner as in civil actions in the superior court.

B. If a witness fails to appear at the time and place designated in the subpoena, or fails to answer questions relating to the matter about which the officer is authorized to take testimony, or fails to produce a document, the officer may, by affidavit setting forth the facts, apply to the superior court of the county where the hearing is held, and the court shall thereupon proceed as though such failure had occurred in an action pending before it.

DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS
Title 20, Chapter 4, Article 6

Amend: R20-4-602, R20-4-603, R20-4-604, R20-4-607, R20-4-611, R20-4-612

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: August 1, 2023

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

FROM: Council Staff

DATE: July 13, 2023

SUBJECT: **DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS**
Title 20, Chapter 4, Article 6

Amend: R20-4-602, R20-4-603, R20-4-604, R20-4-607, R20-4-611, R20-4-612

Summary:

This regular rulemaking from the Department of Insurance and Financial Institutions (Department) seeks to amend six (6) rules in Title 20, Chapter 4, Article 6 related to Debt Management Companies. Specifically, the Department is proposing amendments to reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions on July 1, 2020. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article. Additionally, the Department is also endeavoring to modernize the current rules since the most recent rulemaking for this Article was in 2002. For example, the Department is proposing to remove the requirement that the current organizing documents be certified, eliminate the requirement to submit an Arizona Corporation Commission stamped annual report and certificate of disclosure, increase amount of time, from 10 days to 30 days, to notify the Department of any change in ownership or to the names of its officers, directors, trustees, partners, or managing agents, allow electronic recordkeeping, and remove the requirement to submit copies of all advertising to the Department.

The Department indicates some of the proposed amendments are to complete the Department's proposed course of action outlined in its 2019 Five-Year Review Report.

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

The Department 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?

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

4. Summary of the agency's economic impact analysis:

The Department states that the changes the Department is making will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions, on July 1, 2020. The former Department of Financial Institutions became a division of the new agency. The Department indicates that as a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article. The Department is also intending to modernize the current rules, but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to applicants and licensees.

Stakeholders include the Department and an entity or person who seeks to be licensed as a debt management company and an entity or person licensed by the Department as a debt management company.

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 believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of the regulation of Debt Management Companies.

6. What are the economic impacts on stakeholders?

The Department does not anticipate any costs or benefits in implementing and enforcing the proposed rulemaking. In addition, no political subdivision of this state is directly affected by the implementation of this rule. The Department indicates that the changes impose an additional litigation reporting requirement which should be a minimal cost to licenses. The Department believes the cost should be offset by the elimination of some requirements and the allowance of electronic recordkeeping. In addition, the Department increased the period of time a licensee may report changes of its ownership, or in the names of its officers, directors, trustees, partners, or managing agents from 10 days to 30 days. The Department believes this is a benefit to all licensees including small businesses.

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

The Department indicates it corrected a typographical error in the rules between the Notice of Proposed Rulemaking, which was published in the Administrative Register on January 13, 2023, and the Notice of Final Rulemaking now before the Council. Specifically, the Department states the second sentence in rule R20-4-612(B) in the Notice of Proposed Rulemaking was corrected to read, "[l]iquid assets do not include goodwill and other tangible intangible assets." The Department indicates the current Arizona Corporation Commission version of this Section contains the word "intangible."

Council staff does not believe these changes make the final rules substantially different from the proposed rules pursuant to A.R.S. § 41-1025.

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

The Department indicates it received no public 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?

The rules do not require the issuance of 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?

Not applicable. The Department indicates no federal law is applicable to the subject of these rules.

11. Conclusion

This regular rulemaking from the Department seeks to make structural changes to the rules as a result of the consolidation of the Department Insurance and Department of Financial Institutions in 2022, including replacing references to "Superintendent" with "Director" throughout the Article. Additionally, the Department is also endeavoring to modernize the current rules since the most recent rulemaking for this Article was in 2002. For example, the Department is proposing to remove the requirement that the current organizing documents be certified, eliminate the requirement to submit an Arizona Corporation Commission stamped annual report and certificate of disclosure, increase amount of time, from 10 days to 30 days, to notify the Department of any change in ownership or to the names of its officers, directors, trustees, partners, or managing agents, allow electronic recordkeeping, and remove the requirement to submit copies of all advertising to the Department.

The Department is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A). Council staff recommends approval of this rulemaking.

Arizona Department of Insurance and Financial Institutions
100 N 15th Avenue, Suite 261, Phoenix, Arizona 85007
(602) 364-3100 | difi.az.gov

Katie M. Hobbs, Governor
Barbara D. Richardson, Director

DATE: June 8, 2023

VIA EMAIL: grrc@azdoa.gov
Nicole Sornsin, Chair
Governor's Regulatory Review Council
100 North 15th Ave., Suite 305
Phoenix, AZ 85007

RE: Arizona Department of Insurance and Financial Institutions
Financial Institutions Division
A.A.C. Title 20, Chapter 4, Article 6 – Debt Management Companies

Dear Chairperson Sornsin:

Please find enclosed the Final Rulemaking for A.A.C. Title 20, Chapter 4, Article 6 – Debt Management Companies, being submitted by the Arizona Department of Insurance and Financial Institutions ("Department").

Pursuant to A.A.C. R1-6-201(A)(1), the Department responds as follows:

a. The Department closed the record on this rulemaking on February 12, 2023.
b. This rulemaking relates to the five-year review report submitted by the Arizona Department of Financial Institutions to the Council for Sections R20-4-602 and R20-6-603 and approved at the Council's February 4, 2020 Council Meeting.
c. The rulemaking does not establish a new fee.
d. The rulemaking does not contain a fee increase.
e. The rulemaking does not request an immediate effective date under A.R.S. § 41-1032.
f. The Department certifies that the preamble discloses a reference to any study relevant to the rule that it reviewed and either did or did not rely on in its evaluation of or justification for the rulemaking. The Department did not review or rely on any study relevant to the rulemaking.
g. No new full-time employees are necessary to implement and enforce the rule.
h. The following documents are also submitted to the Council with this cover letter:
    i. The Notice of Final Rulemaking;
    ii. An economic, small business, and consumer impact statement that contains the information required by A.R.S. § 41-1055;
    iii. The general and specific statutes authorizing the rulemaking.

By this submission, the Department is requesting approval of this rulemaking from the Council.

For questions about this rulemaking, please contact Mary Kosinski at (602) 364-3476 or mary.kosinski@difi.az.gov.

Sincerely,

Barbara D. Richardson

Barbara D. Richardson
Director

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

PREAMBLE

1. Articles, Parts, or Sections Affected (as applicable) **Rulemaking Action**

R20-4-602	Amend
R20-4-603	Amend
R20-4-604	Amend
R20-4-607	Amend
R20-4-611	Amend
R20-4-612	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. § 6-123(2)
Implementing statute: A.R.S. §§ 6-123(1) and (3), 6-704, 6-707, 6-709(A), (J), and (M), 6-710(1), and 6-714

3. The effective date of the rule:

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 29 A.A.R. 200, January 13, 2023
Notice of Proposed Rulemaking: 28 A.A.R. 135, January 13, 2023

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

Name: Mary E. Kosinski
Address: Department of Insurance and Financial Institutions
100 N. 15th Ave., Suite 261
Phoenix, Arizona 85007-2630
Telephone: (602)364-3476
E-mail: mary.kosinski@difi.az.gov
Web site: https://difi.az.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:

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 6 – Debt Management Companies. The statutory sections governing debt management companies are found at A.R.S. §§ 6-701 through 6-716.

The changes the Department is proposing will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions (the "new agency"), on July 1, 2020. The former Department of Financial Institutions became a division of the new agency.

As a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article.

When reviewing the rules in the Article, the Department also endeavored to modernize the current rules since the most recent rulemaking for this Article was in 2002. In addition, the changes made to Sections R20-4-602 and R20-4-603 are being made to fulfill a commitment made by the Department in a Five-Year Review in 2019.

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 and does not propose to rely on any study relevant to 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:

The rulemaking updates and removes some requirements for applicants and licensees. The rulemaking does not diminish a previous grant of authority granted to the Department.

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

Pursuant to A.R.S. § 41-1055(A)(1):

- The rulemaking is not designed to change any conduct of applicants seeking licensure with the Department or currently licensed with the Department. Instead, the rule replaces the obsolete title of "Superintendent" with "Director", removes unnecessary requirements, adds some new requirements for applicants and licensees, and allows electronic recordkeeping.
- The Department is not seeking to change any conduct because of a perceived harm.
- The Department is not seeking to change the frequency of any conduct.

Pursuant to A.R.S. § 41-1055(A)(2):

The Department anticipates the following probable costs:

1. To applicants for a debt management company license, the cost to order a credit report if required by the Director (R20-4-602(A));
2. To existing licensees, the cost to report all litigation not only pending litigation to the Department (R20-4-604(A)(6)).

The Department anticipates the following probable benefits:

1. To applicants for a debt management license:
   a. The modification of the requirement to obtain a fidelity bond to when required by the Director (R20-4-602(A)(2)); and
   b. Removal of the requirement that the current organizing documents be certified (R20-4-602(A)(7)).
2. To existing licensees:
   a. The elimination of the requirement to submit an Arizona Corporation Commission stamped annual report and certificate of disclosure (R20-4-603);
   b. An increased amount of time, from 10 days to 30 days, to notify the Department of any change in ownership or to the names of its officers, directors, trustees, partners, or managing agents (R20-4-603);
   c. Allowing electronic recordkeeping (R20-4-604); and
   d. Removing the requirement to submit copies of all advertising to the Department (R20-4-611).

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to applicants and licensees.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The Department corrected a typographical error which it published in the Notice of Proposed Rulemaking. (28 A.A.R. 135, January 13, 2023) The second sentence in the Notice of Proposed Rulemaking in Section R20-4-612(B) has been corrected to read "Liquid assets do not include goodwill and other ~~tangible~~ intangible assets." The current ACC version of this Section contains the word "intangible."

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

The Department published the Notice of Proposed Rulemaking for Debt Management Companies on January 13, 2023. (29 A.A.R. 135, January 13, 2023) At that time it also opened a 30-day Comment Period. During the Comment Period, no one submitted a comment to the Department or requested an Oral Proceeding.

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

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

Not applicable. The rule augments the statutory requirement for a debt management company to obtain a license from the Department to engage in the business, for compensation, of receiving money as an agent of a debtor for the purpose of distributing that money to the debtor's creditors in payment or partial payment of the debtor's obligations. A.R.S. § 6-703.

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:

No federal law is 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 formal analysis has been submitted to the Department that compares the rule's impact of the competitiveness of business in this state to the impact of business in other states.

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

No materials are incorporated by reference.

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. The rule was not previously made, amended or repealed as an emergency rule.

15. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE
CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS
ARTICLE 6. DEBT MANAGEMENT COMPANIES

Section
R20-4-602. Applications
R20-4-603. Reports
R20-4-604. Records
R20-4-607. Budget Analysis
R20-4-611. Advertising
R20-4-612. Solvency and Minimum Liquid Assets

ARTICLE 6. DEBT MANAGEMENT COMPANIES

R20-4-602. Applications

A. An applicant for a debt management company license shall send the Department an application on the form required by the ~~Superintendent.~~ Director. ~~The Department~~ If the Director determines that a credit report is required as authorized under A.R.S. § 6-704(A), the applicant shall order a credit report from a ~~local~~ credit reporting agency disclosing the credit history of the applicant's principals or managing agents~~.~~ and submit the credit report to the Department. ~~The Department shall direct the credit reporting agency to send the credit report directly to the Superintendent. The applicant shall pay the~~

~~cost of obtaining the credit report.~~ A complete application shall include the credit report required by this Section and all of the following:

1. The surety bond required by A.R.S. § 6-704(B);
2. ~~The fidelity bond~~ Fidelity bonds if required by the Director under A.R.S. § 6-704(D);
3. The nonrefundable application fee ~~and original license fee described in A.R.S. § 6-706, and~~ specified in A.R.S. § 6-126(A)(14);
4. ~~A sample of the contract intended to be used by the applicant;~~ An original license fee described in A.R.S. §§ 6-126(B), 6-126(D)(2), and 6-706;
5. ~~Current financial statements as described in Section~~ R20-4-604(A)(5); ~~A~~ A sample of the contract intended to be used by the applicant required by A.R.S. § 6-704(E);
6. ~~A certified copy of the current articles of incorporation, by-laws, partnership agreement or other organizing documents used to form the applicant business entity;~~ Current financial statements as described in Section R20-4-604(A)(5);
7. ~~Statements of personal history, on the form required by the Superintendent, for each of the applicant's principals, principal officers, trustees, partners, and managing agents.~~ A copy of the current articles of incorporation, by-laws, partnership agreement or other organizing documents used to form the applicant business entity;
8. The name and address information required under A.R.S. § 6-704(A); and
9. A background check, on the form required by the Department, for each of the applicant's principals, principal officers, trustees, partners, and managing agents.

B. A debt management company applying to operate a branch office or use an agency shall send the Department an application on the form required by the ~~Superintendent.~~ Director.

C. A debt management company applying to renew a license shall deliver, on or before June 15 of each year, an application to the Department on the form required by the ~~Superintendent.~~ Director. A debt management company shall apply separately to renew ~~the license of~~ each authorized business location. With each application for renewal, a debt management company shall include the renewal fee described in A.R.S. § 6-706 and specified in ~~A.R.S. § 6-126(C)(2).~~ A.R.S. § 6-126(D)(2).

D. The Department may require additional information the ~~Superintendent~~ Director considers necessary in connection with an application under this Section.

R20-4-603. Reports

A. Each debt management company and each nonprofit corporation or association exempt from licensure under A.R.S. § 6-702(4) and (5), shall send the Department an annual report of its business and operations for each place of business during the previous year beginning July 1 and ending June 30, using the form required by the ~~Superintendent.~~ Director. A debt management company shall deliver its report to the Department on or before August 15.

B. ~~Each debt management company organized as a corporation shall send the Department a copy, date-stamped by the Arizona Corporation Commission, of each annual report and certificate of disclosure filed under the authority of A.R.S. § 10-202 or 10-1622 within ten days of filing the report and certificate with the Arizona Corporation Commission.~~

C. Each debt management company shall notify the Department of any change in its ownership or in the names of its officers, directors, trustees, partners, or managing agents within ~~ten~~ 30 days of the change.

R20-4-604. Records

A. A debt management company shall keep books, accounts, and records adequate to provide a clear and readily understandable record of all its business activity. A debt management company may ~~use an electronic recordkeeping system. The Department shall not require a debt management company to keep a written copy of~~ keep its books, accounts, and records as electronic records if the debt management company can generate all information and documentation required by this Section ~~within three days of the Department's request for production of the records~~ in the timeframe set by the Department for examination or other purposes. A debt management company's books, accounts, and records shall include:

1. A file for each account containing:
    a. A copy of all correspondence concerning the account;
    b. Evidence of the notice given to creditors of the debt management contract;
    c. A subsidiary ledger disclosing all financial transactions concerning the account;
    d. A copy of each written statement of account given to the debtor;
    e. The original budget analysis required under Section R20-4-607; and
    f. The original contract between the debt management company and the debtor, including all amendments.

2. A trust account general ledger, which is kept current daily, ~~that~~ which reflects each deposit to and disbursement from the trust account.
3. Each reconciliation of the debt management company's trust account, prepared at least once a month.
4. A general ledger, kept current monthly, ~~that~~ which reflects each financial transaction by the debt management company except those recorded in its trust account general ledger.
5. A financial statement produced in accordance with generally accepted accounting principles at least once every three months, or more frequently if directed by the ~~Superintendent,~~ Director, ~~that~~ which reflects the financial condition of the debt management company. The financial statement shall include:
   a. A balance sheet,
   b. A statement of income and retained earnings,
   c. A statement of changes in financial condition, and
   d. Appropriate footnotes that either:
      i. Explain entries in the documents listed in subsections (A)(5)(a), (b), and (c);
      ii. Contain material information not required or not reportable in documents listed in subsections (A)(5)(a), (b), or (c); or
      iii. Contain other disclosures required by generally accepted accounting principles.
6. A record of all ~~pending~~ litigation naming the debt management company as a party~~. The debt management company shall keep, during the pendency of each case, a copy of the complaint, and a copy of any answer or motion filed by the debt management company in response to the complaint.~~ including:
   a. For pending litigation:
      i. A copy of the complaint;
      ii. A copy of any answer filed by the debt management company in response to the complaint; and
      iii. A copy of any motion filed by the debt management company; and
   b. For any litigation that is no longer pending, a copy of any judgment showing the settlement date, dismissal, or other final order disposing of the litigation.

B. All records required under this Section may be maintained at the debt management company's office in Arizona. A debt management company may keep its records outside this state if it:

1. Makes the records available to the ~~Superintendent,~~ Director, for examination or other purposes, in this state not more than three business days after demand; and
2. Allows its debtor customers to call toll free to obtain information from the records that ~~is~~ are not available from the debt management company's office in Arizona.

C. Each debt management company shall preserve its books, accounts, and records for the period required by A.R.S. §§ 6-709(J) and 6-710(1).

R20-4-607. Budget Analysis

A. A debt management company shall not accept an account unless it first concludes that the debtor can reasonably meet the payments agreed upon by the debt management company and the debtor. The debt management company's conclusion shall be supported by a written budget analysis kept in the company's records.

B. The written budget analysis shall either be part of an application form or a separate document. The debtor shall date and sign the written budget analysis before the debt management company draws any conclusions from the budget analysis.

C. The budget analysis shall disclose the disposable income available for payment to the debt management company after the debtor pays ~~its~~ their reasonable and necessary living expenses including taxes, insurance, child support, alimony, and residential rent or mortgage payments.

R20-4-611. Advertising

A. ~~A debt management company shall send the Department copies of all advertising, communication, or sales material at least five days before the company uses the advertising, communication, or sales material to promote the sale of the company's services. This requirement applies to every type of promotional material used, whether the company will publish, exhibit, broadcast, or personally distribute the material by any other method or medium.~~

~~B.~~ A debt management company shall not use advertising, communication, or sales material that contains:

1. A false, misleading, or deceptive statement about the debt management company's services or charges. A statement is a violation of this Section if the person making the statement does not state a material fact necessary to make the statement true, in light of the circumstances under which it is made;

2. A claim, direct or implied, that the debt management company consolidates debts or makes loans; or

3. A schedule of payments in any form.

~~C.~~**B.** A debt management company's advertising, communication, and sales material shall contain~~:~~

~~1. The name of the debt management company exactly as it appears on the current license; and~~

~~2. The~~ the following legend, conspicuously displayed in at least 12 point type and in bold print: "NOT A LOAN COMPANY."

~~**D.** The Department's failure to object to the advertising, communication, or sales material filed with it is not and shall not be represented as an approval of the material or the statements it contains.~~

R20-4-612. Solvency and Minimum Liquid Assets

A. A debt management company shall not operate if it is insolvent. For purposes of this Section "insolvent" has the same meaning as in A.R.S. § 47-1201(23).

B. To determine compliance with A.R.S. § 6-709(A), a debt management company's liquid assets include funds held in its trust account. Liquid assets do not include goodwill and other ~~tangible~~ intangible assets. A debt management company's total liquid assets shall exceed by $2,500.00 the total of all its current business liabilities together with all balances held for debtors as reflected in the company's subsidiary ledgers.

C. Except as otherwise provided by this Section, or in a specific ruling by the ~~Superintendent,~~ Director, a debt management company shall use generally accepted accounting principles to compute assets and liabilities.

A.R.S. § 41-1055(B) Economic, Small Business, And Consumer Impact Statement

Title 20. Commerce, Financial Institutions and Insurance

Chapter 4. Department of Insurance and Financial Institutions – Financial Institutions

Article 6. Debt Management Companies

A.R.S. § 41-1055(B)(1): An identification of the proposed rulemaking.

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 6 – Debt Management Companies. The statutory sections governing debt management companies are found at A.R.S. §§ 6-701 through 6-716.

The changes the Department is proposing will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions (the "new agency"), on July 1, 2020. The former Department of Financial Institutions became a division of the new agency.

As a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article.

When reviewing the rules in the Article, the Department also endeavored to modernize the current rules since the most recent rulemaking for this Article was in 2002. In addition, the changes made to Sections R20-4-602 and R20-4-603 are being made to fulfill a commitment made by the Department in a Five-Year Review in 2019.

Questions about this Economic Impact Statement can be directed to: Mary E. Kosinski (mary.kosinski@difi.az.gov).

A.R.S. § 41-1055(B)(2): An identification of the persons who will be directly affected by, bear the costs of or directly benefit from the proposed rulemaking.

This Article applies to an entity or person who seeks to be licensed as a debt management company and to an entity or person licensed by the Department as a debt management company. A debt management company means a business entity or natural person who, for compensation, engages in the business of receiving money as an agent of a debtor for the purpose of distributing that money to the creditors of the debtor in payment of the debtor's obligations. A.R.S. § 6-701(4).

A.R.S. § 41-1055(B)(3): A cost benefit analysis of the following:

(a) The probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking. The probable costs to the implementing agency shall include the number of new full-time employees necessary to implement and enforce the proposed rule. The preparer of the economic, small business and consumer impact statement shall notify the joint legislative budget committee of the number of new full-time employees necessary to implement and enforce the rule before the rule is approved by the council.

The Department does not anticipate any costs or benefits in implementing and enforcing the proposed rulemaking. No new full-time employees will be necessary to implement and enforce the proposed rulemaking.

(b) The probable costs and benefits to a political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.

No political subdivision of this state is directly affected by the implementation and enforcement of the proposed rulemaking.

(c) The probable costs and benefits to businesses directly affected by the proposed rulemaking, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the proposed rulemaking.

The Department anticipates the following probable costs:

1. To applicants for a debt management company license, the cost to order a credit report if required by the Director (R20-4-602(A));

2. To existing licensees, the cost to report all litigation, not only pending litigation, to the Department (R20-4-604(A)(6)).

The Department anticipates the following probable benefits:

1. To applicants for a debt management license:

    a. The modification of the requirement to obtain a fidelity bond to when required by the Director (R20-4-602(A)(2)); and

    b. Removal of the requirement that the current organizing documents be certified (R20-4-602(A)(7)).

2. To existing licensees:

    a. The elimination of the requirement to submit an Arizona Corporation Commission stamped annual report and certificate of disclosure (R20-4-603);

    b. An increased amount of time from 10 days to 30 days to notify the Department of any change in ownership or to the names of its officers, directors, trustees, partners, or managing agents (R20-4-603);

    c. Allowing electronic recordkeeping (R20-4-604); and

    d. Removing the requirement to submit copies of all advertising to the Department (R20-4-611).

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to applicants and licensees.

A.R.S. § 41-1055(B)(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 proposed rulemaking.

The Department does not anticipate any impact on the private employment of persons applying for licenses or holding licensees issued by the Department. Likewise, the Department does not anticipate any impact on public employment in the Department.

A.R.S. § 41-1055(B)(5): A statement of the probable impact of the proposed rulemaking on small businesses. The statement shall include:

(a) An identification of the small businesses subject to the proposed rulemaking.

"Small business" is defined as a concern, including its affiliates, which is:

a. Independently owned and operated,

b. Not dominant in its field,

c. Employs fewer than 100 full-time employees, and

d. Had gross annual receipts of less than $4 million in its last fiscal year.

A.R.S. § 41-1001(23).

The Department presumes that some of the businesses that apply for or hold a debt management license may be small businesses. However, it does not collect information about an entity's dominance in the field or the number of full-time employees. In addition, certain entities that may qualify as small businesses may be exempt from licensure under A.R.S. § 6-702.

(b) The administrative and other costs required for compliance with the proposed rulemaking.

The current changes to the Article impose an additional litigation reporting requirement which should be a minimal cost to licensees. This cost should be offset by the elimination of some requirements and the allowance of electronic recordkeeping.

(c) A description of the methods prescribed in section 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 to use each method.

A.R.S. § 41-1035 lists the following methods to reduce the impact on small businesses:

1. Establish less stringent compliance or reporting requirements in the rule for small businesses.

The Department did not establish a less stringent compliance or reporting requirements for debt management companies that are small businesses because

the additional litigation reporting requirement should be a minimal cost to existing licensees and only necessary when a licensee is involved in litigation.

2. Establish less stringent schedules or deadlines in the rule for compliance or reporting requirements for small businesses.

The Department did not establish a less stringent schedules or deadlines for debt management companies that are small businesses. Instead, the Department increased the period of time a licensee may report changes of its ownership, or in the names of its officers, directors, trustees, partners, or managing agents from 10 days to 30 days. This is a benefit to all licensees including small businesses.

3. Consolidate or simplify the rule's compliance or reporting requirements for small businesses.

The Department did not consolidate or simplify the rule's compliance or reporting requirements for debt management companies that are small businesses. Instead, the Department removed the requirement to submit an Arizona Corporation Commission stamped copy of the licensee's annual report or certificate of disclosure and the requirement to submit copies of all advertising to the Department. This is a benefit to all licensees including small businesses.

4. Establish performance standards for small businesses to replace design or operational standards in the rule.

The Department did not establish performance standards for small businesses that are debt management companies to replace design or operational standards in the rule. The performance standards required of licensees in the Article are applied to all licensees equally.

5. Exempt small businesses from any or all requirements of the rule.

The Department made no exemptions for small businesses in the rulemaking because it does not collect adequate information to determine which licensees may qualify as small businesses. The minimal additional costs imposed by the rulemaking to report all litigation instead of only pending litigation should be offset by the benefits afforded licensees, including small businesses.

(d) The probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.

The Department does not anticipate any cost or benefit to private persons and consumers.

A.R.S. § 41-1055(B)(6): A statement of the probable effect on state revenues.

No impact on state revenues is anticipated.

A.R.S. § 41-1055(B)(7): A 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 Department believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of the regulation of Debt Management Companies.

A.R.S. § 41-1055(B)(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. An agency advocating that any data is acceptable data has the burden of proving that the data is acceptable. For the purposes of this paragraph, "acceptable data" means empirical, replicable and testable data as evidenced in supporting documentation, statistics, reports, studies or research.

The rule is not based on any data.

Historical Note
Former Rule 28. R20-4-528 recodified from R4-4-528 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-529. Repealed

Historical Note
Former Rule 29. R20-4-529 recodified from R4-4-529 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-530. Repealed

Historical Note
Former Rule 30. R20-4-530 recodified from R4-4-530 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-531. Repealed

Historical Note
Former Rule 31. R20-4-531 recodified from R4-4-531 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-532. Repealed

Historical Note
Former Rule 32. R20-4-532 recodified from R4-4-532 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-533. Reserved

R20-4-534. Insurance

A. A licensee shall obtain written evidence of the borrower's voluntary election to purchase insurance in connection with a loan if the licensee's sale of insurance to the borrower is intended to secure repayment of a loan. The licensee shall retain this evidence of voluntary election in its records as required by statute. A document sufficient to comply with this Section shall read as follows:

TO SECURE REPAYMENT OF MY LOAN, I ELECT TO PURCHASE INSURANCE IN THE AMOUNT OF $ _____ .

I UNDERSTAND THAT MY TOTAL LOAN OBLIGATION IS THE SUM OF $ _____ .

B. A licensee shall obtain written evidence of the borrower's voluntary election to purchase property insurance in connection with a loan if the licensee's sale of property insurance to the borrower is intended to secure repayment of a loan. The licensee shall retain this evidence of voluntary election in its records as required by statute. A document sufficient to comply with this Section shall read as follows:

TO SECURE REPAYMENT OF MY LOAN, I ELECT TO PURCHASE PROPERTY INSURANCE IN THE AMOUNT OF $ _____ .

I UNDERSTAND THAT MY TOTAL LOAN OBLIGATION IS THE SUM OF $ _____ .

I ATTEST THAT THE VALUE OF MY PROPERTY INSURED IN CONNECTION WITH THIS LOAN IS THE SUM OF $ _____ .

Historical Note
Former Rule 34. R20-4-534 recodified from R4-4-534 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-535. Reserved

R20-4-536. Repealed

Historical Note
Former Rule 36. R20-4-536 recodified from R4-4-536 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

ARTICLE 6. DEBT MANAGEMENT COMPANIES

Article 6, consisting of Sections R4-4-601 through R4-4-620, adopted effective October 26, 1978, except that Sections R4-4-603, R4-4-604 and R4-4-607 shall become effective January 1, 1979. R20-4-601 through R20-4-620 recodified from R4-4-601 through R4-4-620 (Supp. 95-1).

Former Article 6 consisting of Section R4-4-601 repealed effective October 26, 1978. R20-4-601 recodified from R4-4-601 (Supp. 95-1).

R20-4-601. Repealed

Historical Note
Former Rule 1; Former Section R4-4-601 repealed, new Section R4-4-601 adopted effective October 26, 1978 (Supp. 78-5). R20-4-601 recodified from R4-4-601 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-602. Applications

A. An applicant for a debt management company license shall send the Department an application on the form required by the Superintendent. The Department shall order a credit report from a local credit reporting agency disclosing the credit history of the applicant's principals or managing agents. The Department shall direct the credit reporting agency to send the credit report directly to the Superintendent. The applicant shall pay the cost of obtaining the credit report. A complete application shall include the credit report required by this Section and all of the following:

1. The surety bond required by A.R.S. § 6-704(B);
2. The fidelity bond required by A.R.S. § 6-704(D);
3. The nonrefundable application fee and original license fee described in A.R.S. § 6-706, and specified in A.R.S. § 6-126(A)(14);
4. A sample of the contract intended to be used by the applicant;
5. Current financial statements as described in R20-4-604(A)(5);
6. A certified copy of the current articles of incorporation, by-laws, partnership agreement or other organizing documents used to form the applicant business entity; and
7. Statements of personal history, on the form required by the Superintendent, for each of the applicant's principals, principal officers, trustees, partners, and managing agents.

B. A debt management company applying to operate a branch office or use an agency shall send the Department an application on the form required by the Superintendent.

C. A debt management company applying to renew a license shall deliver, on or before June 15 of each year, an application to the Department on the form required by the Superintendent. A debt management company shall apply separately to renew the license of each authorized business location. With each application for renewal, a debt management company shall include the renewal fee described in A.R.S. § 6-706 and specified in A.R.S. § 6-126(C)(2).

D. The Department may require additional information the Superintendent considers necessary in connection with an application under this Section.

Historical Note

Adopted effective October 26, 1978 (Supp. 78-5). R20-4-602 recodified from R4-4-602 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-603. Reports

A. Each debt management company and each nonprofit corporation or association exempt from licensure under A.R.S. § 6-702(4) and (5), shall send the Department an annual report of its business and operations for each place of business during the previous year beginning July 1 and ending June 30, using the form required by the Superintendent. A debt management company shall deliver its report to the Department on or before August 15.

B. Each debt management company organized as a corporation shall send the Department a copy, date-stamped by the Arizona Corporation Commission, of each annual report and certificate of disclosure filed under the authority of A.R.S. § 10-202 or 10-1622 within ten days of filing the report and certificate with the Arizona Corporation Commission.

C. Each debt management company shall notify the Department of any change in its ownership or in the names of its officers, directors, trustees, partners, or managing agents within ten days of the change.

Historical Note

Adopted effective January 1, 1979 (Supp. 78-5). R20-4-603 recodified from R4-4-603 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-604. Records

A. A debt management company shall keep books, accounts, and records adequate to provide a clear and readily understandable record of all its business activity. A debt management company may use an electronic recordkeeping system. The Department shall not require a debt management company to keep a written copy of its books, accounts, and records if the debt management company can generate all information and documentation required by this Section within three days of the Department's request for production of the records for examination or other purposes. A debt management company's books, accounts, and records shall include:

1. A file for each account containing:
   a. A copy of all correspondence concerning the account;
   b. Evidence of the notice given to creditors of the debt management contract;
   c. A subsidiary ledger disclosing all financial transactions concerning the account;
   d. A copy of each written statement of account given to the debtor;
   e. The original budget analysis required under R20-4-607; and
   f. The original contract between the debt management company and the debtor, including all amendments.
2. A trust account general ledger, kept current daily, that reflects each deposit to and disbursement from the trust account.
3. Each reconciliation of the debt management company's trust account, prepared at least once a month.
4. A general ledger, kept current monthly, that reflects each financial transaction by the debt management company except those recorded in its trust account general ledger.
5. A financial statement produced in accordance with generally accepted accounting principles at least once every three months, or more frequently if directed by the Superintendent, that reflects the financial condition of the debt management company. The financial statement shall include:
   a. A balance sheet,
   b. A statement of income and retained earnings,
   c. A statement of changes in financial condition, and
   d. Appropriate footnotes that either:
      i. Explain entries in the documents listed in subsections (A)(5)(a), (b), and (c);
      ii. Contain material information not required or not reportable in documents listed in subsections (A)(5)(a), (b), or (c); or
      iii. Contain other disclosures required by generally accepted accounting principles.
6. A record of all pending litigation naming the debt management company as a party. The debt management company shall keep, during the pendency of each case, a copy of the complaint, and a copy of any answer or motion filed by the debt management company in response to the complaint.

B. All records required under this Section may be maintained at the debt management company's office in Arizona. A debt management company may keep its records outside this state if it:

1. Makes the records available to the Superintendent, for examination or other purposes, in this state not more than three business days after demand; and
2. Allows its debtor customers to call toll free to obtain information from the records that is not available from the debt management company's office in Arizona.

C. Each debt management company shall preserve its books, accounts, and records for the period required by A.R.S. §§ 6-709(J) and 6-710(1).

Historical Note

Adopted effective January 1, 1979 (Supp. 78-5). R20-4-604 recodified from R4-4-604 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-605. Reserved

R20-4-606. Reserved

R20-4-607. Budget Analysis

A. A debt management company shall not accept an account unless it first concludes that the debtor can reasonably meet the payments agreed upon by the debt management company and the debtor. The debt management company's conclusion shall be supported by a written budget analysis kept in the company's records.

B. The written budget analysis shall either be part of an application form or a separate document. The debtor shall date and sign the written budget analysis before the debt management company draws any conclusions from the budget analysis.

C. The budget analysis shall disclose the disposable income available for payment to the debt management company after the debtor pays its reasonable and necessary living expenses including taxes, insurance, child support, alimony, and residential rent or mortgage payments.

Historical Note
Adopted effective January 1, 1979 (Supp. 78-5). R20-4-607 recodified from R4-4-607 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-608. Reserved

R20-4-609. Repealed

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-609 recodified from R4-4-609 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-610. Repealed

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-610 recodified from R4-4-610 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-611. Advertising

A. A debt management company shall send the Department copies of all advertising, communication, or sales material at least five days before the company uses the advertising, communication, or sales material to promote the sale of the company's services. This requirement applies to every type of promotional material used, whether the company will publish, exhibit, broadcast, or personally distribute the material by any other method or medium.

B. A debt management company shall not use advertising, communication, or sales material that contains:
1. A false, misleading, or deceptive statement about the debt management company's services or charges. A statement is a violation of this Section if the person making the statement does not state a material fact necessary to make the statement true, in light of the circumstances under which it is made;
2. A claim, direct or implied, that the debt management company consolidates debts or makes loans; or
3. A schedule of payments in any form.

C. A debt management company's advertising, communication, and sales material shall contain:
1. The name of the debt management company exactly as it appears on the current license; and
2. The following legend, conspicuously displayed in at least 12 point type and in bold print:
"NOT A LOAN COMPANY."

D. The Department's failure to object to the advertising, communication, or sales material filed with it is not and shall not be represented as an approval of the material or the statements it contains.

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-611 recodified from R4-4-611 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-612. Solvency and Minimum Liquid Assets

A. A debt management company shall not operate if it is insolvent. For purposes of this Section "insolvent" has the same meaning as in A.R.S. § 47-1201(23).

B. To determine compliance with A.R.S. § 6-709(A), a debt management company's liquid assets include funds held in its trust account. Liquid assets do not include goodwill and other intangible assets. A debt management company's total liquid assets shall exceed by $2,500.00 the total of all its current business liabilities together with all balances held for debtors as reflected in the company's subsidiary ledgers.

C. Except as otherwise provided by this Section, or in a specific ruling by the Superintendent, a debt management company shall use generally accepted accounting principles to compute assets and liabilities.

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-612 recodified from R4-4-612 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-613. Reserved

R20-4-614. Reserved

R20-4-615. Reserved

R20-4-616. Reserved

R20-4-617. Reserved

R20-4-618. Reserved

R20-4-619. Reserved

R20-4-620. Repealed

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-620 recodified from R4-4-620 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

ARTICLE 7. ESCROW AGENTS

R20-4-701. Change in Location of Business

An escrow agent shall mail the Superintendent written notice of any change in the location of the escrow agent's business. The escrow agent shall ensure that the Superintendent receives the notice at least five days before the escrow agent conducts business at the new location. The escrow agent shall mail the fee required by A.R.S. § 6-126(A), together with the current escrow license, to the Superintendent with the notice of the location change. The Superintendent shall change the submitted license to reflect the new business location and return it to the escrow agent.

Historical Note
Former Rule 1. R20-4-701 recodified from R4-4-701 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-702. Account Practices and Records

An escrow agent shall maintain records to enable the Superintendent to reconstruct the details of each escrow transaction. The records shall include the following:
1. The seller's name and address;
2. The buyer's name and address;
3. The lender's name and address, if any;
4. The borrower's name and address, if any;
5. The real estate agent's name and address, if any;
6. Complete escrow instructions;
7. Records and supporting documentation for each receipt and disbursement made through the escrow; and
8. A copy of the escrow settlement.

Authorizing Statute: A.R.S. § 6-123(2)

6-123. Deputy director; powers

In addition to the other powers, express or implied, the deputy director may:

1. Exercise all powers that are necessary for the administration and enforcement of the laws and rules relating to financial institutions and enterprises.

2. In accordance with title 41, chapter 6, adopt rules that are necessary or appropriate to administer, enforce and accomplish the purposes of this title and adopt rules and issue orders that limit transactions between financial institutions or enterprises and the directors, officers or employees of the financial institutions or enterprises.

3. Require appropriate records, documents, information and reports from any financial institution or enterprise.

4. Submit to the department of public safety, or the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor, the name and fingerprints of any applicant, licensee, active manager or responsible individual or the name and fingerprints of any organizer, director or officer of any corporate applicant or licensee for:

(a) A banking permit.

(b) Permission to organize a savings and loan association or credit union.

(c) Any license.

(d) Any certificate.

(e) Authority to engage in interstate banking and branching in this state.

The department of public safety shall report the criminal record, if any, of such applicant, licensee or organizer, director or officer of such corporate applicant or licensee within ninety days after receipt of the deputy director's request.

5. Employ appraisers to appraise any property that is owned or held as security by any financial institution or enterprise. The reasonable expenses and compensation of such appraisers shall be paid by the financial institution or enterprise.

6. Hold membership in, pay dues to and attend the convention of the national and regional organizations of state officials occupying like offices or performing similar functions.

7. Cooperate with other regulatory agencies and professional associations to promote the efficient, safe and sound operation and regulation of interstate banking and branching activities, including the formulation of interstate examination policies and procedures and the drafting of model rules and agreements.

8. Participate in the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor. The deputy director may allow the system to collect licensing fees on behalf of the deputy director, to collect a processing fee for the services of the system directly from each applicant for a license or licensee and to process and maintain records on behalf of the deputy director, including information collected pursuant to this section and section 6-123.01. This paragraph does not affect the records disclosure requirements and limitations prescribed in section 6-129.01.

Implementing Statutes: A.R.S. §§ 6-123(1) and (3), 6-704, 6-707, 6-709(A), (J), and (M), 6-710(1) and 6-714

6-123. Deputy director; powers

In addition to the other powers, express or implied, the deputy director may:

1. Exercise all powers that are necessary for the administration and enforcement of the laws and rules relating to financial institutions and enterprises.

2. In accordance with title 41, chapter 6, adopt rules that are necessary or appropriate to administer, enforce and accomplish the purposes of this title and adopt rules and issue orders that limit transactions between financial institutions or enterprises and the directors, officers or employees of the financial institutions or enterprises.

3. Require appropriate records, documents, information and reports from any financial institution or enterprise.

4. Submit to the department of public safety, or the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor, the name and fingerprints of any applicant, licensee, active manager or responsible individual or the name and fingerprints of any organizer, director or officer of any corporate applicant or licensee for:

(a) A banking permit.

(b) Permission to organize a savings and loan association or credit union.

(c) Any license.

(d) Any certificate.

(e) Authority to engage in interstate banking and branching in this state.

The department of public safety shall report the criminal record, if any, of such applicant, licensee or organizer, director or officer of such corporate applicant or licensee within ninety days after receipt of the deputy director's request.

5. Employ appraisers to appraise any property that is owned or held as security by any financial institution or enterprise. The reasonable expenses and compensation of such appraisers shall be paid by the financial institution or enterprise.

6. Hold membership in, pay dues to and attend the convention of the national and regional organizations of state officials occupying like offices or performing similar functions.

7. Cooperate with other regulatory agencies and professional associations to promote the efficient, safe and sound operation and regulation of interstate banking and branching activities, including the formulation of interstate examination policies and procedures and the drafting of model rules and agreements.

8. Participate in the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor. The deputy director may allow the system to collect licensing fees on behalf of the deputy director, to collect a processing fee for the services of the system directly from each applicant for a license or licensee and to process and maintain records on behalf of the deputy director, including information collected pursuant to this section and section 6-123.01. This paragraph does not affect the records disclosure requirements and limitations prescribed in section 6-129.01.

6-704. Application for license; bonds; contract

A. An application for a license shall be in writing, under oath and in a form prescribed by the deputy director, and shall contain the name and address, both of the residence and place of business, of the applicant and if the applicant is an association or society, of every member thereof, and if a corporation or partnership, of every officer and director thereof and a copy of the articles of incorporation, and the specific address or addresses at which the business is to be conducted. The deputy director may require as part of the application a credit report and such other information as the deputy director deems necessary.

B. At the time of filing the application the applicant shall furnish a cash or surety bond payable to the people of the state in the sum of not less than $5,000 for licensees disbursing less than $100,000 each year and for the following amounts based on the amounts disbursed by the licensee in the previous license year:

Yearly disbursements	Amount of bond
$100,000 - $250,000	$10,000.00
$250,001 - $500,000	$15,000.00
$500,001 - $1,000,000	$20,000.00
More than $1,000,000	$25,000.00

C. Each bond prescribed in subsection B of this section shall be conditioned on the faithful accounting of all monies collected on accounts entrusted to such person engaged in debt management, and their employees and agents, and on the faithful observance of the provisions of this article and the contract between the licensee and the debtor. The bond shall be approved by the deputy director and filed in the office of the deputy director. The bond shall remain in force and effect until the surety is released from liability by the deputy director, or until the surety bond is canceled by the surety. The surety may cancel the surety bond and be relieved of further

liability by delivering thirty days' written notice to the deputy director. The cancellation does not affect any liability incurred or accrued prior to the termination of the thirty-day period. Any person who suffers any loss or damage by reason of the neglect or default of a licensee or his employees or agents or by the licensee's violation of any of the provisions of this article or of the contract between the licensee and the debtor shall have a right of action against the licensee and the sureties on his bond. An action may not be brought on the bond by any person after the expiration of two years after the time when the act or default occurred. When an action is commenced on the bond of a licensee, the deputy director may require the filing of a new bond, and immediately on the recovery of any action on the bond the licensee shall file a new bond. Failure to file a new bond within ten days after the recovery on a bond, or within ten days after notification that a bond is required, constitutes sufficient grounds for the suspension or revocation of a license.

D. In addition to the bond provided in subsection B of this section, the deputy director may require an applicant to obtain an adequate fidelity bond for each officer, employee, or agent having access to funds collected by or for the licensee or having authority to draw against such funds. The fidelity bond required to be filed in accordance with this section shall remain in force and effect until the surety is released from liability by the deputy director, or until the bond is canceled by the surety. The surety may cancel the bond and be relieved of further liability by delivering thirty days' written notice to the deputy director. The cancellation shall not affect any liability incurred or accrued prior to the termination of the thirty-day period.

E. Each applicant for a license shall file with his application a blank copy of the contract intended to be used between the licensee and the debtor and shall file with the deputy director a copy of all changes and amendments thereto.

6-707. Issuance of license; display; renewal

A. On the filing of the application and the payment of the fees and the approval of the bond, or bonds, the deputy director shall investigate the facts, and if the deputy director finds that the financial responsibility and experience of the applicant are such as to command the confidence of the community to warrant belief that the business will be operated fairly and honestly and within the purposes of this article, the deputy director shall issue the applicant a license to do business as a debt management company.

B. The license shall be kept conspicuously posted in the business office of the licensee. The license is not transferable or assignable.

C. Licenses expire on June 30 following the date of the issuance unless sooner surrendered, revoked or suspended but may be renewed by filing an application with the deputy director on or before June 15 each year. The application for renewal shall be in the form prescribed by the deputy director and shall be accompanied by the fee prescribed in section 6-126. A separate application shall be made for each initial license of a principal place of business, agency or branch office.

6-709. Requirements

A. A licensee at all times shall maintain minimum liquid assets of at least $2,500 in excess of the licensee's business liabilities and of the licensee's liabilities on account of monies received in the business of a debt management company. The deputy director may determine by general rule what assets are liquid assets within the meaning of this section and may determine by specific ruling or demand that a particular asset is or is not a liquid asset within the meaning of this section.

B. A licensee shall make a written contract between the licensee and a debtor and immediately furnish the debtor with a copy of the completed contract. The licensee shall concurrently furnish the debtor with a list of the creditors, as of the time of the signing of the contract, with whom the licensee agrees to manage the debtor's obligations. All contracts shall contain a provision allowing the termination of the contract by either party at any time. Such termination shall be without penalty, except that the licensee shall retain the retainer fee if the termination is by the debtor. Termination shall only be on a five-day notice to the other party.

C. The basis of fees charged to a debtor by a licensee for assuming the responsibility of debt management shall be agreed on in advance and clearly stated in the contract. The fees charged to a debtor shall not exceed:

1. A retainer fee of $39.

2. Three-quarters of one percent of the total indebtedness or $50, whichever is less, may be charged monthly and shall be due and payable at the time such deposited funds are remitted to the creditors. Unusual and necessary "out of pocket" expense items by the licensee may be charged to the debtor's account if the incurrence of the expense has advance written approval of the debtor and deputy director.

D. The total debt shall be calculated not less often than annually and the charges adjusted based on the new total debt. Any fees charged by the licensee shall not be based on a total debt which includes a mortgage on the residence or a rent payment as a liability or a debt.

E. A licensee shall not be entitled to any fee until the licensee has given notice of the debt management contract to all creditors listed in the application form.

F. A licensee shall make remittances to creditors within seven days after receipt of any funds, unless the reasonable payment of one or more of the debtor's obligations requires that such funds be held for a longer period so as to accumulate a certain sum.

G. A licensee shall on request furnish the debtor with a written statement of the debtor's account each month or a verbal accounting at any time the debtor may request it during normal business hours.

H. A licensee shall, if a compromise of a debt is arranged by the licensee with any one or more creditors, allow the debtor the full benefit of that compromise.

I. A licensee shall maintain a trustee checking account in a bank in this state for the benefit of debtors in which all payments received from the debtors shall be deposited and in which all payments shall remain until disbursed by the licensee in accordance with the terms of the contract.

J. A licensee shall keep and use in the licensee's business books, accounts and records that will enable the deputy director to determine whether such licensee is complying with this article and with the rules of the department. Each licensee shall preserve such books, accounts and records for at least three years after making the final entry on any transaction recorded in the books, accounts or records.

K. If a licensee desires to change the licensee's place of business or the name of the company under which the license is issued, the licensee shall give written notice of the change within fifteen days to the deputy director and shall submit the license to the deputy director who shall enter an order allowing the change and who shall amend the license accordingly.

L. A licensee shall, within fifteen days after termination of a debt management company, a branch office or an agency, inform the deputy director of the name and address of such company, branch office or agency and shall surrender the license to the deputy director.

M. A licensee shall annually on or before August 15 file a report with the deputy director giving such relevant information as the deputy director may require concerning the business and operations of each place of business during the preceding year beginning July 1 and ending June 30. The deputy director may assess a penalty of $5 for each day the licensee fails to file such report.

6-710. Prohibitions

It is unlawful for a licensee to:

1. Accept an account unless it appears on the basis of a reasonable budget analysis, reduced to writing, that the debtor can reasonably meet the payments agreed on by the licensee and the debtor and that the agreed on payment is sufficient to pay the service charges to the licensee and the full amount of the proposed payments to creditors as agreed on by the licensee and debtor. The licensee shall retain the written budget analysis for at least three years after the termination of the contract in the files of the licensee. The licensee shall make the analysis available for inspection by the deputy director, except that such a budget analysis is not deemed unreasonable if facts that would prove it to be such were not furnished to the licensee by the debtor on request.

2. Unless agreed on by the debtor, attempt to alter any scheduled payment listed on the original application from the debtor to any figure other than the amount agreed on by the debtor and creditors in those cases when a contractual installment exists. Acceptance of the proposed payment by the creditor shall not alter any rights the creditor has under the creditor's original contract with the debtor.

3. Purchase from a creditor any obligation of a debtor.

4. Operate as a collection agent and as a licensee as to the same debtor's account.

5. Execute any contract or agreement to be signed by the debtor unless the contract or agreement is fully and completely filled in.

6. Receive or charge any fee in the form of a promissory note or other promise to pay or receive or accept any mortgage or other security for any fee either as to real or personal property.

7. Pay any bonus or other consideration to any person for the referral of a debtor to the person's business, nor accept or receive any bonus, commission or other consideration for referring any debtor to any person for any reason.

8. Advertise the licensee's services, display, distribute, broadcast or televise or allow to be displayed, advertised, distributed, broadcasted or televised the licensee's services in any manner whatsoever in which any false, misleading or deceptive statement or representation is made with regard to the services to be performed by the licensee or the charges to be made for those services.

6-714. Advertising

The rules and regulations of the deputy director shall include standards and criteria for proper advertising and may include specific prohibitions as to improper advertising by a licensee. A debt management company's advertising, communication and sales materials shall contain the license name or other assumed name or trade name that is submitted to the department pursuant to section 6-117.

DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS
Title 20, Chapter 4, Article 5

Amend: Article 5, R20-4-503, R20-4-508, R20-4-518, R20-4-59, R20-4-524, R20-4-534

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: August 1, 2023

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

FROM: Council Staff

DATE: July 13, 2023

SUBJECT: **DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS**
Title 20, Chapter 4, Article 5

Amend: Article 5, R20-4-503, R20-4-508, R20-4-518, R20-4-59, R20-4-524, R20-4-534

Summary:

This regular rulemaking from the Department of Insurance and Financial Institutions (Department) seeks to amend six (6) rules in Title 20, Chapter 4, Article 5 as well as amend the title of the Article from "Small Loans" to "Consumer Lenders." The Department is proposing this title change to allow a reader to more easily understand that the correlated statutory sections are contained in the Arizona Consumer Lenders Act, A.R.S. §§ 6-601 through 6-639. Additionally, the Department is proposing amendments to allow electronic recordkeeping without notification to the Director and removing the requirement for verbatim recitation of the rule language relating to insurance found at Section R20-4-534.

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

The Department 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?

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

4. Summary of the agency's economic impact analysis:

The rulemaking changes the title of the Article, updates some rule language for clarity, allows electronic recordkeeping without notice to the Director, and removes some unnecessary requirements.

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to licensees.

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 believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of the regulation of Consumer Lenders.

6. What are the economic impacts on stakeholders?

The Department anticipates the following probable benefits to licensees:

1. The removal of the requirement to notify the Director before using an electronic recordkeeping system; and
2. The removal of a verbatim recitation of rule language in connection with a consumer's purchase of insurance (R20-4-534).

The Department does not anticipate any probable costs to licensees.

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

Between the Notice of Proposed Rulemaking, which was published in the Administrative Register on January 20, 2023, and the Notice of Final Rulemaking now before the Council, the Department indicates it added A.R.S. § 6-612 (Rules) to the list of implementing statutes in Section 2 of the Preamble.

Council staff does not believe these changes make the final rules substantially different from the proposed rules pursuant to A.R.S. § 41-1025.

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

The Department indicates it received no public 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?

The rules do not require the issuance of 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?

The Department indicates the statutes governing consumer lending transactions work in conjunction with the federal Consumer Credit Protection Act (15 U.S.C. 1601 through 1666j) and the Alternative Mortgage Transactions Act (12 U.S.C. 3801 through 3806). In addition, the Department indicates the federal Truth in Lending regulations (12 CFR 3801 through 3806) apply to consumer lender transactions. The Department indicates the specific rules in this Article do not reference these federal laws or regulations directly.

11. Conclusion

This regular rulemaking from the Department seeks to amend six (6) rules in Title 20, Chapter 4, Article 5 as well as amend the title of the Article from "Small Loans" to "Consumer Lenders." The Department is proposing this title change to allow a reader to more easily understand that the correlated statutory sections are contained in the Arizona Consumer Lenders Act, A.R.S. §§ 6-601 through 6-639. Additionally, the Department is proposing amendments to allow electronic recordkeeping without notification to the Director and removing the requirement for verbatim recitation of the rule language relating to insurance found at Section R20-4-534.

The Department is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A). Council staff recommends approval of this rulemaking.

Arizona Department of Insurance and Financial Institutions
100 N 15th Avenue, Suite 261, Phoenix, Arizona 85007
(602) 364-3100 | difi.az.gov

Katie M. Hobbs, Governor
Barbara D. Richardson, Director

DATE: June 8, 2023

VIA EMAIL: grrc@azdoa.gov
Nicole Sornsin, Chair
Governor's Regulatory Review Council
100 North 15th Ave., Suite 305
Phoenix, AZ 85007

RE: Arizona Department of Insurance and Financial Institutions
Financial Institutions Division
A.A.C. Title 20, Chapter 4, Article 5 – Small Loans

Dear Chairperson Sornsin:

Please find enclosed the Final Rulemaking for A.A.C. Title 20, Chapter 4, Article 5 – Small Loans, being submitted by the Arizona Department of Insurance and Financial Institutions ("Department").

Pursuant to A.A.C. R1-6-201(A)(1), the Department responds as follows:

a. The Department closed the record on this rulemaking on February 19, 2023.
b. This rulemaking does not relate to a previous five-year review report. The Department of Financial Institutions submitted the previous five-year review report on this Article to the Council which it approved at the Council's April 2, 2019 Council Meeting.
c. The rulemaking does not establish a new fee.
d. The rulemaking does not contain a fee increase.
e. The rulemaking does not request an immediate effective date under A.R.S. § 41-1032.
f. The Department certifies that the preamble discloses a reference to any study relevant to the rule that it reviewed and either did or did not rely on in its evaluation of or justification for the rulemaking. The Department did not review or rely on any study relevant to the rulemaking.
g. No new full-time employees are necessary to implement and enforce the rule.
h. The following documents are also submitted to the Council with this cover letter:
    i. The Notice of Final Rulemaking;
    ii. An economic, small business, and consumer impact statement that contains the information required by A.R.S. § 41-1055;
    iii. The general and specific statutes authorizing the rulemaking.

By this submission, the Department is requesting approval of this rulemaking from the Council.

For questions about this rulemaking, please contact Mary Kosinski at (602) 364-3476 or mary.kosinski@difi.az.gov.

Sincerely,

Barbara D. Richardson

Barbara D. Richardson
Director

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

PREAMBLE

1. Articles, Parts, or Sections Affected (as applicable) Rulemaking Action

Article 5	Amend
R20-4-503	Amend
R20-4-508	Amend
R20-4-518	Amend
R20-4-519	Amend
R20-4-524	Amend
R20-4-534	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. § 6-123(2)
Implementing statute: A.R.S. §§ 6-607, 6-612, 6-634, 6-635, and 6-636

3. The effective date of the rule:

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 29 A.A.R. 249, January 20, 2023
Notice of Proposed Rulemaking: 28 A.A.R. 221, January 20, 2023

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

Name: Mary E. Kosinski
Address: Department of Insurance and Financial Institutions
100 N. 15th Ave., Suite 261
Phoenix, Arizona 85007-2630
Telephone: (602)364-3476
E-mail: mary.kosinski@difi.az.gov
Web site: https://difi.az.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:

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 5 – Small Loans. The statutory sections governing consumer lenders are found at A.R.S. §§ 6-601 through 6-639.

When reviewing the rules in the Article, the Department endeavored to clarify the language of the current rules since the most recent rulemaking for this Article was in 2000. The Department is changing the title of the Article to "Consumer Lenders" to allow a reader to more easily understand that the correlate statutory sections are contained in the Arizona Consumer Lenders Act, A.R.S. §§ 6-601 through 6-639. In addition, the Department is allowing electronic recordkeeping without notification to the Director and removing the requirement for verbatim recitation of the rule language relating to insurance found at Section R20-4-534.

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 and does not propose to rely on any study relevant to 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:

The rulemaking updates language and removes some requirements for licensees. The rulemaking does not diminish a previous grant of authority granted to the Department.

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

Pursuant to A.R.S. § 41-1055(A)(1):

- The rulemaking is not designed to change any conduct of licensees because of a perceived harm or to change the frequency of any violative conduct. Instead, the rulemaking changes the title of the Article, updates some rule language for clarity, allows electronic recordkeeping without notice to the Director, and removes some unnecessary requirements.

Pursuant to A.R.S. § 41-1055(A)(2):

The Department does not anticipate any probable costs to licensees.

The Department anticipates the following probable benefits to licensees:

1. The removal of the requirement to notify the Director before using an electronic recordkeeping system; and

2. The removal of a verbatim recitation of rule language in connection with a consumer's purchase of insurance (R20-4-534).

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to licensees.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The Department added A.R.S. § 6-612 (Rules) to the list of implementing statutes in item 2 of this Notice.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

The Department published the Notice of Proposed Rulemaking for Small Loans on January 20, 2023. (29 A.A.R. 221, January 20, 2023) At that time it also opened a 30-day Comment Period. During the Comment Period, no one submitted a comment to the Department or requested an Oral Proceeding.

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

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

Not applicable. The rulemaking does not address the licensing requirements for consumer lenders. Instead, the statutory sections require any person who seeks to be a consumer lender to obtain a license from the Department to advertise, hold themselves out, or to make or procure consumer lender loans to consumers in this state. A.R.S. § 6-603.

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

The statutes governing consumer lending transactions work in conjunction with the federal Consumer Credit Protection Act (15 U.S.C. 1601 through 1666j) and the Alternative Mortgage Transactions Act (12 U.S.C. 3801 through 3806). In addition, the federal Truth in Lending regulations (12 CFR 3801 through 3806) apply to consumer lender transactions.
The specific rules in this Article do not reference these federal laws or regulations directly.

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

No formal analysis has been submitted to the Department that compares the rule's impact of the competitiveness of business in this state to the impact of business in other states.

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

No materials are incorporated by reference.

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. The rule was not previously made, amended or repealed as an emergency rule.

15. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE
CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS
ARTICLE 5. ~~SMALL LOANS~~ CONSUMER LENDERS

Section

ARTICLE 5. ~~SMALL LOANS~~ CONSUMER LENDERS

R20-4-503. Adjustments in Precomputed Charges

A licensee shall adjust the total precomputed charges if the first installment period is more or less than one month ~~long.~~ in duration. The licensee's records shall reflect the adjustment's collection in one of three ways.

1. In the first installment payment,
2. Amortized over the life of the contract, or
3. As part of the final payment.

R20-4-508. Cut-off Date for Computing Refunds upon Early Repayment in Full

If a borrower repays a loan before the due date of the final installment, ~~a~~ the licensee shall calculate any refund or credit due on the precomputed loan using the following rules:

1. A licensee shall credit any full repayment, made on or before the 15th day following an installment date, as if received on the last previous installment date.
2. A licensee shall credit any full repayment, made on or after the 16th day following an installment date, as if received on the next installment date.

R20-4-518. Deferral Fee

A. A licensee may collect a deferral fee at the time it agrees to a deferment or at any time after the assessment of a deferral fee. If a licensee receives a payment ~~when~~ after it agrees to ~~the~~ a deferment, it may apply the payment first to the deferral fee. Any remainder of the payment shall be applied to the balance of the loan.

B. If a licensee receives a payment that is large enough to pay in full a delinquent installment and all allowable delinquency fees, the licensee shall apply the payment first to the delinquent installment and fees. The licensee shall not show the paid installment as deferred, and shall not collect a deferral fee.

R20-4-519. Deferment Statement

A licensee shall give the borrower a statement at the time ~~a deferment is made,~~ it agrees to a deferment and shall retain a copy of the statement in the borrower's credit file. The statement shall contain the following information:

1. The amount of the deferral fee,
2. The date of the borrower's next scheduled payment,
3. The amount of the borrower's next scheduled payment, and
4. The extended maturity date of the loan.

R20-4-524. Books, Accounts, and Records

A. A licensee may ~~use a computer recordkeeping system if the licensee gives the Superintendent advanced written notice that it intends to do so. The Department shall not require a licensee to keep a written copy of~~ keep its books, accounts, and records as electronic records if the licensee can generate all information and copies required by this Section ~~in a timely manner~~ within the timeframe set by the Department for examination or other purposes. ~~A licensee may modify a computer recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a licensee shall report to the Superintendent any modification that changes a computer system back to a paper-based recordkeeping system;~~

B. ~~A licensee shall keep its books, accounts, and records of operations licensed under A.R.S. Title 6, Chapter 5 separate from the books, accounts, and records of its other business activities.~~

A licensee authorized under A.R.S. Title 6, Chapter 5 shall:

1. Keep its books, accounts, and records of operations separate from the books, accounts, and records of its other business activities; and
2. In addition to any statutory requirements, the books, accounts, and records of operations shall include the following:
   a. A file containing a record of all legal actions brought during the fiscal year which the licensee shall keep until the Department conducts its examination of the licensee;
   b. An itemized record of disbursement of the proceeds of each loan which shall also include, if the licensee makes precomputed loans, the amount of refund on each loan that is renewed or refinanced;
   c. A record of the receipt of all allowable fees;
   d. A record for each borrower and each loan that contains documentary evidence of filing or recording each instrument of record for the loan; and
   e. A record of the borrower's voluntary election to purchase any insurance in connection with a loan if that insurance is sold by the licensee.

~~**C.** In addition to any statutory requirements, the books, accounts, and records maintained by a Small Loan Company shall include the following:~~

~~1. A file containing a record of all legal actions brought during the fiscal year. A licensee shall keep the file until the Department of Financial Institutions conducts its examination of the licensee.~~

~~2. An itemized record of disbursing the proceeds of each loan. The itemized record shall include the amount of refund on each loan that is renewed or refinanced if the licensee makes precomputed loans.~~

~~3. A record of the receipt of all allowable fees.~~

~~4. A record for each borrower and each loan that contains documentary evidence of filing or recording each instrument of record for the loan.~~

~~5. A record of the borrower's voluntary election to purchase any insurance in connection with a loan, if that insurance is sold by the licensee.~~

R20-4-534. Insurance

A. A licensee shall obtain written evidence of the borrower's voluntary election to purchase insurance in connection with a loan if the licensee's sale of insurance to the borrower is intended to secure repayment of a loan. The licensee shall retain this evidence of voluntary election in its records as required by statute. A document sufficient to comply with this Section shall read substantially as follows:

TO SECURE REPAYMENT OF MY LOAN, I ELECT TO PURCHASE INSURANCE IN THE AMOUNT OF $ _____ .

I UNDERSTAND THAT MY TOTAL LOAN OBLIGATION IS THE SUM OF $ _____ .

B. A licensee shall obtain written evidence of the borrower's voluntary election to purchase property insurance in connection with a loan if the licensee's sale of property insurance to the borrower is intended to secure repayment of a loan. The licensee shall retain this evidence of voluntary election in its records as required by statute. A document sufficient to comply with this Section shall read substantially as follows:

TO SECURE REPAYMENT OF MY LOAN, I ELECT TO PURCHASE PROPERTY INSURANCE IN THE AMOUNT OF $ _____ .

I UNDERSTAND THAT MY TOTAL LOAN OBLIGATION IS THE SUM OF $ _____ .

I ATTEST THAT THE VALUE OF MY PROPERTY INSURED IN CONNECTION WITH THIS LOAN IS THE SUM OF $ _____ .

A.R.S. § 41-1055(B) Economic, Small Business, And Consumer Impact Statement

Title 20. Commerce, Financial Institutions and Insurance

Chapter 4. Department of Insurance and Financial Institutions – Financial Institutions

Article 5. Small Loans

A.R.S. § 41-1055(B)(1): An identification of the proposed rulemaking.

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 5 – Small Loans. The statutory sections governing consumer lenders are found at A.R.S. §§ 6-601 through 6-639.

When reviewing the rules in the Article, the Department endeavored to clarify the language of the current rules since the most recent rulemaking for this Article was in 2000. The Department is changing the title of the Article to "Consumer Lenders" to allow a reader to more easily understand that the correlate statutory sections are contained in the Arizona Consumer Lenders Act, A.R.S. §§ 6-601 through 6-639. In addition, the Department is allowing electronic recordkeeping without notification to the Director and removing the requirement for verbatim recitation of the rule language regarding insurance in Section R20-4-534.

Questions about this Economic Impact Statement can be directed to: Mary E. Kosinski (mary.kosinski@difi.az.gov).

A.R.S. § 41-1055(B)(2): An identification of the persons who will be directly affected by, bear the costs of or directly benefit from the proposed rulemaking.

This Article applies to an entity or person who is licensed by the Department as a consumer lender. A consumer lender advertises, holds themselves out, or makes or procures consumer lender loans to consumers in this state. A.R.S. § 6-601(5). A consumer loan means the direct closed end loan of money, whether unsecured or secured by personal or real property, in an amount of $10,000 or less that is subject to a finance charge in which only the principal amount of the loan is considered, and not any finance

charges or other fees allowed pursuant to A.R.S. § 6-635, for the purpose of determining whether the consumer loan is $10,000 or less. A.R.S. § 6-601(7).

A.R.S. § 41-1055(B)(3): A cost benefit analysis of the following:

(a) The probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking. The probable costs to the implementing agency shall include the number of new full-time employees necessary to implement and enforce the proposed rule. The preparer of the economic, small business and consumer impact statement shall notify the joint legislative budget committee of the number of new full-time employees necessary to implement and enforce the rule before the rule is approved by the council.

The Department does not anticipate any costs or benefits in implementing and enforcing the proposed rulemaking. No new full-time employees will be necessary to implement and enforce the proposed rulemaking.

(b) The probable costs and benefits to a political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.

No political subdivision of this state is directly affected by the implementation and enforcement of the proposed rulemaking.

(c) The probable costs and benefits to businesses directly affected by the proposed rulemaking, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the proposed rulemaking.

The Department does not anticipate any probable costs to licensees.

The Department anticipates the following probable benefits to licensees:

1. The removal of the requirement to notify the Director before using an electronic recordkeeping system; and
2. The removal of a verbatim recitation of rule language in connection with a consumer's purchase of insurance (R20-4-534).

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to licensees.

A.R.S. § 41-1055(B)(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 proposed rulemaking.

The Department does not anticipate any impact on the private employment of persons holding licenses issued by the Department. Likewise, the Department does not anticipate any impact on public employment in the Department.

A.R.S. § 41-1055(B)(5): A statement of the probable impact of the proposed rulemaking on small businesses. The statement shall include:

(a) An identification of the small businesses subject to the proposed rulemaking.

"Small business" is defined as a concern, including its affiliates, which is:

a. Independently owned and operated,

b. Not dominant in its field,

c. Employs fewer than 100 full-time employees, and

d. Had gross annual receipts of less than $4 million in its last fiscal year.

A.R.S. § 41-1001(23).

The Department presumes that some of the businesses that apply for or hold a consumer lender license may be small businesses. However, it does not collect information about an entity's dominance in the field or the number of full-time employees.

(b) The administrative and other costs required for compliance with the proposed rulemaking.

The proposed changes to the Article do not impose any costs to licensees.

(c) A description of the methods prescribed in section 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 to use each method.

A.R.S. § 41-1035 lists the following methods to reduce the impact on small businesses:

1. Establish less stringent compliance or reporting requirements in the rule for small businesses.

The Department did not establish a less stringent compliance or reporting requirements for consumer lenders that are small businesses because the Department did not impose any additional costs to licensees in the rulemaking.

2. Establish less stringent schedules or deadlines in the rule for compliance or reporting requirements for small businesses.

The Department did not establish less stringent schedules or deadlines for consumer lenders that are small businesses because the Department did not impose any additional schedules or deadlines upon licensees in the rulemaking.

3. Consolidate or simplify the rule's compliance or reporting requirements for small businesses.

The Department did not consolidate or simplify the rule's compliance or reporting requirements for consumer lenders that are small businesses because the Department did not impose any additional compliance or reporting requirements upon licensees in the rulemaking.

4. Establish performance standards for small businesses to replace design or operational standards in the rule.

The Department did not establish performance standards for small businesses that are consumer lenders because the Department did not impose any additional performance standards upon licensees in the rulemaking.

5. Exempt small businesses from any or all requirements of the rule.

The Department made no exemptions for small businesses in the rulemaking because it does not collect adequate information to determine which licensees may qualify as small businesses and because it did not impose any additional requirements upon licensees with the rulemaking.

(d) The probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.

The Department does not anticipate any cost or benefit to private persons and consumers.

A.R.S. § 41-1055(B)(6): A statement of the probable effect on state revenues.

No impact on state revenues is anticipated.

A.R.S. § 41-1055(B)(7): A 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 Department believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of the regulation of Consumer Lenders.

A.R.S. § 41-1055(B)(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. An agency advocating that any data is acceptable data has the burden of proving that the data is acceptable. For the purposes of this paragraph, "acceptable data" means empirical, replicable and testable data as evidenced in supporting documentation, statistics, reports, studies or research.

The rule is not based on any data.

B. A fidelity bond purchased by a credit union to comply with this Section shall include faithful-performance-of-duty coverage.

C. A credit union shall purchase its fidelity bond from an insurer that holds a certificate of authority from the Arizona Director of Insurance to transact surety business in Arizona.

Historical Note
Former Rule 1. R20-4-401 recodified from R4-4-401 (Supp. 95-1). Amended effective April 21, 1995 (Supp. 95-2). Amended by final rulemaking at 7 A.A.R. 2229, effective May 3, 2001 (Supp. 01-2).

R20-4-402. Repealed

Historical Note
Former Rule 2. R20-4-402 recodified from R4-4-402 (Supp. 95-1). Repealed effective April 21, 1995 (Supp. 95-2).

ARTICLE 5. SMALL LOANS

R20-4-501. Repealed

Historical Note
Former Rule 1. R20-4-501 recodified from R4-4-501 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-502. Repealed

Historical Note
Former Rule 2. R20-4-502 recodified from R4-4-502 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-503. Adjustments in Precomputed Charges
A licensee shall adjust the total precomputed charges if the first installment period is more or less than one month long. The licensee's records shall reflect the adjustment's collection in one of three ways.

1. In the first installment payment,
2. Amortized over the life of the contract, or
3. As part of the final payment.

Historical Note
Former Rule 3. R20-4-503 recodified from R4-4-503 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-504. Repealed

Historical Note
Former Rule 4. R20-4-504 recodified from R4-4-504 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-505. Repealed

Historical Note
Former Rule 5. R20-4-505 recodified from R4-4-505 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-506. Repealed

Historical Note
Former Rule 6. R20-4-506 recodified from R4-4-506 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-507. Repealed

Historical Note
Former Rule 7. R20-4-507 recodified from R4-4-507 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-508. Cut-off Date for Computing Refunds upon Early Repayment in Full
If a borrower repays a loan before the due date of the final installment, a licensee shall calculate any refund or credit due on the precomputed loan using the following rules:

1. A licensee shall credit any full repayment, made on or before the 15th day following an installment date, as if received on the last previous installment date.
2. A licensee shall credit any full repayment, made on or after the 16th day following an installment date, as if received on the next installment date.

Historical Note
Former Rule 8. R20-4-508 recodified from R4-4-508 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, November 14, 2000 (Supp. 00-4).

R20-4-509. Repealed

Historical Note
Former Rule 9. R20-4-509 recodified from R4-4-509 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-510. Repealed

Historical Note
Former Rule 10. R20-4-510 recodified from R4-4-510 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-511. Repealed

Historical Note
Former Rule 11. R20-4-511 recodified from R4-4-511 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-512. Reserved

R20-4-513. Repealed

Historical Note
Former Rule 13. R20-4-513 recodified from R4-4-513 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-514. Repealed

Historical Note
Former Rule 14. R20-4-514 recodified from R4-4-514 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-515. Repealed

Historical Note
Former Rule 15. R20-4-515 recodified from R4-4-515 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-516. Repealed

Historical Note
Former Rule 16. R20-4-516 recodified from R4-4-516 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-517. Repealed

Historical Note
Former Rule 17. R20-4-517 recodified from R4-4-517 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-518. Deferral Fee

A. A licensee may collect a deferral fee at the time it agrees to a deferment or at any time after the assessment of a deferral fee. If a licensee receives a payment when it agrees to the deferment, it may apply the payment first to the deferral fee. Any remainder of the payment shall be applied to the balance of the loan.

B. If a licensee receives a payment that is large enough to pay in full a delinquent installment and all allowable delinquency fees, the licensee shall apply the payment first to the delinquent installment and fees. The licensee shall not show the paid installment as deferred, and shall not collect a deferral fee.

Historical Note
Former Rule 18. R20-4-518 recodified from R4-4-518 (Supp. 95-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-519. Deferment Statement

A licensee shall give the borrower a statement at the time a deferment is made, and shall retain a copy of the statement in the borrower's credit file. The statement shall contain the following information:

1. The amount of the deferral fee,
2. The date of the borrower's next scheduled payment,
3. The amount of the borrower's next scheduled payment, and
4. The extended maturity date of the loan.

Historical Note
Former Rule 19. R20-4-519 recodified from R4-4-519 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-520. Repealed

Historical Note
Former Rule 20. R20-4-520 recodified from R4-4-520 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-521. Repealed

Historical Note
Former Rule 21. R20-4-521 recodified from R4-4-521 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-522. Repealed

Historical Note
Former Rule 22. R20-4-522 recodified from R4-4-522 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-523. Repealed

Historical Note
Former Rule 23. R20-4-523 recodified from R4-4-523 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-524. Books, Accounts, and Records

A. A licensee may use a computer recordkeeping system if the licensee gives the Superintendent advanced written notice that it intends to do so. The Department shall not require a licensee to keep a written copy of its books, accounts, and records if the licensee can generate all information required by this Section in a timely manner for examination or other purposes. A licensee may modify a computer recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a licensee shall report to the Superintendent any modification that changes a computer system back to a paper-based recordkeeping system;

B. A licensee shall keep its books, accounts, and records of operations licensed under A.R.S. Title 6, Chapter 5 separate from the books, accounts, and records of its other business activities.

C. In addition to any statutory requirements, the books, accounts, and records maintained by a Small Loan Company shall include the following:

1. A file containing a record of all legal actions brought during the fiscal year. A licensee shall keep the file until the Department of Financial Institutions conducts its examination of the licensee.
2. An itemized record of disbursing the proceeds of each loan. The itemized record shall include the amount of refund on each loan that is renewed or refinanced if the licensee makes precomputed loans.
3. A record of the receipt of all allowable fees.
4. A record for each borrower and each loan that contains documentary evidence of filing or recording each instrument of record for the loan.
5. A record of the borrower's voluntary election to purchase any insurance in connection with a loan, if that insurance is sold by the licensee.

Historical Note
Former Rule 24. R20-4-524 recodified from R4-4-524 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-525. Repealed

Historical Note
Former Rule 25. R20-4-525 recodified from R4-4-525 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-526. Repealed

Historical Note
Former Rule 26. R20-4-526 recodified from R4-4-526 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-527. Repealed

Historical Note
Former Rule 27. R20-4-527 recodified from R4-4-527 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-528. Repealed

Historical Note
Former Rule 28. R20-4-528 recodified from R4-4-528 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-529. Repealed

Historical Note
Former Rule 29. R20-4-529 recodified from R4-4-529 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-530. Repealed

Historical Note
Former Rule 30. R20-4-530 recodified from R4-4-530 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-531. Repealed

Historical Note
Former Rule 31. R20-4-531 recodified from R4-4-531 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-532. Repealed

Historical Note
Former Rule 32. R20-4-532 recodified from R4-4-532 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-533. Reserved

R20-4-534. Insurance

A. A licensee shall obtain written evidence of the borrower's voluntary election to purchase insurance in connection with a loan if the licensee's sale of insurance to the borrower is intended to secure repayment of a loan. The licensee shall retain this evidence of voluntary election in its records as required by statute. A document sufficient to comply with this Section shall read as follows:

TO SECURE REPAYMENT OF MY LOAN, I ELECT TO PURCHASE INSURANCE IN THE AMOUNT OF $ _____ .

I UNDERSTAND THAT MY TOTAL LOAN OBLIGATION IS THE SUM OF $ _____ .

B. A licensee shall obtain written evidence of the borrower's voluntary election to purchase property insurance in connection with a loan if the licensee's sale of property insurance to the borrower is intended to secure repayment of a loan. The licensee shall retain this evidence of voluntary election in its records as required by statute. A document sufficient to comply with this Section shall read as follows:

TO SECURE REPAYMENT OF MY LOAN, I ELECT TO PURCHASE PROPERTY INSURANCE IN THE AMOUNT OF $ _____ .

I UNDERSTAND THAT MY TOTAL LOAN OBLIGATION IS THE SUM OF $ _____ .

I ATTEST THAT THE VALUE OF MY PROPERTY INSURED IN CONNECTION WITH THIS LOAN IS THE SUM OF $ _____ .

Historical Note
Former Rule 34. R20-4-534 recodified from R4-4-534 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-535. Reserved

R20-4-536. Repealed

Historical Note
Former Rule 36. R20-4-536 recodified from R4-4-536 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

ARTICLE 6. DEBT MANAGEMENT COMPANIES

Article 6, consisting of Sections R4-4-601 through R4-4-620, adopted effective October 26, 1978, except that Sections R4-4-603, R4-4-604 and R4-4-607 shall become effective January 1, 1979. R20-4-601 through R20-4-620 recodified from R4-4-601 through R4-4-620 (Supp. 95-1).

Former Article 6 consisting of Section R4-4-601 repealed effective October 26, 1978. R20-4-601 recodified from R4-4-601 (Supp. 95-1).

R20-4-601. Repealed

Historical Note
Former Rule 1; Former Section R4-4-601 repealed, new Section R4-4-601 adopted effective October 26, 1978 (Supp. 78-5). R20-4-601 recodified from R4-4-601 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-602. Applications

A. An applicant for a debt management company license shall send the Department an application on the form required by the Superintendent. The Department shall order a credit report from a local credit reporting agency disclosing the credit history of the applicant's principals or managing agents. The Department shall direct the credit reporting agency to send the credit report directly to the Superintendent. The applicant shall pay the cost of obtaining the credit report. A complete application shall include the credit report required by this Section and all of the following:

1. The surety bond required by A.R.S. § 6-704(B);
2. The fidelity bond required by A.R.S. § 6-704(D);
3. The nonrefundable application fee and original license fee described in A.R.S. § 6-706, and specified in A.R.S. § 6-126(A)(14);
4. A sample of the contract intended to be used by the applicant;
5. Current financial statements as described in R20-4-604(A)(5);
6. A certified copy of the current articles of incorporation, by-laws, partnership agreement or other organizing documents used to form the applicant business entity; and
7. Statements of personal history, on the form required by the Superintendent, for each of the applicant's principals, principal officers, trustees, partners, and managing agents.

B. A debt management company applying to operate a branch office or use an agency shall send the Department an application on the form required by the Superintendent.

C. A debt management company applying to renew a license shall deliver, on or before June 15 of each year, an application to the Department on the form required by the Superintendent. A debt management company shall apply separately to renew the license of each authorized business location. With each application for renewal, a debt management company shall include the renewal fee described in A.R.S. § 6-706 and specified in A.R.S. § 6-126(C)(2).

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

ARTICLE 5. SMALL LOANS

Authorizing Statute: A.R.S. § 6-123(2)

6-123. Deputy director; powers

In addition to the other powers, express or implied, the deputy director may:

1. Exercise all powers that are necessary for the administration and enforcement of the laws and rules relating to financial institutions and enterprises.

2. In accordance with title 41, chapter 6, adopt rules that are necessary or appropriate to administer, enforce and accomplish the purposes of this title and adopt rules and issue orders that limit transactions between financial institutions or enterprises and the directors, officers or employees of the financial institutions or enterprises.

3. Require appropriate records, documents, information and reports from any financial institution or enterprise.

4. Submit to the department of public safety, or the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor, the name and fingerprints of any applicant, licensee, active manager or responsible individual or the name and fingerprints of any organizer, director or officer of any corporate applicant or licensee for:

(a) A banking permit.

(b) Permission to organize a savings and loan association or credit union.

(c) Any license.

(d) Any certificate.

(e) Authority to engage in interstate banking and branching in this state.

The department of public safety shall report the criminal record, if any, of such applicant, licensee or organizer, director or officer of such corporate applicant or licensee within ninety days after receipt of the deputy director's request.

5. Employ appraisers to appraise any property that is owned or held as security by any financial institution or enterprise. The reasonable expenses and compensation of such appraisers shall be paid by the financial institution or enterprise.

6. Hold membership in, pay dues to and attend the convention of the national and regional organizations of state officials occupying like offices or performing similar functions.

7. Cooperate with other regulatory agencies and professional associations to promote the efficient, safe and sound operation and regulation of interstate banking and branching activities, including the formulation of interstate examination policies and procedures and the drafting of model rules and agreements.

8. Participate in the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor. The deputy director may allow the system to collect licensing fees on behalf of the deputy director, to collect a processing fee for the services of the system directly from each applicant for a license or licensee and to process and maintain records on behalf of the deputy director, including information collected pursuant to this section and section 6-123.01. This paragraph does not affect the records disclosure requirements and limitations prescribed in section 6-129.01.

Implementing Statutes: A.R.S. §§ 6-607, 6-612, 6-634, 6-635, and 6-636

6-607. Books; accounts; records; access

A. A licensee shall maintain books, accounts and records that enable the deputy director to determine whether the licensee is in compliance with this chapter.

B. A licensee shall preserve its books, accounts and records of consumer lender loans for at least two years after making the final entry for any consumer lender loan. A licensee that uses an electronic record keeping system is not required to keep a written copy of the accounts and records if the licensee is able to generate all of the information required by this section in a timely manner for examination or other purposes.

C. Every licensee shall observe generally accepted accounting principles and practices.

D. A licensee shall make any books, accounts and records that are kept outside of this state available to the deputy director in this state not more than three business days after demand is made by the deputy director, or the deputy director may choose to perform the examination or investigation at the office of the licensee located outside this state.

E. For the purposes of this chapter, the deputy director or the deputy director's duly authorized representatives shall have access during normal business hours to the offices and places of business, files, safes and vaults of all licensees regarding that business or the subject matter of any examination, investigation or hearing.

6-612. Rules

The deputy director may adopt rules that are necessary to regulate the proper conduct of a licensee.

6-634. Precomputation of consumer loan

A. A precomputed consumer loan shall require repayment in substantially equal consecutive monthly installments of principal and finance charges combined. The first installment of a precomputed consumer loan is due not less than fifteen days but not more than forty-five days after the precomputed consumer loan is made. The licensee may precompute finance charges at the agreed consumer loan rate on scheduled unpaid principal balances and add those charges to the principal amount of the precomputed consumer loan. The licensee shall calculate the finance charges on precomputed loans on an annual basis of twelve months of thirty days per month. All computations are based on the assumption that all payments are made as scheduled. The licensee may round the consumer loan rate to the nearest one-quarter of one per cent.

B. If a precomputed consumer loan is prepaid in full, the licensee shall provide the consumer with a refund or credit of the precomputed finance charges that apply to all of the fully unexpired months of the precomputed consumer loan as originally scheduled, or if deferred, as deferred, and that follow the installment date nearest to the date of the prepayment. For this purpose the

applicable finance charge is the total of those finance charges that would have been made for each unexpired month by applying scheduled payments to unpaid balances of principal according to the actuarial method at that single consumer loan rate that would result in the original amount of precomputed finance charges on the consumer loan, assuming finance charges had not been precomputed at the agreed to consumer loan rate but had been computed by the actuarial method at the agreed to single consumer loan rate from the inception of the consumer loan.

C. The licensee may agree to defer payment of all wholly unpaid installments for one or more full months and extend the due date of each installment and the maturity of the precomputed consumer loan for the same amount of time. The deferment period is the month or months in which the consumer makes no scheduled payment or in which no payment is required by reason of the deferment. If a deferment is made, the licensee may charge and collect a deferral fee that is not more than the agreed to consumer loan rate applied to the amount or amounts deferred for the period of deferral without regard to differences in the lengths of months, but applied proportionately for a part of a month by counting each day as one-thirtieth of a month. The licensee may collect a deferral fee at the time the licensee assesses the deferral fee or at any time after the assessment. No rebate of deferral fees is required unless prepayment occurs before the due date of the first deferred installment.

D. If the maturity of a precomputed consumer loan is accelerated, the licensee shall reduce the outstanding balance of that precomputed consumer loan by the refund or credit of precomputed finance charges that the consumer would be entitled to receive pursuant to subsection B on prepayment in full on the date of acceleration. After application of that refund or credit, the licensee may charge and receive finance charges at the agreed to consumer loan rate computed on the unpaid balances of the consumer loan for the actual time outstanding from the installment date nearest the date of acceleration until paid in full.

E. The note or agreement evidencing a precomputed consumer loan may provide that the licensee, with or without accelerating maturity, may recompute the entire consumer loan on a per cent per month basis or may reduce the outstanding balance as of any installment date by the refund or credit of precomputed finance charges that the consumer would be entitled to receive pursuant to subsection B on prepayment in full on the installment date. After recomputing the loan or applying the refund or credit of precomputed finance charges, the licensee may charge and receive finance charges at the agreed to consumer loan rate computed on unpaid balances of the consumer loan for the actual time outstanding from the installment date until the consumer loan is paid in full.

6-635. Other allowable fees; annual reporting

A. In addition to the finance charges authorized by section 6-632, a licensee may contract for and receive, and collect finance charges on, the following fees:

1. A delinquency charge in an amount equal to five percent of the amount of any installment not paid in full within seven days after its due date.

2. The actual costs of charges that are paid to a third party who is not an employee of the licensee and that are incurred in making consumer lender loans secured in whole or in part by real property, including the charges for a preliminary title search, title examination and report, title insurance premiums, property survey and appraisal fees.

3. Lawful fees for the acknowledging, filing and recording, continuing or releasing in any public office of any instrument or financing statement evidencing or perfecting a lien or security interest in real or personal property securing a consumer lender loan or the premiums paid for insurance in lieu of filing or recording that shall not exceed the filing or recording fee.

4. A loan origination fee of not more than five percent of a closed end consumer loan or the agreed credit limit of a consumer revolving loan but in no event in an amount that is more than $150. A licensee shall not charge a loan origination fee:

(a) For the refinancing of a closed end consumer loan or the renegotiating of an agreed credit limit of a consumer revolving loan if the refinancing or renegotiating occurs within one year of the collection of a prior loan origination fee.

(b) If the licensee charges prepaid finance charges pursuant to section 6-632, subsection E, paragraph 1.

5. Deferral fees authorized in section 6-634 for precomputed consumer loans.

6. Insurance premiums as provided in section 6-636.

7. Court costs.

8. Reasonable attorney fees if the consumer lender loan is referred for collection to an attorney other than a salaried employee of the licensee.

9. Costs, expenses and fees authorized in section 33-813, subsection B for reinstatement of a deed of trust encumbering real property that secures a consumer lender loan.

10. Costs and expenses of exercising the power of sale in a deed of trust encumbering real property that secures a consumer lender loan and costs and expenses of a sale that are included in a credit bid or that are applied from the proceeds of a trustee's sale pursuant to section 33-812, including the payment of trustee fees and reasonable attorney fees actually incurred.

11. Costs and expenses of retaking, holding, preparing for sale and selling any personal property in accordance with title 47, chapter 9, article 6.

B. If a licensee receives a check, draft, negotiable order of withdrawal or similar instrument drawn on a depository institution that is offered by a consumer in full or partial payment on a consumer lender loan and the instrument is not paid or is dishonored by the depository institution, the licensee may charge and collect from the consumer a dishonored check service fee pursuant to section 44-6852.

C. In addition to the finance charges and fees provided in this article, the licensee shall not directly or indirectly charge, contract for or receive any further or other amount in connection with a consumer lender loan.

D. In conjunction with the reporting requirements prescribed in section 6-609, on or before October 1 each year, a licensee shall report to the deputy director the number of closed end consumer loans and consumer revolving loans under $1,000 made in the prior two years.

6-636. Insurance securing loan; cancellation; notice

A. The following types of insurance may be sold to the consumer in connection with a consumer lender loan and the consumer may contract for:

1. Property insurance covering any property securing a consumer lender loan.

2. Life insurance insuring the life of one or more consumers obligated on a consumer lender loan.

3. Credit disability insurance that provides indemnity for payments due on a consumer lender loan while any covered consumer has a disability.

4. Credit involuntary unemployment insurance that provides indemnity for payments due on a consumer lender loan while one or more consumers are involuntarily unemployed.

5. Accidental death and dismemberment insurance providing a benefit if death occurs as a result of an accident or if dismemberment occurs.

6. Disability income protection insurance providing a benefit if a total disability occurs during the term of insurance.

B. Any insurance purchased by a consumer from or through a licensee, except insurance on property securing a consumer lender loan, is optional, and a licensee shall not refuse to make a consumer lender loan based on the consumer's refusal to purchase the insurance. The consumer may cancel any insurance purchased in connection with a consumer lender loan for any reason at any time within thirty days after the consumer lender loan is made and shall mail or deliver a written notice of the cancellation to the licensee's place of business. If the consumer cancels the insurance pursuant to this subsection, the consumer is entitled to a full refund of any premiums paid for the insurance. Before executing the note or agreement evidencing a consumer lender loan that includes a premium for insurance, the licensee shall give the consumer the disclosures required to exclude those insurance premiums from the finance charge in accordance with the truth in lending act.

C. At the time the insurance is sold the licensee shall mail or deliver a written receipt or binder to the consumer. Within thirty days after mailing or delivering the written receipt or binder, the licensee shall deliver to the consumer, or if more than one, to any one of them, a policy or certificate of insurance covering any insurance purchased by or through the licensee or any

employee or affiliate of the licensee in connection with the consumer lender loan that sets forth the amount of any premium that the consumer has paid or is obligated to pay, the amount of insurance, the term of insurance and a description of the coverage. The policy or certificate may contain a mortgagee clause or other appropriate provisions to protect the insurable interest of the licensee.

D. All property insurance sold pursuant to this section shall bear a reasonable bona fide relation to the existing hazard or risk of loss and shall be written by an agent licensed in this state and by an insurance company authorized to conduct property insurance business in this state. A licensee shall not require the purchase of property insurance from the licensee or any employee, affiliate or associate of the licensee as a condition precedent to the making of a consumer lender loan. The licensee may otherwise designate the company in which the insurance shall be placed as long as the insurance company is authorized to conduct business in this state.

E. Property insurance, if sold by a licensee in connection with a consumer loan, is at the option of the consumer in an amount not exceeding the greater of the reasonable value of the property insured as designated in writing by the consumer or the approximate amount of the consumer loan and shall be for a term not exceeding the approximate term of the consumer loan. However, the amount of this property insurance may not exceed the designated value of the property insured.

F. If a licensee sells property insurance in connection with a consumer revolving loan or a home equity revolving loan, the amount of the property insurance shall not exceed the greater of the reasonable value of the property insured as designated in writing by the consumer or the agreed on credit limit. However, the amount of property insurance shall not exceed the designated value of the insured property. The licensee may sell property insurance for renewable terms of not more than two years. Alternatively, the amount of property insurance may be equal to the balance outstanding on a consumer revolving loan or a home equity revolving loan from time to time with the premiums calculated on the basis of the actual daily unpaid balance or the average daily balance of the account during each billing cycle period. Premiums for property insurance may be charged as an advance on a consumer revolving loan or a home equity revolving loan.

G. If the licensee sells the consumer property insurance for a renewable term, the licensee shall mail a notice to the consumer at least thirty days before the renewal date that states all of the following:

1. The consumer's property insurance is about to expire.

2. The consumer may obtain property insurance from any source chosen by the consumer subject to the licensee's right to reasonably reject the insurer chosen by the consumer by providing written notice to the consumer of those reasons for rejection.

3. The term, coverage and premium for the renewal of property insurance.

4. The property insurance will be renewed on expiration unless the consumer provides the licensee before the expiration date with evidence that the consumer has obtained other property insurance.

H. Notwithstanding any other provision of this chapter, any advantage, commission, dividend, gain or identifiable charge for insurance authorized by this section, or otherwise, to the licensee or any employee or affiliate of the licensee from that insurance or its sale is not an additional finance charge or other allowed fee in connection with the consumer lender loan. If the licensee provides a new consumer lender loan or renews a contract of a consumer lender loan and the licensee sells the consumer new insurance, the licensee shall apply the insurance provided for in this section to the new loan or renewal, or the licensee shall cancel the prior insurance and provide the consumer with a refund or credit of the unearned premium or identifiable charge before selling the new insurance to the consumer.

I. The licensee shall determine the refund of unearned premiums for credit life insurance and credit disability insurance on prepayment in full according to title 20, chapter 6, article 10.

J. Except as otherwise specifically provided in this chapter, insurance transactions pursuant to this chapter are subject in all respects to the applicable laws pertaining to that insurance pursuant to title 20 and to the applicable rules adopted pursuant to title 20.

DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS
Title 20, Chapter 4, Article 7

Amend: R20-4-701, R20-4-702, R20-4-703, R20-4-704, R20-4-708

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: August 1, 2023

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

FROM: Council Staff

DATE: July 13, 2023

SUBJECT: **DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS**
Title 20, Chapter 4, Article 7

Amend: R20-4-701, R20-4-702, R20-4-703, R20-4-704, R20-4-708

Summary:

This regular rulemaking from the Department of Insurance and Financial Institutions (Department) seeks to amend five (5) rules in Title 20, Chapter 4, Article 7 related to Escrow Agents. Specifically, the Department is proposing amendments to reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions on July 1, 2020. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article. Additionally, the Department is endeavoring to update some of the current requirements since most recent rulemaking for this Article was in 2001. For example, the Department is allowing electronic recordkeeping without notification to the Director and removing the requirement for a licensee to return a copy of the paper license to the Department when the licensee changes its business location.

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

The Department 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?

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

4. Summary of the agency's economic impact analysis:

The rulemaking seeks to modernize practices, correct references, and clarify language. The Department does not anticipate any costs or burdens in implementing and enforcing the proposed rulemaking. No new full-time employees will be necessary to implement and enforce the proposed rulemaking.

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 believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of the regulation of escrow agents.

6. What are the economic impacts on stakeholders?

Stakeholders of this rulemaking are identified as any entity or person who is licensed by the Department as an escrow agent. The rulemaking does not impose any additional requirements to stakeholders; there are no associated costs to the rulemaking. Benefits of the rulemaking include no longer needing to notify the Director when using an electronic recordkeeping system, no longer needing to return a paper copy of an escrow agent's license when it changes business location, and the removal of mailing requirements.

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

The Department indicates it made no changes between the Notice of Proposed Rulemaking 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?

The Department indicates it received no public 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?

The rules do not require the issuance of 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?

Not applicable. The Department indicates the statute governing escrow disbursements, A.R.S. § 6-843(A)(2), requires disbursements of monies in accordance with the Expedited Funds Availability Act (12 U.S.C. 4001 through 4010). The specific rules in this Article do not reference these federal laws.

11. Conclusion

This regular rulemaking from the Department seeks to amend five (5) rules in Title 20, Chapter 4, Article 7 related to Escrow Agents. Specifically, the Department is proposing amendments to reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions on July 1, 2020. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article. Additionally, the Department is endeavoring to update some of the current requirements since most recent rulemaking for this Article was in 2001. For example, the Department is allowing electronic recordkeeping without notification to the Director and removing the requirement for a licensee to return a copy of the paper license to the Department when the licensee changes its business location.

The Department is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A). Council staff recommends approval of this rulemaking.

Arizona Department of Insurance and Financial Institutions
100 N 15th Avenue, Suite 261, Phoenix, Arizona 85007
(602) 364-3100 | difi.az.gov

Katie M. Hobbs, Governor
Barbara D. Richardson, Director

DATE: June 8, 2023

VIA EMAIL: grrc@azdoa.gov
Nicole Sornsin, Chair
Governor's Regulatory Review Council
100 North 15th Ave., Suite 305
Phoenix, AZ 85007

RE: Arizona Department of Insurance and Financial Institutions
Financial Institutions Division
A.A.C. Title 20, Chapter 4, Article 7 – Escrow Agents

Dear Chairperson Sornsin:

Please find enclosed the Final Rulemaking for A.A.C. Title 20, Chapter 4, Article 7 – Escrow Agents, being submitted by the Arizona Department of Insurance and Financial Institutions ("Department").

Pursuant to A.A.C. R1-6-201(A)(1), the Department responds as follows:

a. The Department closed the record on this rulemaking on February 19, 2023.
b. This rulemaking relates to a five-year review report. The Department of Financial Institutions submitted the previous five-year review report on this Article to the Council in September, 2019. The Council approved the report at the Council's February 4, 202 Council Meeting.
c. The rulemaking does not establish a new fee.
d. The rulemaking does not contain a fee increase.
e. The rulemaking does not request an immediate effective date under A.R.S. § 41-1032.
f. The Department certifies that the preamble discloses a reference to any study relevant to the rule that it reviewed and either did or did not rely on in its evaluation of or justification for the rulemaking. The Department did not review or rely on any study relevant to the rulemaking.
g. No new full-time employees are necessary to implement and enforce the rule.
h. The following documents are also submitted to the Council with this cover letter:
    i. The Notice of Final Rulemaking;
    ii. An economic, small business, and consumer impact statement that contains the information required by A.R.S. § 41-1055;
    iii. The general and specific statutes authorizing the rulemaking.

By this submission, the Department is requesting approval of this rulemaking from the Council.

For questions about this rulemaking, please contact Mary Kosinski at (602) 364-3476 or mary.kosinski@difi.az.gov.

Sincerely,

Barbara D. Richardson

Barbara D. Richardson
Director

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

PREAMBLE

1. Articles, Parts, or Sections Affected (as applicable) Rulemaking Action

R20-4-701	Amend
R20-4-702	Amend
R20-4-703	Amend
R20-4-704	Amend
R20-4-708	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. § 6-123(2)
Implementing statute: A.R.S. §§ 6-126, 6-813, 6-817, 6-831and 6-837

3. The effective date of the rule:

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 29 A.A.R. 250, January 20, 2023

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

Name: Mary E. Kosinski
Address: Department of Insurance and Financial Institutions
100 N. 15th Ave., Suite 261
Phoenix, Arizona 85007-2630
Telephone: (602)364-3476
E-mail: mary.kosinski@difi.az.gov
Web site: https://difi.az.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:

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 7 – Escrow Agents. The statutory sections governing escrow agents are found at A.R.S. §§ 6-801 through 6-846.04.

The changes the Department is proposing will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions (the "new agency"), on July 1, 2020. The former Department of Financial Institutions became a division of the new agency.

As a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article.

When reviewing the rules in the Article, the Department also endeavored to update some of the current requirements since most recent rulemaking for this Article was in 2001. In addition, the Department is allowing electronic recordkeeping without notification to the Director and removing the requirement for a licensee to return a copy of the paper license to the Department when the licensee changes its business location. The Department also reviewed the commitment it made in a 2019 Five-Year Review to replace "settlement date" with "transaction" in Section R20-4-703. It decided, however, that the current language of the rule was clear and understandable and that no change to Section R20-4-703 is needed.

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 and does not propose to rely on any study relevant to 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:

The rulemaking removes some requirements for licensees. The rulemaking does not diminish a previous grant of authority granted to the Department.

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

Pursuant to A.R.S. § 41-1055(A)(1):

- The rulemaking is not designed to change any conduct of licensees because of a perceived harm or to change the frequency of any violative conduct. Instead, the rulemaking modernizes some requirements and allows electronic recordkeeping without notice to the Director.

Pursuant to A.R.S. § 41-1055(A)(2):

The Department does not anticipate any probable costs to licensees.

The Department anticipates the following probable benefits to licensees:

1. The removal of the requirement to notify the Director before using an electronic recordkeeping system; and
2. The removal of mailing requirements under Section R20-4-701.

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to licensees.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The Department made no changes to the Notice of Final Rulemaking from the Notice of Proposed 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 published the Notice of Proposed Rulemaking for Escrow Agents on January 20, 2023. (29 A.A.R. 224, January 20, 2023) At that time it also opened a 30-day Comment Period. During the Comment Period, no one submitted a comment to the Department or requested an Oral Proceeding.

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

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

Not applicable. The rulemaking does not address the licensing requirements for escrow agents. Instead, the statutory sections require any person who seeks to be an escrow agent to obtain a license from the Department to engage in or carry on, or to hold themselves out as engaging in or carrying on, the escrow business or act in the capacity of an escrow agent in this state. A.R.S. § 6-813.

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

The statute governing escrow disbursements, A.R.S. § 6-843(A)(2), requires disbursements of monies in accordance with the Expedited Funds Availability Act (12 U.S.C. 4001 through 4010). The specific rules in this Article do not reference these federal laws.

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

No formal analysis has been submitted to the Department that compares the rule's impact of the competitiveness of business in this state to the impact of business in other states.

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

No materials are incorporated by reference.

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. The rule was not previously made, amended or repealed as an emergency rule.

15. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE
CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS
ARTICLE 7. ESCROW AGENTS

Section

ARTICLE 7. ESCROW AGENTS

R20-4-701. Change in Location of Business

An escrow agent shall ~~mail the Superintendent written~~ submit to the Director notice of any change in the location of the escrow agent's business. The escrow agent shall ensure that the ~~Superintendent~~ Director receives the notice at least five days before the escrow agent conducts business at the new location. The escrow agent shall ~~mail~~ remit the fee required by A.R.S. § 6-126(A), ~~together with the current escrow license,~~ to the ~~Superintendent~~ Director with the notice of the location change. ~~The Superintendent shall change the submitted license to reflect the new business location and return it to the escrow agent.~~

R20-4-702. Account Practices and Records

An escrow agent shall maintain records to enable the ~~Superintendent~~ Director to reconstruct the details of each escrow transaction. The records shall include the following:

1. The seller's name and address;
2. The buyer's name and address;
3. The lender's name and address, if any;
4. The borrower's name and address, if any;
5. The real estate agent's name and address, if any;
6. Complete escrow instructions;
7. Records and supporting documentation for each receipt and disbursement made through the escrow; and
8. A copy of the escrow settlement.

R20-4-703. Preservation of Records

An escrow agent shall preserve the records, books, and accounts pertaining to each escrow transaction for at least three years following the final settlement date of the transaction. An escrow agent may ~~use an electronic recordkeeping system. The Department shall not require an escrow agent to keep a written copy of the records, books, and accounts~~ keep its records as electronic records if the escrow agent can generate

all information and copies of documents required by A.R.S. § 6-831 ~~in a timely manner~~ within the timeframe set by the Department for examination or other purposes.

R20-4-704. Subsidiary Account Records

An escrow agent shall maintain subsidiary account records that identify the funds deposited in each escrow~~.~~ account. The total of all credit balances in the subsidiary accounts shall always equal the balance of the general ledger control account.

R20-4-708. Financial Condition and Resources

The ~~Superintendent~~ Director shall consider the following criteria in evaluating an escrow agent's, other escrow agent's, or applicant's financial condition and resources under A.R.S. § 6-817:

1. Amount of positive net worth,
2. Amount of tangible net worth,
3. Amount of liquid assets,
4. Amount of cash provided by operations,
5. Ratio of debt to net worth,
6. Owner's personal financial resources,
7. Outside resources available,
8. Profitability,
9. Projected operating results,
10. Status as agent for a title insurance company, and
11. Sources of new business.

A.R.S. § 41-1055(B) Economic, Small Business, And Consumer Impact Statement

Title 20. Commerce, Financial Institutions and Insurance

Chapter 4. Department of Insurance and Financial Institutions – Financial Institutions

Article 7. Escrow Agents

A.R.S. § 41-1055(B)(1): An identification of the proposed rulemaking.

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 7 – Escrow Agents. The statutory sections governing escrow agents are found at A.R.S. §§ 6-801 through 6-846.04.

The changes the Department is proposing will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions (the "new agency"), on July 1, 2020. The former Department of Financial Institutions became a division of the new agency.

As a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article.

When reviewing the rules in the Article, the Department also endeavored to update some of the current requirements since most recent rulemaking for this Article was in 2001. In addition, the Department is allowing electronic recordkeeping without notification to the Director and removing the requirement for a licensee to return a copy of the paper license to the Department when the licensee changes its business location. The Department also reviewed the commitment it made in a 2019 Five-Year Review to replace "settlement date" with "transaction" in Section R20-4-703. It decided, however, that the current language of the rule was clear and understandable and that no change to Section R20-4-703 is needed.

Questions about this Economic Impact Statement can be directed to: Mary E. Kosinski (mary.kosinski@difi.az.gov).

A.R.S. § 41-1055(B)(2): An identification of the persons who will be directly affected by, bear the costs of or directly benefit from the proposed rulemaking.

This Article applies to an entity or person who is licensed by the Department as an escrow agent. An escrow agent is any person engaged in the business of accepting escrows. A.R.S. § 6-801(5).

A.R.S. § 41-1055(B)(3): A cost benefit analysis of the following:

(a) The probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking. The probable costs to the implementing agency shall include the number of new full-time employees necessary to implement and enforce the proposed rule. The preparer of the economic, small business and consumer impact statement shall notify the joint legislative budget committee of the number of new full-time employees necessary to implement and enforce the rule before the rule is approved by the council.

The Department does not anticipate any costs or benefits in implementing and enforcing the proposed rulemaking. No new full-time employees will be necessary to implement and enforce the proposed rulemaking.

(b) The probable costs and benefits to a political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.

No political subdivision of this state is directly affected by the implementation and enforcement of the proposed rulemaking.

(c) The probable costs and benefits to businesses directly affected by the proposed rulemaking, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the proposed rulemaking.

The Department does not anticipate any probably costs to licensees.

The Department anticipates the following probable benefits to licensees:

1. The removal of the requirement to notify the Director before using an electronic recordkeeping system;

2. The removal of the requirement to return a paper copy of the escrow agent's license when it changes its business location; and

3. The removal of mailing requirements.

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to licensees.

A.R.S. § 41-1055(B)(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 proposed rulemaking.

The Department does not anticipate any impact on the private employment of persons holding licenses issued by the Department. Likewise, the Department does not anticipate any impact on public employment in the Department.

A.R.S. § 41-1055(B)(5): A statement of the probable impact of the proposed rulemaking on small businesses. The statement shall include:

(a) An identification of the small businesses subject to the proposed rulemaking.

"Small business" is defined as a concern, including its affiliates, which is:

a. Independently owned and operated,

b. Not dominant in its field,

c. Employs fewer than 100 full-time employees, and

d. Had gross annual receipts of less than $4 million in its last fiscal year.

A.R.S. § 41-1001(23).

The Department presumes that some of the businesses that apply for or hold an escrow agent license may be small businesses. However, it does not collect information about an entity's dominance in the field or the number of full-time employees.

(b) The administrative and other costs required for compliance with the proposed rulemaking.

The proposed changes to the Article do not impose any costs to licensees.

(c) A description of the methods prescribed in section 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 to use each method.

A.R.S. § 41-1035 lists the following methods to reduce the impact on small businesses:

1. Establish less stringent compliance or reporting requirements in the rule for small businesses.

The Department did not establish a less stringent compliance or reporting requirements for escrow agents that are small businesses because the Department did not impose any additional costs to licensees in the rulemaking.

2. Establish less stringent schedules or deadlines in the rule for compliance or reporting requirements for small businesses.

The Department did not establish less stringent schedules or deadlines for escrow agents that are small businesses because the Department did not impose any additional schedules or deadlines upon licensees in the rulemaking.

3. Consolidate or simplify the rule's compliance or reporting requirements for small businesses.

The Department did not consolidate or simplify the rule's compliance or reporting requirements for escrow agents that are small businesses because the Department did not impose any additional compliance or reporting requirements upon licensees in the rulemaking.

4. Establish performance standards for small businesses to replace design or operational standards in the rule.

The Department did not establish performance standards for small businesses that are escrow agents and that are small businesses because the Department did not impose any additional performance standards upon licensees in the rulemaking.

5. Exempt small businesses from any or all requirements of the rule.

The Department made no exemptions for small businesses in the rulemaking because it does not collect adequate information to determine which licensees may qualify as small businesses and because it did not impose any additional requirements upon licensees with the rulemaking.

(d) The probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.

The Department does not anticipate any cost or benefit to private persons and consumers.

A.R.S. § 41-1055(B)(6): A statement of the probable effect on state revenues.

No impact on state revenues is anticipated.

A.R.S. § 41-1055(B)(7): A 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 Department believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of the regulation of Escrow Agents.

A.R.S. § 41-1055(B)(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. An agency advocating that any data is acceptable data has the burden of proving that the data is acceptable. For the purposes of this paragraph, "acceptable data" means empirical, replicable and testable data as evidenced in supporting documentation, statistics, reports, studies or research.

The rule is not based on any data.

Historical Note
Adopted effective January 1, 1979 (Supp. 78-5). R20-4-607 recodified from R4-4-607 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-608. Reserved

R20-4-609. Repealed

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-609 recodified from R4-4-609 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-610. Repealed

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-610 recodified from R4-4-610 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-611. Advertising

A. A debt management company shall send the Department copies of all advertising, communication, or sales material at least five days before the company uses the advertising, communication, or sales material to promote the sale of the company's services. This requirement applies to every type of promotional material used, whether the company will publish, exhibit, broadcast, or personally distribute the material by any other method or medium.

B. A debt management company shall not use advertising, communication, or sales material that contains:
1. A false, misleading, or deceptive statement about the debt management company's services or charges. A statement is a violation of this Section if the person making the statement does not state a material fact necessary to make the statement true, in light of the circumstances under which it is made;
2. A claim, direct or implied, that the debt management company consolidates debts or makes loans; or
3. A schedule of payments in any form.

C. A debt management company's advertising, communication, and sales material shall contain:
1. The name of the debt management company exactly as it appears on the current license; and
2. The following legend, conspicuously displayed in at least 12 point type and in bold print:
"NOT A LOAN COMPANY."

D. The Department's failure to object to the advertising, communication, or sales material filed with it is not and shall not be represented as an approval of the material or the statements it contains.

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-611 recodified from R4-4-611 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-612. Solvency and Minimum Liquid Assets

A. A debt management company shall not operate if it is insolvent. For purposes of this Section "insolvent" has the same meaning as in A.R.S. § 47-1201(23).

B. To determine compliance with A.R.S. § 6-709(A), a debt management company's liquid assets include funds held in its trust account. Liquid assets do not include goodwill and other intangible assets. A debt management company's total liquid assets shall exceed by $2,500.00 the total of all its current business liabilities together with all balances held for debtors as reflected in the company's subsidiary ledgers.

C. Except as otherwise provided by this Section, or in a specific ruling by the Superintendent, a debt management company shall use generally accepted accounting principles to compute assets and liabilities.

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-612 recodified from R4-4-612 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-613. Reserved

R20-4-614. Reserved

R20-4-615. Reserved

R20-4-616. Reserved

R20-4-617. Reserved

R20-4-618. Reserved

R20-4-619. Reserved

R20-4-620. Repealed

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-620 recodified from R4-4-620 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

ARTICLE 7. ESCROW AGENTS

R20-4-701. Change in Location of Business

An escrow agent shall mail the Superintendent written notice of any change in the location of the escrow agent's business. The escrow agent shall ensure that the Superintendent receives the notice at least five days before the escrow agent conducts business at the new location. The escrow agent shall mail the fee required by A.R.S. § 6-126(A), together with the current escrow license, to the Superintendent with the notice of the location change. The Superintendent shall change the submitted license to reflect the new business location and return it to the escrow agent.

Historical Note
Former Rule 1. R20-4-701 recodified from R4-4-701 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-702. Account Practices and Records

An escrow agent shall maintain records to enable the Superintendent to reconstruct the details of each escrow transaction. The records shall include the following:
1. The seller's name and address;
2. The buyer's name and address;
3. The lender's name and address, if any;
4. The borrower's name and address, if any;
5. The real estate agent's name and address, if any;
6. Complete escrow instructions;
7. Records and supporting documentation for each receipt and disbursement made through the escrow; and
8. A copy of the escrow settlement.

Historical Note

Former Rule 2. R20-4-702 recodified from R4-4-702 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-703. Preservation of Records

An escrow agent shall preserve the records, books, and accounts pertaining to each escrow transaction for at least three years following the final settlement date of the transaction. An escrow agent may use an electronic recordkeeping system. The Department shall not require an escrow agent to keep a written copy of the records, books, and accounts if the escrow agent can generate all information and copies of documents required by A.R.S. § 6-831 in a timely manner for examination or other purposes.

Historical Note

Former Rule 3. R20-4-703 recodified from R4-4-703 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-704. Subsidiary Account Records

An escrow agent shall maintain subsidiary account records that identify the funds deposited in each escrow. The total of all credit balances in the subsidiary accounts shall always equal the balance of the general ledger control account.

Historical Note

Former Rule 4. R20-4-704 recodified from R4-4-704 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-705. Reserved

R20-4-706. Repealed

Historical Note

Former Rule 6. R20-4-706 recodified from R4-4-706 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-707. Expired

Historical Note

Adopted effective June 25, 1993 (Supp. 93-2). R20-4-707 recodified from R4-4-707 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 21 A.A.R. 411, effective September 30, 2014 (Supp. 15-1).

R20-4-708. Financial Condition and Resources

The Superintendent shall consider the following criteria in evaluating an escrow agent's, other escrow agent's, or applicant's financial condition and resources under A.R.S. § 6-817:

1. Amount of positive net worth,
2. Amount of tangible net worth,
3. Amount of liquid assets,
4. Amount of cash provided by operations,
5. Ratio of debt to net worth,
6. Owner's personal financial resources,
7. Outside resources available,
8. Profitability,
9. Projected operating results,
10. Status as agent for a title insurance company, and
11. Sources of new business.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

ARTICLE 8. TRUST COMPANIES

R20-4-801. Definitions

In this Article, unless the context otherwise requires:

"Account" means the trust, estate, or other fiduciary relationship established with a trust department or trust company.

"Affiliate" has the meaning stated at A.R.S. § 6-801.

"Certificate" has the meaning stated at A.R.S. § 6-851.

"Fiduciary" has the meaning stated at A.R.S. § 6-851.

"Governing instrument" means a document, and all its operative amendments, that:

Creates a trust and regulates the trustee's conduct,

Creates an agency relationship between a trust department or trust company and a client, or

Otherwise evidences a fiduciary relationship between a trust department or trust company and a client.

"Investment responsibility" means full and unrestricted discretion to invest trust funds without direction from anyone as to any matter, including the terms of the trade or the identity of the broker.

"Person" has the meaning stated at A.R.S. § 1-215.

"Superintendent" has the meaning stated at A.R.S. § 6-851.

"Trust asset" means any property or property right held by a trust department or trust company for the benefit of another.

"Trust business" has the meaning stated at A.R.S. § 6-851.

"Trust company" has the meaning stated at A.R.S. § 6-851.

"Trust department" means a permittee under both A.R.S. § 6-201 et seq. and Article 2 of this Chapter that possesses a banking permit authorizing it to engage in trust business.

"Trust funds" means any money held by a trust department or trust company for the benefit of another.

"Trustor" means a person who creates or funds a trust, or both.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-801 recodified from R4-4-801 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-802. Reserved

R20-4-803. Reserved

R20-4-804. Repealed

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-804 recodified from R4-4-804 (Supp. 95-1). Repealed by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2).

R20-4-805. Reports

A. Within 90 days following each December 31, each trust department and trust company shall file an annual report of trust assets with the Superintendent on the form prescribed by the Superintendent. The annual report shall include the current market value of all trust assets held by the trust department or trust company as of December 31. The report shall also identify and briefly describe all transactions conducted in the

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

ARTICLE 7. ESCROW AGENTS

Authorizing Statute: A.R.S. § 6-123(2)

6-123. Deputy director; powers

In addition to the other powers, express or implied, the deputy director may:

1. Exercise all powers that are necessary for the administration and enforcement of the laws and rules relating to financial institutions and enterprises.

2. In accordance with title 41, chapter 6, adopt rules that are necessary or appropriate to administer, enforce and accomplish the purposes of this title and adopt rules and issue orders that limit transactions between financial institutions or enterprises and the directors, officers or employees of the financial institutions or enterprises.

3. Require appropriate records, documents, information and reports from any financial institution or enterprise.

4. Submit to the department of public safety, or the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor, the name and fingerprints of any applicant, licensee, active manager or responsible individual or the name and fingerprints of any organizer, director or officer of any corporate applicant or licensee for:

(a) A banking permit.

(b) Permission to organize a savings and loan association or credit union.

(c) Any license.

(d) Any certificate.

(e) Authority to engage in interstate banking and branching in this state.

The department of public safety shall report the criminal record, if any, of such applicant, licensee or organizer, director or officer of such corporate applicant or licensee within ninety days after receipt of the deputy director's request.

5. Employ appraisers to appraise any property that is owned or held as security by any financial institution or enterprise. The reasonable expenses and compensation of such appraisers shall be paid by the financial institution or enterprise.

6. Hold membership in, pay dues to and attend the convention of the national and regional organizations of state officials occupying like offices or performing similar functions.

7. Cooperate with other regulatory agencies and professional associations to promote the efficient, safe and sound operation and regulation of interstate banking and branching activities, including the formulation of interstate examination policies and procedures and the drafting of model rules and agreements.

8. Participate in the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor. The deputy director may allow the system to collect licensing fees on behalf of the deputy director, to collect a processing fee for the services of the system directly from each applicant for a license or licensee and to process and maintain records on behalf of the deputy director, including information collected pursuant to this section and section 6-123.01. This paragraph does not affect the records disclosure requirements and limitations prescribed in section 6-129.01.

Implementing Statutes: A.R.S. §§ 6-126, 6-813, 6-817, 6-831, and 6-837

6-126. Application fees for financial institutions and enterprises

A. The following nonrefundable fees are payable to the department with the filing of the following:

1. To apply for a banking permit, $1,000.

2. To apply for an amendment to a banking or savings and loan association permit, $1,000.

3. To establish each banking branch office, $750.

4. To move a banking office to other than an established office of a bank, $1,000.

5. To apply for a savings and loan association permit, $5,000.

6. To establish each savings and loan association branch office, $1,500.

7. To move an office of a savings and loan association to other than an established office, $1,000.

8. To organize and establish a credit union, $100.

9. To establish each credit union branch or to move a credit union office to other than an established office of a credit union, $250.

10. To organize and establish any other financial institutions for which an application or investigation fee is not otherwise provided by law, $1,000.

11. To acquire control of a financial institution other than a consumer lender, $5,000.

12. To apply for a trust company license, $1,000.

13. To apply for a commercial mortgage banker, mortgage banker, escrow agent or consumer lender license, $1,000.

14. To apply for a mortgage broker, commercial mortgage broker, sales finance company or debt management company license, $500.

15. To apply for a collection agency license, $1,500.

16. To apply for a branch office of an escrow agent, consumer lender, commercial mortgage banker, mortgage banker or trust company, $500.

17. To apply for a branch office of a mortgage broker, commercial mortgage broker, debt management company or sales finance company, $250.

18. To apply for approval for the merger or consolidation of two or more financial institutions, $5,000 per institution.

19. To apply for approval to convert from a national bank or federal savings and loan charter to a state chartered institution, $1,000.

20. To apply for approval to convert from a federal credit union to a state chartered credit union, $500.

21. To apply for approval to merge or consolidate two or more credit unions, $500 per credit union.

22. To change the licensee name on a financial institution or enterprise license, except for a loan originator or appraiser license, not more than $250.

23. To apply for a license pursuant to chapter 12, article 1 of this title, $1,500 plus $25 for each branch office and authorized delegate to a maximum of $4,500.

24. To acquire control of a person that is licensed pursuant to chapter 12, article 1 of this title or a controlling person pursuant to chapter 12 of this title, $2,500.

25. To receive the following publications:

(a) Quarterly bank and savings and loan statement of condition, not more than $10 per copy.

(b) Monthly summary of actions report, not more than $5 per copy.

(c) A list of licensees, a monthly pending actions report and all other in-house prepared reports or listings made available to the public, not more than $1 per page.

26. To apply for a loan originator license, an amount to be determined by the deputy director.

27. To apply for a loan originator license transfer, an amount to be determined by the deputy director.

28. To apply for a conversion from a mortgage banker license to a mortgage broker license, an amount to be determined by the deputy director.

29. For a premium finance company, $300 plus $300 for each branch office.

30. For an advance fee loan broker, $50.

B. On application for a license or permit for an enterprise or consumer lender, the applicant shall pay the first year's annual assessment listed in subsection D of this section, prorated according to the number of quarters remaining until the date of the next annual assessment or renewal. If the result of the application ends in a denial, the department shall refund the prorated annual assessment that the applicant paid. Annual renewal fees are nonrefundable.

C. On issuance of a license or permit for a financial institution, the department shall collect the first year's annual assessment or renewal fee for the financial institution, except for a consumer lender that paid on application, prorated according to the number of quarters remaining until the date of the next annual assessment or renewal.

D. The following annual assessments and renewal fees shall be paid each year:

1. For an escrow agent or trust company, $1,000 plus $250 for each branch office.

2. For a debt management company or sales finance company, $500 plus $200 for each branch office.

3. For a collection agency, $600.

4. For an inactive mortgage broker or commercial mortgage broker, $250.

5. For a mortgage banker that negotiates or closes in the aggregate one hundred loans or less in the immediately preceding calendar year, $750, and for a mortgage banker that negotiates or closes in the aggregate over one hundred loans in the immediately preceding calendar year, $1,250. In addition, a mortgage banker shall pay $250 for each branch office.

6. For a commercial mortgage banker, $1,250. In addition, a commercial mortgage banker shall pay $250 for each branch office.

7. For a mortgage broker or commercial mortgage broker that negotiates or closes in the aggregate fifty loans or less in the immediately preceding calendar year, $250 and for a mortgage broker or commercial mortgage broker that negotiates or closes in the aggregate more than fifty loans in the immediately preceding calendar year, $500. In addition, a mortgage broker or commercial mortgage broker shall pay $200 for each branch office.

8. For a consumer lender, $1,000 plus $200 for each branch office.

9. For a licensee pursuant to chapter 12, article 1 of this title, $500 plus $25 for each branch office and each authorized delegate to a maximum of $2,500.

10. For a loan originator, an amount to be determined by the deputy director.

11. For a loan originator change to inactive status, an amount to be determined by the deputy director.

12. For a premium finance company, $300 plus $300 for each branch office.

13. For an advance fee loan broker, $25.

6-813. License of agent; nontransferable; posting

A. A person, except those exempt under section 6-811, shall not engage in or carry on, or hold himself out as engaging in or carrying on, the escrow business or act in the capacity of an escrow agent in this state without first obtaining a license.

B. An escrow agent's license is not transferable or assignable and control of a license shall not be acquired through stock purchase or other devices without the prior written consent of the deputy director.

C. A license shall be kept conspicuously posted in all licensed places of business of the licensee.

6-817. Refusal to license; suspension; revocation

A. The deputy director on investigation may refuse to license any applicant or may suspend or revoke any license pursuant to title 41, chapter 6, article 10 by entering an order to that effect, together with findings in respect to the order and by notifying the applicant or escrow agent either personally or by certified mail, return receipt requested, sent to the agent's stated address, on the determination by the deputy director that the applicant or escrow agent:

1. Is unable to pay debts as they fall due in the regular course of business.

2. Has not conducted the applicant's or agent's business in accordance with law or has violated this chapter or the rules relating to this chapter.

3. Is in such a financial condition that the applicant or agent cannot continue in business with safety to the applicant's or agent's customers or the public.

4. Has been found guilty of fraud in a legal or administrative proceeding in this jurisdiction or any other jurisdiction.

5. Has made any material misrepresentations or false statements to, or concealed any essential or material fact from, any person in the course of the escrow business.

6. Has knowingly made or caused to be made to the deputy director any false representation of a material fact, or has suppressed or withheld from the deputy director any information that the applicant or agent possesses, and that if submitted by the applicant or agent would have caused the issuance of a license to be withheld or be grounds for the suspension or revocation of a license.

7. Has failed to account properly for escrow property as required by the terms of the escrow.

8. Refuses to allow an examination or investigation by the deputy director of the applicant's or agent's books and affairs or has refused or failed within a reasonable time to furnish any information or make any report required by the deputy director under this chapter or rules relating to this chapter.

9. Has been convicted of any criminal offense involving moral turpitude within the last fifteen years.

10. Does not have the financial resources, experience or competence to adequately serve the public or to warrant the belief that the business will be operated lawfully, honestly, fairly and efficiently pursuant to this chapter.

11. Has disbursed monies in violation of escrow instructions.

12. Has failed to maintain an adequate internal control structure as prescribed by section 6-841.

13. Has caused or allowed any overdraft or returned check for insufficient funds on any of the escrow agent's trust or fiduciary accounts.

14. Has failed to authorize each financial institution with which it has deposited trust or fiduciary funds to notify the deputy director of any overdraft or check returned for insufficient funds on any trust or fiduciary accounts of the escrow agent.

B. It is sufficient cause for refusal, suspension or revocation of a license, in case of a partnership, a corporation or any other group or association, if any member of such persons, or officer or director thereof, has been guilty of any act or omission that would be cause for refusing a license or suspending or revoking the license of an individual agent.

6-831. Records

All escrow agents shall keep and maintain at all times in their principal places of business complete and suitable records of all escrow transactions made by them, together with books, papers and data clearly reflecting the financial condition of the business of such agents.

6-837. Duty of escrow agent to produce escrow records for inspection; violation; classification

A. Any escrow agent shall produce for inspection any escrow records concerning the assets, existence, condition, management and administration and the names of the parties, including any or all beneficiaries, of any escrow of which the person is the escrow agent to any peace officer or local, state or federal law enforcement agency, provided such person requesting information signs and submits a sworn statement to the escrow agent that the request is made in the lawful performance of such person's duties. The peace officer or local, state or federal law enforcement agency shall be prohibited from using or releasing said information except in the proper performance of the person's duties.

B. Any escrow agent shall produce for inspection required by law any escrow records of any escrow of which he or she is the escrow agent to the deputy director or to any state or federal administrative agency lawfully requiring such disclosure. The deputy director or any state or federal administrative agency shall be prohibited from using or releasing said information except in the proper performance of the deputy director's or agency's duties.

C. Any person who knowingly fails to produce records pursuant to this section or who obtains information under subsection A or B of this section and is prohibited from releasing such information but does release such information is guilty of a class 2 misdemeanor.

DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS
Title 20, Chapter 4, Article 15

Amend: R20-4-1501, R20-4-1502, R20-4-1503, R20-4-1504, R20-4-1505, R20-4-1506, R20-4-1507, R20-4-1508, R20-4-1509, R20-4-1510, R20-4-1511, R20-4-1512, R20-4-1513, R20-4-1514, R20-4-1515, R20-4-1516, R20-4-1518, R20-4-1519, R20-4-1520, R20-4-1521

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: **Aug 1, 2023**

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

FROM: Council Staff

DATE: **Jul 6, 2023**

SUBJECT: **DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS**
Title 20, Chapter 4, Article 15

Amend: R20-4-1501, R20-4-1502, R20-4-1503, R20-4-1504, R20-4-1505, R20-4-1506, R20-4-1507, R20-4-1508, R20-4-1509, R20-4-1510, R20-4-1511, R20-4-1512, R20-4-1513, R20-4-1514, R20-4-1515, R20-4-1516, R20-4-1518, R20-4-1519, R20-4-1520, R20-4-1521

Summary:

This regular rulemaking for the Arizona Department of Insurance and Financial Institutions seeks to amend twenty (20) rules in Title 20, Chapter 4, Article 15, Collection Agencies. The purpose of the Department is to execute laws of this state relating to financial institutions and enterprises.

On July 1, 2020, the Department of Financial Institutions merged with the Department of Insurance to form the Department of Insurance and Financial Institutions. The proposed changes in this rulemaking reflect the structural changes of that merger, updates and modernizes terminology, increases the retention period for records from six to seven years to comply with federal requirements, require funds to be deposited in a trust account at a federally insured depository institution, and updates to statutory references.

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

The Department cites both general and specific statutory authority for these rules.

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

The Department indicates that the rules do 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?

The Department did not review or rely on any study relevant to the proposed amended rules.

4. Summary of the agency's economic impact analysis:

The rulemaking seeks to modernize practices, correct references, clarify language, and remove unnecessary subsections. The Department anticipates any benefits in implementing and enforcing the proposed rulemaking will offset any associated costs. No new full-time employees will be necessary to implement and enforce the proposed rulemaking.

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 believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of the regulation of Collection Agencies.

6. What are the economic impacts on stakeholders?

Stakeholders affected by the rulemaking include any entity or person who is licensed under the Department as a collection agency. They incur the costs and benefits associated with modernizing any established practices. Costs are associated with the increase in time to hold records from six to seven years and requiring deposits into federally insured depository institutions. Probable benefits include the removal of the need to notify the Director prior to utilizing an electronic recordkeeping system, the removal of the requirement to keep records or books of account listing all clients' accounts in only alphabetic or numerical order, and the removal of the requirement to submit an ACC stamped copy of amendments to a corporation's articles of incorporation. The Department anticipates that the costs being imposed will be offset by the benefits realized by licensees subject to the rulemaking.

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

The Department indicates that the final rules are not a substantial change from the proposed rules.

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

The Department did not receive any public or stakeholder comments.

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 that a permit is not required for this rulemaking, but that A.R.S. § 32-1055(A) makes it unlawful for a person to conduct a collection agency without a license issued under Title 32, Chapter 9.

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

The Department states that no federal law is applicable to the subject of this rulemaking.

11. Conclusion

This regular rulemaking for the Arizona Department of Insurance and Financial Institutions seeks to amend twenty (20) rules in Title 20, Chapter 4, Article 15, Collection Agencies. As mentioned above, the amendments will reflect the structural changes of the Department, update and modernize terminology, increase the retention period for records from six to seven years to comply with federal requirements, require funds to be deposited in a trust account at a federally insured depository institution, and update statutory references.

The Department is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A). Council staff recommends approval of this rulemaking.

Arizona Department of Insurance and Financial Institutions
100 N 15th Avenue, Suite 261, Phoenix, Arizona 85007
(602) 364-3100 | difi.az.gov

Katie M. Hobbs, Governor
Barbara D. Richardson, Director

DATE: June 8, 2023

VIA EMAIL: grrc@azdoa.gov
Nicole Sornsin, Chair
Governor's Regulatory Review Council
100 North 15th Ave., Suite 305
Phoenix, AZ 85007

RE: Arizona Department of Insurance and Financial Institutions
Financial Institutions Division
A.A.C. Title 20, Chapter 4, Article 15 – Collection Agencies

Dear Chairperson Sornsin:

Please find enclosed the Final Rulemaking for A.A.C. Title 20, Chapter 4, Article 15 – Collection Agencies, being submitted by the Arizona Department of Insurance and Financial Institutions ("Department").

Pursuant to A.A.C. R1-6-201(A)(1), the Department responds as follows:

a. The Department closed the record on this rulemaking on February 19, 2023.
b. This rulemaking relates to a previous five-year review report. The Department of Financial Institutions submitted the previous five-year review report on this Article to the Council which it tabled at its January 5, 2021 Council meeting and subsequently approved at the Council's February 2, 2021 Council Meeting.
c. The rulemaking does not establish a new fee.
d. The rulemaking does not contain a fee increase.
e. The rulemaking does not request an immediate effective date under A.R.S. § 41-1032.
f. The Department certifies that the preamble discloses a reference to any study relevant to the rule that it reviewed and either did or did not rely on in its evaluation of or justification for the rulemaking. The Department did not review or rely on any study relevant to the rulemaking.
g. No new full-time employees are necessary to implement and enforce the rule.
h. The following documents are also submitted to the Council with this cover letter:
    i. The Notice of Final Rulemaking;
    ii. An economic, small business, and consumer impact statement that contains the information required by A.R.S. § 41-1055;
    iii. The general and specific statutes authorizing the rulemaking.

By this submission, the Department is requesting approval of this rulemaking from the Council.

For questions about this rulemaking, please contact Mary Kosinski at (602) 364-3476 or mary.kosinski@difi.az.gov.

Sincerely,

Barbara D. Richardson

Barbara D. Richardson
Director

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS

– financial institutions

PREAMBLE

1. Articles, Parts, or Sections Affected (as applicable)	**Rulemaking Action**
R20-4-1501	Amend
R20-4-1502	Amend
R20-4-1503	Amend
R20-4-1504	Amend
R20-4-1505	Amend
R20-4-1506	Amend
R20-4-1507	Amend
R20-4-1508	Amend
R20-4-1509	Amend
R20-4-1510	Amend
R20-4-1511	Amend
R20-4-1512	Amend
R20-4-1513	Amend
R20-4-1514	Amend
R20-4-1515	Amend
R20-4-1516	Amend
R20-4-1518	Amend
R20-4-1519	Amend
R20-4-1520	Amend
R20-4-1521	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. §§ 6-123(2), and 6-126

Implementing statute: A.R.S. §§ 6-123(1), 32-1021, 32-1022, 32-1023, 32-1024, 32-1027, 32-1028, 32-1051, 32-1055, and 32-1056

3. The effective date of the rule:

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening:	29 A.A.R. 251, January 20, 2023
Notice of Proposed Rulemaking:	28 A.A.R. 227, January 20, 2023

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

Name: Mary E. Kosinski
Address: Department of Insurance and Financial Institutions
100 N. 15th Ave., Suite 261
Phoenix, Arizona 85007-2630
Telephone: (602)364-3476
E-mail: mary.kosinski@difi.az.gov
Web site: https://difi.az.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:

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 15 – Collection Agencies. The statutory sections governing collection agencies are found at A.R.S. §§ 32-1001 through 32-1057.

The changes the Department is proposing will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions (the "new agency"), on July 1, 2020. The former Department of Financial Institutions became a division of the new agency.

As a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article.

When reviewing the rules in the Article, the Department also endeavored to modernize the current rules since the most recent rulemakings for this Article were in 2000 (Sections

R20-4-1502, R20-4-1504 and R20-4-1505) and 2006 (the remaining Sections in the Article). The Department is allowing the use of electronic recordkeeping, and eliminating the requirement for a collection agency organized as a corporation to submit an Arizona Corporation Commission stamped copy of an amendment to its Articles of Incorporation. In addition, the Department is increasing the retention period for records from six to seven years in line with other states and federal requirements and requiring funds to be deposited in a trust account at a federally insured depository institution.

In response to suggested changes in a 2020 Five-Year Review Report, the Department is correcting a statutory reference (R20-4-1501), removing an unnecessary subsection which is duplicative of a statutory requirement (R20-4-1503), clarifying "timely manner" (R20-4-1504), correcting a citation (R20-4-1505), and amending a subsection and deleting an unnecessary subsection (R20-4-1512). After review, the Department did not find it necessary to clarify duplicates and correct references in Section R20-4-1502 as suggested in the report.

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 and does not propose to rely on any study relevant to 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:

The rulemaking modernizes the rules and updates some requirements to be in line with other states' and federal requirements for licensees. The rulemaking does not diminish a previous grant of authority granted to the Department.

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

Pursuant to A.R.S. § 41-1055(A)(1):

- The rulemaking is not designed to change any conduct of licensees because of a perceived harm or to change the frequency of any violative conduct. Instead, the rulemaking replaces the title "Superintendent" with "Director," updates some rule language for clarity, allows electronic recordkeeping without notice to the Director, and removes some unnecessary requirements. The rulemaking adds requirements for licensees by increasing the time to hold records from six to seven years (R20-4-1504) and requiring deposits to be into federally insured deposit institutions (R20-4-1505).

Pursuant to A.R.S. § 41-1055(A)(2):

The Department anticipates the following probable costs to licensees:

1. An increase of the time to hold records from six to seven years (R20-4-1504); and
2. Requiring deposits into federally insured depository institutions (R20-4-1505).

The Department anticipates the following probable benefits to licensees:

1. The removal of the requirement to notify the Director before using an electronic recordkeeping system (R20-4-1504);
2. The removal of the requirement to keep records or books of account listing all clients' accounts in only alphabetic or numerical order (R20-4-1504(B)(1)); and
3. The removal of the requirement to submit an ACC stamped copy of amendments to a corporation's articles of incorporation (R20-4-1506).

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce

minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to licensees.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The Department has made the following change from the Notice of Proposed Rulemaking it published (28 A.A.R. 227, January 20, 2023) and this final rulemaking:

1. The Department has amended subsection R20-4-1504(B)(1) to eliminate the requirement to keep a listing of clients' accounts in only numerical or alphabetical order. The Department does not consider this a substantive change within the meaning of A.R.S. §41-1025 because:

1. The changed language does not affect the interests of persons affected. It allows them to maintain a listing of clients' accounts in any order that makes sense to them;

2. The changed language is the same subject matter as the language from the Notice of Proposed Rulemaking; and

3. The effect of the changed language allows licensees to maintain their clients' lists in any order they chose. They can still opt to maintain those lists in either alphabetical or numeric order, but it is no longer a requirement.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

The Department published the Notice of Proposed Rulemaking for Collection Agencies on January 20, 2023. (29 A.A.R. 227, January 20, 2023) At that time it also opened a 30-day Comment Period. During the Comment Period, no one submitted a comment to the Department or requested an Oral Proceeding.

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

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

The rulemaking does not require a permit and does not use a general permit. A.R.S. § 32-1055(A) makes it unlawful for a person to conduct a collection agency without licensure.

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:

No federal law is applicable to the subject of the rulemaking.

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

No formal analysis has been submitted to the Department that compares the rule's impact of the competitiveness of business in this state to the impact of business in other states.

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

No materials are incorporated by reference.

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 Department previously adopted the rules in this Article as an emergency rule valid for 90 days (except for Sections R20-4-1503, R20-4-1505, R20-4-1506, and R20-4-1518 through R20-4-1521), effective September 6, 1978 (Arizona Office of Secretary of State, *Arizona Administrative Digest 78, Number 9, September 30, 1978*. Arizona Memory Project, accessed 02/03/2023, https://azmemory.azlibrary.gov/nodes/view/85322) (*Arizona Administrative Code 1974- Supplement 78-6, Title 4*. Arizona Memory Project, accessed 02/03/2023, https://azmemory.azlibrary.gov/nodes/view/203036).

The Department adopted the emergency rule effective December 6, 1978. (*Arizona Administrative Code 1974- Supplement 78-6, Title 4*. Arizona Memory Project, accessed 02/03/2023, https://azmemory.azlibrary.gov/nodes/view/203036) The Department did not make any changes from the emergency rulemaking to the final rulemaking.

Subsequent changes have been made by the Department in 2000 to Sections R20-4-1502, R20-4-1504, R20-4-1505, and R20-4-1530 (6 A.A.R. 4742, December 22, 2000) and in 2006 to Sections R20-4-1501, R20-4-1503, R20-4-1506 through R20-4-1521 (12 A.A.R. 1331, April 21, 2006).

15. The full text of the rules follows:

Title 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

ARTICLE 15. COLLECTION AGENCIES

Section

ARTICLE 15. COLLECTION AGENCIES

R20-4-1501. Definitions

In this Article, unless the context otherwise requires:

1. "Account" means a contractual arrangement between a client and a collection agency that obligates the collection agency to attempt to collect one or more debts on the client's behalf.
2. "Active Manager" means the person who is in active management of the conduct of the collection agency's business, and who meets the qualifications listed in A.R.S. § 32-1023(A).
3. "Client" means a person who has hired a collection agency to collect a debt.
4. "Collection agency" has the meaning in A.R.S. ~~§ 32-1001(A)(2).~~ § 32-1001(2).
5. "Contact" means to communicate with, and includes attempted communications.
6. "Credit bureau" or "credit reporting agency" means any person engaged exclusively in the business of gathering, recording, and disseminating information about the credit-worthiness, financial responsibility, paying habits, and character of persons being considered for credit extension.
7. "Creditor" means a person who offers or extends credit creating a debt, or to whom a debt is owed. The term does not include a person that receives an assignment or transfer of a defaulted debt solely for use in collecting the debt for someone else.
8. "Debt" means a debtor's actual or claimed obligation to pay money, whether or not the obligation has been reduced to judgment.
9. "Debtor" means a person obligated to pay a debt. The term also means a person claimed to be obligated to pay a debt.
10. ~~"Superintendent" has the meaning in A.R.S. § 6-101.~~ "Director" has the meaning stated at A.R.S. § 20-102.

R20-4-1502. Applications

A. An applicant for a license shall complete and file an application, as required by the Department, by delivering the application to the ~~Superintendent,~~ Director, together with the following documents and payment:

1. The bond required by A.R.S. § 32-1021;
2. The nonrefundable investigation fee and original license fee required by A.R.S. § 32-1028 and stated in A.R.S. § 6-126;
3. A current financial statement in the form required by the Department;
4. A certified copy of the current articles of incorporation, by-laws, partnership agreement, or other organizational documents under which the applicant proposes to conduct business; and
5. A statement of personal history for each principal officer, partner, and manager of the applicant, in the form required by the Department.

B. An out-of-state collection agency applying for a license under A.R.S. § 32-1024 shall complete and file the application required by subsection (A), together with a signed statement declaring that:

1. The requirements for securing the out-of-state license were, when issued, substantially the same or equivalent to the requirements imposed under A.R.S. Title 32, Chapter 9, Article 2. The statement shall also contain a complete description of those requirements.
2. The state issuing the out-of-state license extends reciprocity to Arizona licensees under similar circumstances. The statement shall also contain a complete description of the conditions for reciprocity in the other state.

C. A licensee applying for license renewal shall complete and file an application, as required by the Department, by delivering the renewal application to the ~~Superintendent~~ Director before January 1, together with the renewal fee required by A.R.S. § 32-1028 and stated in A.R.S. § 6-126. An application for renewal shall also include a current financial statement in the form required by the Department.

D. An applicant for a provisional license under A.R.S. § 32-1027 shall complete and file an application as required by the Department, by delivering the application to the

~~Superintendent~~ Director within 30 days of the event justifying a provisional license. The applicant shall deliver the application together with each of the following:

1. A bond that satisfies the requirements of A.R.S. § 32-1022;
2. A current financial statement as required by the Department;
3. A detailed description of the facts justifying the issuance of a provisional license; and
4. Evidence that the licensee notified the ~~Superintendent~~ Director as required by A.R.S. § 32-1023, in the event the licensee has terminated its active manager.

E. An applicant for a provisional license shall, in each instance, be appropriate to the circumstances justifying the provisional license, as follows:

1. A licensee's personal representative, or the personal representative's appointee, shall complete and file an application if the licensee, a natural person, has died;
2. The surviving partners shall complete and file an application if the licensee, a partnership, has dissolved;
3. A licensee shall complete and file an application if an active manager's employment was terminated.

F. An applicant for a provisional license shall clearly label the top of the first page with the heading "APPLICATION FOR PROVISIONAL LICENSE UNDER A.R.S. § 32-1027."

G. The ~~Superintendent~~ Director may require additional information the ~~Superintendent~~ Director considers necessary in connection with any application under this rule.

R20-4-1503. Reports

~~A.~~ A collection agency shall notify the ~~Superintendent~~ Director in writing of any change in the officers, directors, partners, or active manager of the collection agency not more than ~~ten~~ 10 days after the change. With the notice, the collection agency shall provide the ~~Superintendent~~ Director with a Statement of Personal History for each new officer, director, partner, or active manager on a form obtained from the Department.

~~B.~~ ~~A collection agency shall notify the Superintendent in writing of any change in its place of business not more than 10 days after the change.~~

R20-4-1504. Records

A. A licensee may ~~use a computer recordkeeping system if the licensee gives the Superintendent advanced written notice that it intends to do so. The Department shall not require a licensee to keep a written copy of~~ keep its books, accounts, and records as electronic records if the licensee can generate all information and copies required by this Section ~~in a timely manner~~ within the timeframe set by the Department for examination or other purposes. ~~A licensee may modify a computer recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a licensee shall report to the Superintendent any modification that changes a computer system back to a paper-based recordkeeping system;~~

B. All licensees shall keep and maintain books, accounts, and records adequate to provide a clear and readily understandable record of all business conducted by the collection agency, including:

1. Records or books of account listing all clients' accounts, ~~in numerical order, or in alphabetical order according to the clients' names. If a collection agency keeps books of accounting in numerical order, the collection agency shall alphabetically cross-index each client name with the corresponding account's number.~~ Each account shall reflect its true condition at each calendar month's end, and shall include:
   a. The client's name and address;
   b. Each debtor's name worked for collection in that month;
   c. The amount, description, and date of each debit and each credit to the account; and
   d. The balance due to, or owing from, the client.
2. A record and history of each debt for collection that clearly shows:
   a. The debtor's name;
   b. The debt's principal amount;
   c. The interest charged or collected;
   d. The amount, and ~~a~~ description, of any other charges;
   e. The amount, and date, of each payment received or collected; and

f. The current balance due on the debt.

3. An original of each written contract~~;~~ between the licensee and a client, including any contract amendments.
4. A trust general ledger reflecting all deposits to and payments from a trust account. A licensee shall post transactions to its trust general ledger at least every five business days. A licensee shall bring its trust general ledger current within 24 hours when requested by the ~~Superintendent.~~ Director.
5. The licensee's trust account reconciliation, prepared at least once a month.
6. Books, records, and files maintained so that the ~~Superintendent~~ Director can easily conduct an unannounced spot check, as well as the examinations and investigations required by A.R.S. §§ 6-122 and 6-124.
7. A copy of all pleadings in pending litigation that names the collection agency as a defendant.
8. A record of fictitious names used by the agency's debt collectors as required by Section R20-4-1520.

C. A person issuing a receipt for a collection agency shall sign the receipt using that person's true name. Each receipt shall also show the collection agency's name.

D. A licensee shall maintain all records required under this Section and shall make them available for examination, investigation, or audit in Arizona within three working days after the ~~Superintendent~~ Director demands the records.

E. A licensee shall retain the records required by this Section for the following periods:

1. A licensee shall retain all records described in subsections (B)(1), (B)(3), (B)(4), (B)(5), (B)(6), (B)(7), and (B)(8) for at least ~~six~~ seven years following their creation.
2. A licensee shall retain all records described in subsection (B)(2) for at least three years from an account's assignment to the licensee. If a licensee collects any money on an account, the licensee shall retain the records described in subsection (B)(2) for at least three years from the last collection date.

R20-4-1505. Trust Account

A. A licensee that maintains an office in Arizona shall deposit all funds collected for a client in a trust account ~~with an~~ at a federally insured depository institution in Arizona ~~bank, or savings and loan association~~. A licensee that does not maintain an office in Arizona shall deposit all funds collected for a client in a trust account at a federally insured depository institution in the state where the licensee maintains its principal office. A licensee shall deposit all client funds before the close of its business on the third business day after the licensee receives the funds. Client funds shall remain on deposit as required by this Section until:

1. Paid over to a client, or
2. Otherwise paid as provided in this Section.

B. A licensee shall pay funds from the trust account either:

1. By prenumbered printed checks, or
2. By electronic payment.

C. A licensee shall deposit in its trust account only the funds it has collected for its client. A licensee, its officers, directors, partners, managers, members, or employees shall not commingle, or permit the commingling of, their own funds with client funds. This prohibition includes any funds that a licensee, or any officer, director, partner, manager, member, or employee claims an interest in if that interest arises outside the licensee's contract with a client.

D. A licensee shall keep unpaid client funds in its trust account. A licensee may maintain a separate trust account for dormant accounts into which the licensee deposits unpaid funds such as those of a client that cannot be located, or any trust account check issued to a client that is returned without being negotiated. As to all those unpaid funds, under A.R.S. ~~§ 44-317,~~ § 44-307, a licensee shall file an abandoned property report at the Arizona Department of Revenue as and when required by law.

E. A licensee shall withdraw from its trust account all fees and commissions due the licensee under its contract with a client and deposit them directly into its own operating account.

F. A licensee shall not pay funds from its trust account except as:

1. Provided in this Section,
2. Expressly authorized in its contract with a client, or

3. Authorized in writing by the ~~Superintendent.~~ Director.

R20-4-1506. Articles of Incorporation; Bylaws; Organizing Documents

A. A collection agency organized as a corporation shall file with the ~~Superintendent~~ Director a copy of each amendment to its articles of incorporation within 30 days after the amendment is adopted. Before filing with the ~~Superintendent,~~ Director, an officer of the collection agency shall~~:~~

~~1. Certify~~ certify the copy filed in compliance with this Section, in writing, signed by the certifying officer, attesting to the completeness, accuracy, and authenticity of the certified copy~~; and~~

~~2. Ensure the copy bears a stamp affixed by the Arizona Corporation Commission to evidence filing with the Commission~~.

B. A collection agency organized as a corporation shall file with the ~~Superintendent~~ Director a copy of each amendment to its bylaws within 10 days after the amendment is adopted. An officer of the collection agency shall certify the copy filed in compliance with this Section, in writing, attesting to the completeness, accuracy, and authenticity of the certified copy.

C. A collection agency not organized as a corporation shall file with the ~~Superintendent~~ Director a copy of each amendment to its organizing documents within 10 days after the amendment is adopted. A partner, active manager, or agent of the collection agency shall certify the copy filed in compliance with this Section, in writing, attesting to the completeness, accuracy, and authenticity of the certified copy.

R20-4-1507. Representations of Collection Agency's Identity

In all communications with debtors, either orally or in writing, all the following rules apply:

1. A collection agency shall represent itself as a collection agency~~.~~ .
2. A collection agency shall not directly or indirectly claim to be a credit reporting agency or credit bureau if it is not~~.~~ .

3. A collection agency shall not directly or indirectly claim to be a law enforcement agency~~.~~ , and
4. A collection agency shall not directly or indirectly claim to be a law firm.

R20-4-1508. Representations of the Law

A collection agency shall not:

1. Misrepresent the state of the law to a debtor~~,~~ ;
2. Send a debtor written material that simulates legal process~~,~~ ; or
3. Represent or imply that a debtor is, or may be, subject to criminal prosecution or arrest because of a failure to pay the debt.

R20-4-1509. Representations as to Fees, Costs, and Legal Proceedings; Disinterested Counsel Required

A. A collection agency shall ~~neither~~ not threaten to collect, ~~nor~~ or attempt to collect, an attorney's fee, collection cost, or other fee that the debtor is not obliged to pay under the debtor's contract with the collection agency's creditor client.

B. A collection agency shall not inform a debtor that legal proceedings have been started unless, in fact, a lawsuit has been filed against the debtor.

C. A collection agency shall not threaten to start legal proceedings against a debtor unless the collection agency actually intends, at the time of the threat, to sue.

D. A collection agency shall not threaten to turn an account over to a lawyer unless the collection agency actually intends to do so at the time of the threat.

E. A collection agency shall not file a lawsuit against a debtor unless the lawsuit is filed by an attorney who has no personal or financial interest in ~~that~~ the collection agency~~.~~ filing the lawsuit against the debtor.

R20-4-1510. Representations as to Rights Waived or Remedies Available

A. A collection agency shall not inform a debtor that: ~~the debtor waives any legal right or legal defense by a failure to contact the collection agency.~~

~~B.~~ ~~A collection agency shall not inform a debtor that the collection agency has the power or right to bypass the legal process.~~

1. The debtor waives any legal right or legal defense by a failure to contact the collection agency, and
2. The collection agency has the power or right to bypass the legal process.

~~C.~~ **B.** A collection agency shall not misrepresent the remedies available to the collection agency.

R20-4-1511. Prohibition of Harassment

A. A collection agency shall not use unauthorized or oppressive tactics designed to harass any person to pay a debt.

B. A collection agency shall not use written or oral communications that ~~either~~ ridicule, disgrace, or humiliate any person, or tend to ridicule, disgrace, or humiliate any person.

C. A collection agency shall not state, imply, or tend to imply, in written or oral communications, that any person is guilty of fraud or any other crime.

D. A collection agency shall not permit its agents, employees, representatives, debt collectors, or officers to use obscene or abusive language in efforts to collect a debt.

E. A collection agency or its agents, employees, representatives or officers are subject to penalties listed in A.R.S. § 32-1056(B) for any violation of this Article, as well as other liabilities imposed under any other provision of law.

R20-4-1512. Contacts with Debtors and Others

A. A collection agency shall contact a debtor by telephone only during reasonable hours. A collection agency shall make a reasonable attempt to contact a debtor at the debtor's residence. A collection agency may contact a debtor at the debtor's place of employment if a reasonable attempt to contact the debtor at the debtor's residence has failed.

B. A collection agency shall not threaten to or contact a third party, including a debtor's friend, relative, neighbor, or employer and:

1. Inform the third party of the debt;
2. Ask the third party to pressure the debtor into paying the debt~~,~~ ; or~~;~~
3. Ask the third party to pay the debt, unless the third party is legally obligated to pay the debt.

~~**C.** A collection agency shall not threaten to contact a third party listed in subsection (B) for any purpose listed in subsection (B).~~

~~**D.**~~ **C.** Despite the other provisions of this Section, a collection agency may make lawful service on third parties, including employers, of a writ of garnishment or other writ in aid of execution after judgment has been entered against a debtor.

R20-4-1513. Cessation of Communication with the Debtor

A. A collection agency shall stop contacting a debtor, directly or indirectly, if the debtor tells the collection agency that the debtor is represented by a lawyer and wants the collection agency to communicate with the debtor through ~~that~~ the debtor's lawyer. The collection agency may later contact the debtor if the collection agency contacts the lawyer named by the debtor and learns that the lawyer does not represent the debtor.

B. A collection agency shall stop contacting a debtor, directly or indirectly, if the debtor gives the collection agency written notice that the debtor:

1. Refuses to pay the debt, or~~;~~
2. Wants the collection agency to stop all further communication with the debtor.

C. Despite the provisions of subsection (B), a collection agency may contact a debtor to inform the debtor that:

1. The collection agency has stopped trying to collect the debt, or
2. The collection agency or the creditor may invoke specific remedies that are customarily used by the collection agency or the creditor.

D. The debtor's written notice under subsection (B) is effective upon receipt by the collection agency if delivered by mail.

R20-4-1514. Disclosure of Information to Debtor

A. Within five days after the initial communication with the debtor, a collection agency shall obtain~~,~~ and be able to inform the debtor of:

1. The name of the creditor;
2. The time and place of the creation of the debt;
3. The merchandise, services, or other value provided in exchange for the debt; and
4. The date when the account was turned over to the collection agency by the creditor.

B. A collection agency shall give the debtor access to any of the collection agency's records that contain the information listed in subsection (A).

C. At the debtor's request, the collection agency shall give the debtor, free of charge, a copy of any document from its records that contains the information listed in subsection (A).

R20-4-1515. Aiding and Abetting

A collection agency shall not help or encourage, directly or indirectly, any ~~other~~ person to evade or violate any provision of:

1. This Article, or
2. A.R.S. Title 32, Chapter 9.

R20-4-1516. Advertising

A collection agency shall not use any form of communication to state or imply that ~~it~~ the collection agency is:

1. Approved, bonded by, or affiliated with the state of Arizona;
2. A state agency;
3. The director of any state agency; or
4. Authorized to practice law.

R20-4-1518. Agreements with Clients

A collection agency's records shall document each client's account in writing. The records for an account shall include either a written agreement between the client creditor and the collection agency, or a written direction from the creditor to the collection agency concerning a specific debt placed for collection. The collection agency shall keep records that are specific, easily understood, and unambiguous. A provision of a written agreement or written direction that suggests the collection agency has authority to represent the client in court, or to practice law in any other way, is void and prohibited by this Section. The records for an account shall separately state:

1. The names of the parties to the agreement or written direction,
2. The terms or rate of compensation paid to the collection agency,
3. The length of time the agreement or written direction is intended to be in effect, and
4. Any conditions regarding collection of a particular debt.

R20-4-1519. Licensee Names and Control

A. The Department shall not issue a license with a name that is:

1. Similar to, or that may be confused with, any federal, state, county, or municipal government function or agency;
2. Descriptive of any business activity that the applicant does not actually conduct;
3. The same as, or similar to, the name of any existing collection agency, or~~;~~
4. Otherwise deceptive or misleading.

B. The Department may permit the use of a name otherwise prohibited under subsection (A)(3) based on its analysis of whether the name includes geographic or other information that distinguishes it from the ~~other~~ existing collection agency.

C. A collection agency shall not use a collection agency license to do business under more than one name. Each collection agency shall apply for and obtain a separate license for each business name it intends to use in Arizona.

R20-4-1520. Representations of Collection Agency Employees' Identity or Position

A. A collection agency shall not allow its debt collector, agent, representative, employee, or officer to:

1. Misrepresent the person's true position with the collection agency~~,~~ ;
2. Claim to be, or imply that the person is, an attorney unless the person is licensed to practice law~~,~~ ; ~~or~~
3. Claim to be, or imply that the person is, a public official, peace officer, or any other type of public employee~~,~~ ; or
4. Claim to be, or imply that the person is, any other third party.

B. In any communication with a debtor, a person working for a collection agency shall indicate that the person is a debt collector.

C. A collection agency shall keep a record of all fictitious names used by its debt collectors during their employment. The collection agency shall record the information required by this subsection before permitting the use of a fictitious name. The collection agency shall file a copy of the record of fictitious names with the Department on July 1 and December 31 of each year. After filing the initial report, a collection agency shall identify all changes to the record on July 1 and December 31 of each year. The collection agency's record of fictitious names shall include:

1. The true name of each debt collector that uses a fictitious name~~,~~ ;
2. Each fictitious name used by the debt collector, together with the dates when the name is used~~,~~ ; and
3. The residential street address and residential mailing address of each debt collector that uses a fictitious name.

R20-4-1521. Duty of Investigation

A collection agency shall give copies of its evidence of the debt to the debtor or the debtor's attorney ~~on~~ upon request. After providing the evidence, but before continuing its collection

efforts against the debtor, the collection agency shall investigate any claim by the debtor or the debtor's attorney that:

1. The debtor has been misidentified,
2. The debt has been paid,
3. The debt has been discharged in bankruptcy, or
4. Based on any other reasonable claim, the debt is not owed.

A.R.S. § 41-1055(B) Economic, Small Business, And Consumer Impact Statement
Title 20. Commerce, Financial Institutions and Insurance
Chapter 4. Department of Insurance and Financial Institutions – Financial Institutions
Article 15. Collection Agencies

A.R.S. § 41-1055(B)(1): An identification of the proposed rulemaking.

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 15 – Collection Agencies. The statutory sections governing collection agencies are found at A.R.S. §§ 32-1001 through 32-1057.

The changes the Department is proposing will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions (the "new agency"), on July 1, 2020. The former Department of Financial Institutions became a division of the new agency.

As a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article.

When reviewing the rules in the Article, the Department also endeavored to modernize the current rules since the most recent rulemakings for this Article were in 2000 (Sections R20-4-1502, R20-4-1504 and R20-4-1505) and 2006 (the remaining Sections in the Article). The Department is allowing the use of electronic recordkeeping, and eliminating the requirement for a collection agency organized as a corporation to submit an Arizona Corporation Commission stamped copy of an amendment to its Articles of Incorporation. In addition, the Department is increasing the retention period for records from six to seven years in line with other states and federal requirements and requiring funds to be deposited in a trust account at a federally insured depository institution.

In response to suggested changes in a 2020 Five-Year Review Report, the Department is correcting a statutory reference (R20-4-1501), removing an unnecessary subsection

which is duplicative of a statutory requirement (R20-4-1503), clarifying "timely manner" (R20-4-1504), correcting a citation (R20-4-1505), and amending a subsection and deleting an unnecessary subsection (R20-4-1512). After review, the Department did not find it necessary to clarify duplicates and correct references in Section R20-4-1502 as suggested in the report.

Questions about this Economic Impact Statement can be directed to: Mary E. Kosinski (mary.kosinski@difi.az.gov).

A.R.S. § 41-1055(B)(2): An identification of the persons who will be directly affected by, bear the costs of or directly benefit from the proposed rulemaking.

This Article applies to an entity or person who is licensed by the Department as a collection agency. A collection agency means all persons engaged directly or indirectly in soliciting claims for collection or in collection of claims owed, due, or asserted to be due. A.R.S. § 32-1001(2). A collection agency also includes any person who, in the process of collecting debts occurring in the operation of the person's own business, uses any name other than the person's own name, which would indicate that a third person is collecting or attempting to collect the debts. *Id.*

A.R.S. § 41-1055(B)(3): A cost benefit analysis of the following:

(a) The probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking. The probable costs to the implementing agency shall include the number of new full-time employees necessary to implement and enforce the proposed rule. The preparer of the economic, small business and consumer impact statement shall notify the joint legislative budget committee of the number of new full-time employees necessary to implement and enforce the rule before the rule is approved by the council.

The Department does not anticipate any costs or benefits in implementing and enforcing the proposed rulemaking. No new full-time employees will be necessary to implement and enforce the proposed rulemaking.

(b) The probable costs and benefits to a political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.

No political subdivision of this state is directly affected by the implementation and enforcement of the proposed rulemaking.

(c) The probable costs and benefits to businesses directly affected by the proposed rulemaking, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the proposed rulemaking.

The Department anticipates the following probable costs to licensees:

1. An increase of the time to hold records from six to seven years (R20-4-1504); and

2. Requiring deposits into federally insured depository institutions (R20-4-1505).

The Department anticipates the following probable benefits to licensees:

1. The removal of the requirement to notify the Director before using an electronic recordkeeping system (R20-4-1504);

2. The removal of the requirement to keep records or books of account listing all clients' accounts in only alphabetic or numerical order (R20-4-1504(B)(1)); and

3. The removal of the requirement to submit an ACC stamped copy of amendments to a corporation's articles of incorporation (R20-4-1506).

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to licensees.

A.R.S. § 41-1055(B)(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 proposed rulemaking.

The Department does not anticipate any impact on the private employment of persons holding licenses issued by the Department. Likewise, the Department does not anticipate any impact on public employment in the Department.

A.R.S. § 41-1055(B)(5): A statement of the probable impact of the proposed rulemaking on small businesses. The statement shall include:

(a) An identification of the small businesses subject to the proposed rulemaking.

"Small business" is defined as a concern, including its affiliates, which is:

a. Independently owned and operated,

b. Not dominant in its field,

c. Employs fewer than 100 full-time employees, and

d. Had gross annual receipts of less than $4 million in its last fiscal year.

A.R.S. § 41-1001(23).

The Department presumes that some of the businesses that apply for or hold a collection agency license may be small businesses. However, it does not collect information about an entity's dominance in the field or the number of full-time employees.

(b) The administrative and other costs required for compliance with the proposed rulemaking.

The proposed changes to the Article are anticipated to impose minimal costs to licensees which should be offset by the benefits realized by licensees.

(c) A description of the methods prescribed in section 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 to use each method.

A.R.S. § 41-1035 lists the following methods to reduce the impact on small businesses:

1. Establish less stringent compliance or reporting requirements in the rule for small businesses.

The Department did not establish a less stringent compliance or reporting requirements for collection agencies that are small businesses because the Department anticipates that the costs being imposed will be offset by the benefits realized by licensees subject to the rulemaking.

2. Establish less stringent schedules or deadlines in the rule for compliance or reporting requirements for small businesses.

The Department did not establish less stringent schedules or deadlines for collection agencies that are small businesses because the Department feels that the increased requirement to hold records for seven years (from six years) is a minimal cost and is offset by benefits realized by all licensees subject to the rulemaking.

3. Consolidate or simplify the rule's compliance or reporting requirements for small businesses.

The Department did not consolidate or simplify the rule's compliance or reporting requirements for collection agencies that are small businesses because the additional compliance or reporting requirements upon licensees should be offset by the benefits realized by all licensees subject to the rulemaking.

4. Establish performance standards for small businesses to replace design or operational standards in the rule.

The Department did not establish performance standards for small businesses that are collection agencies because the Department did not impose any additional performance standards upon licensees subject to the rulemaking.

5. Exempt small businesses from any or all requirements of the rule.

The Department made no exemptions for small businesses in the rulemaking because it does not collect adequate information to determine which licensees may qualify as small businesses and because it did not impose any additional requirements upon licensees with the rulemaking that are not offset by benefits to licensees.

(d) The probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.

The Department does not anticipate any cost or benefit to private persons and consumers.

A.R.S. § 41-1055(B)(6): A statement of the probable effect on state revenues.

No impact on state revenues is anticipated.

A.R.S. § 41-1055(B)(7): A 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 Department believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of the regulation of Collection Agencies.

A.R.S. § 41-1055(B)(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. An agency advocating that any data is acceptable data has the burden of proving that the data is acceptable. For the purposes of this paragraph, "acceptable data" means empirical, replicable and testable data as evidenced in supporting documentation, statistics, reports, studies or research.

The rule is not based on any data.

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

ARTICLE 15. COLLECTION AGENCIES

Authorizing Statute: A.R.S. §§ 6-123(2), 6-126

6-123. Deputy director; powers

In addition to the other powers, express or implied, the deputy director may:

1. Exercise all powers that are necessary for the administration and enforcement of the laws and rules relating to financial institutions and enterprises.

2. In accordance with title 41, chapter 6, adopt rules that are necessary or appropriate to administer, enforce and accomplish the purposes of this title and adopt rules and issue orders that limit transactions between financial institutions or enterprises and the directors, officers or employees of the financial institutions or enterprises.

3. Require appropriate records, documents, information and reports from any financial institution or enterprise.

4. Submit to the department of public safety, or the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor, the name and fingerprints of any applicant, licensee, active manager or responsible individual or the name and fingerprints of any organizer, director or officer of any corporate applicant or licensee for:

(a) A banking permit.

(b) Permission to organize a savings and loan association or credit union.

(c) Any license.

(d) Any certificate.

(e) Authority to engage in interstate banking and branching in this state.

The department of public safety shall report the criminal record, if any, of such applicant, licensee or organizer, director or officer of such corporate applicant or licensee within ninety days after receipt of the deputy director's request.

5. Employ appraisers to appraise any property that is owned or held as security by any financial institution or enterprise. The reasonable expenses and compensation of such appraisers shall be paid by the financial institution or enterprise.

6. Hold membership in, pay dues to and attend the convention of the national and regional organizations of state officials occupying like offices or performing similar functions.

7. Cooperate with other regulatory agencies and professional associations to promote the efficient, safe and sound operation and regulation of interstate banking and branching activities, including the formulation of interstate examination policies and procedures and the drafting of model rules and agreements.

8. Participate in the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor. The deputy director may allow the system to collect licensing fees on behalf of the deputy director, to collect a processing fee for the services of the system directly from each applicant for a license or licensee and to process and maintain records on behalf of the deputy director, including information collected pursuant to this section and section 6-123.01. This paragraph does not affect the records disclosure requirements and limitations prescribed in section 6-129.01.

6-126. Application fees for financial institutions and enterprises

A. The following nonrefundable fees are payable to the department with the filing of the following:

1. To apply for a banking permit, $1,000.

2. To apply for an amendment to a banking or savings and loan association permit, $1,000.

3. To establish each banking branch office, $750.

4. To move a banking office to other than an established office of a bank, $1,000.

5. To apply for a savings and loan association permit, $5,000.

6. To establish each savings and loan association branch office, $1,500.

7. To move an office of a savings and loan association to other than an established office, $1,000.

8. To organize and establish a credit union, $100.

9. To establish each credit union branch or to move a credit union office to other than an established office of a credit union, $250.

10. To organize and establish any other financial institutions for which an application or investigation fee is not otherwise provided by law, $1,000.

11. To acquire control of a financial institution other than a consumer lender, $5,000.

12. To apply for a trust company license, $1,000.

13. To apply for a commercial mortgage banker, mortgage banker, escrow agent or consumer lender license, $1,000.

14. To apply for a mortgage broker, commercial mortgage broker, sales finance company or debt management company license, $500.

15. To apply for a collection agency license, $1,500.

16. To apply for a branch office of an escrow agent, consumer lender, commercial mortgage banker, mortgage banker or trust company, $500.

17. To apply for a branch office of a mortgage broker, commercial mortgage broker, debt management company or sales finance company, $250.

18. To apply for approval for the merger or consolidation of two or more financial institutions, $5,000 per institution.

19. To apply for approval to convert from a national bank or federal savings and loan charter to a state chartered institution, $1,000.

20. To apply for approval to convert from a federal credit union to a state chartered credit union, $500.

21. To apply for approval to merge or consolidate two or more credit unions, $500 per credit union.

22. To change the licensee name on a financial institution or enterprise license, except for a loan originator or appraiser license, not more than $250.

23. To apply for a license pursuant to chapter 12, article 1 of this title, $1,500 plus $25 for each branch office and authorized delegate to a maximum of $4,500.

24. To acquire control of a person that is licensed pursuant to chapter 12, article 1 of this title or a controlling person pursuant to chapter 12 of this title, $2,500.

25. To receive the following publications:

(a) Quarterly bank and savings and loan statement of condition, not more than $10 per copy.

(b) Monthly summary of actions report, not more than $5 per copy.

(c) A list of licensees, a monthly pending actions report and all other in-house prepared reports or listings made available to the public, not more than $1 per page.

26. To apply for a loan originator license, an amount to be determined by the deputy director.

27. To apply for a loan originator license transfer, an amount to be determined by the deputy director.

28. To apply for a conversion from a mortgage banker license to a mortgage broker license, an amount to be determined by the deputy director.

29. For a premium finance company, $300 plus $300 for each branch office.

30. For an advance fee loan broker, $50.

B. On application for a license or permit for an enterprise or consumer lender, the applicant shall pay the first year's annual assessment listed in subsection D of this section, prorated according to the number of quarters remaining until the date of the next annual assessment or renewal. If the result of the application ends in a denial, the department shall refund the prorated annual assessment that the applicant paid. Annual renewal fees are nonrefundable.

C. On issuance of a license or permit for a financial institution, the department shall collect the first year's annual assessment or renewal fee for the financial institution, except for a consumer lender that paid on application, prorated according to the number of quarters remaining until the date of the next annual assessment or renewal.

D. The following annual assessments and renewal fees shall be paid each year:

1. For an escrow agent or trust company, $1,000 plus $250 for each branch office.

2. For a debt management company or sales finance company, $500 plus $200 for each branch office.

3. For a collection agency, $600.

4. For an inactive mortgage broker or commercial mortgage broker, $250.

5. For a mortgage banker that negotiates or closes in the aggregate one hundred loans or less in the immediately preceding calendar year, $750, and for a mortgage banker that negotiates or closes in the aggregate over one hundred loans in the immediately preceding calendar year, $1,250. In addition, a mortgage banker shall pay $250 for each branch office.

6. For a commercial mortgage banker, $1,250. In addition, a commercial mortgage banker shall pay $250 for each branch office.

7. For a mortgage broker or commercial mortgage broker that negotiates or closes in the aggregate fifty loans or less in the immediately preceding calendar year, $250 and for a mortgage broker or commercial mortgage broker that negotiates or closes in the aggregate more than fifty loans in the immediately preceding calendar year, $500. In addition, a mortgage broker or commercial mortgage broker shall pay $200 for each branch office.

8. For a consumer lender, $1,000 plus $200 for each branch office.

9. For a licensee pursuant to chapter 12, article 1 of this title, $500 plus $25 for each branch office and each authorized delegate to a maximum of $2,500.

10. For a loan originator, an amount to be determined by the deputy director.

11. For a loan originator change to inactive status, an amount to be determined by the deputy director.

12. For a premium finance company, $300 plus $300 for each branch office.

13. For an advance fee loan broker, $25.

Implementing Statutes: A.R.S. §§ 6-123(1), 32-1021, 32-1022, 32-1023, 32-1024, 32-1027, 32-1028, 32-1051, 32-1055 and 32-1056

6-123. Deputy director; powers

In addition to the other powers, express or implied, the deputy director may:

1. Exercise all powers that are necessary for the administration and enforcement of the laws and rules relating to financial institutions and enterprises.

2. In accordance with title 41, chapter 6, adopt rules that are necessary or appropriate to administer, enforce and accomplish the purposes of this title and adopt rules and issue orders that limit transactions between financial institutions or enterprises and the directors, officers or employees of the financial institutions or enterprises.

3. Require appropriate records, documents, information and reports from any financial institution or enterprise.

4. Submit to the department of public safety, or the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor, the name and fingerprints of any applicant, licensee, active manager or responsible individual or the name and fingerprints of any organizer, director or officer of any corporate applicant or licensee for:

(a) A banking permit.

(b) Permission to organize a savings and loan association or credit union.

(c) Any license.

(d) Any certificate.

(e) Authority to engage in interstate banking and branching in this state.

The department of public safety shall report the criminal record, if any, of such applicant, licensee or organizer, director or officer of such corporate applicant or licensee within ninety days after receipt of the deputy director's request.

5. Employ appraisers to appraise any property that is owned or held as security by any financial institution or enterprise. The reasonable expenses and compensation of such appraisers shall be paid by the financial institution or enterprise.

6. Hold membership in, pay dues to and attend the convention of the national and regional organizations of state officials occupying like offices or performing similar functions.

7. Cooperate with other regulatory agencies and professional associations to promote the efficient, safe and sound operation and regulation of interstate banking and branching activities, including the formulation of interstate examination policies and procedures and the drafting of model rules and agreements.

8. Participate in the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor. The deputy director may allow the system to collect licensing fees on behalf of the deputy director, to collect a processing fee for the services of the system directly from each applicant for a license or licensee and to process and maintain records on behalf of the deputy director, including information collected pursuant to this section and section 6-123.01. This paragraph does not affect the records disclosure requirements and limitations prescribed in section 6-129.01.

32-1021. Original application for license; financial statement; bond; definition

A. A person desiring to conduct a collection agency shall make an original application to the department on forms prescribed by the deputy director setting forth verified information to assist the deputy director in determining the applicant's ability to meet the requirements of this chapter.

B. An application for an original or a renewal license shall be accompanied by:

1. A financial statement in the form provided in section 32-1022, showing the applicant's assets and liabilities and truly reflecting the applicant's net worth in cash or its equivalent.

2. A bond in the form provided in section 32-1022, computed on a base consisting of the gross annual income of the licensee generated from all business transacted in this state by the licensee during the preceding year, in the minimum amount as follows:

Base	Minimum Bond
Not over $250,000	$10,000
$250,001 to $500,000	$15,000
$500,001 to $750,000	$25,000
$750,001 and over	$35,000

C. The deputy director may require from all applicants additional information that the deputy director deems necessary in determining whether the applicant is entitled to the license sought.

D. For the purposes of this section, "all business transacted in this state" includes:

1. The collection of debts from debtors who reside in this state, regardless of where the licensee is located.

2. The collection of debts made from an office in this state, regardless of where the debtor resides.

3. The collection of debts made on behalf of creditors who reside in this state, regardless of where the debtor and the collection agent reside.

32-1022. Contents of financial statement; bond provisions

A. The financial statement required by section 32-1021 shall be sworn to by the applicant, if the applicant is an individual, or by a partner, director, manager or treasurer in its behalf if the applicant is a partnership, corporation or incorporated association. The information in the financial statement shall be confidential and is not a public record.

B. The bond shall run to the people of the state and shall be executed and acknowledged by the applicant as principal and by a corporation, licensed by this state to transact fidelity and surety insurance business, as surety. The bond shall be continuous in form and shall remain in full force and effect at all times while holding a license. The bond shall be conditioned that the applicant, within thirty days after the last day of the month in which a collection is made, shall make an account of and pay to the client the proceeds collected for the client by the applicant, less charges for collection in accordance with the agreement between the applicant and client, but when the amount due the client is less than $5, payment may be deferred for an additional thirty days.

C. Any surety company intending to withdraw as surety of any licensee shall give sixty days' notice of such intention to the deputy director, which notice shall be by registered mail and shall also give sixty days' notice by registered mail to the licensee addressed to the licensee's last known address. When a surety shall for any cause cancel the bond of any licensee, the deputy director shall immediately notify such licensee by registered mail addressed to the licensee's last known address as shown by the files of the department. The license of any licensee shall be void unless, prior to the termination, a new bond has been filed with the department. A licensee changing the licensee's surety shall file a new bond with the department with a surety on the new bond meeting the qualifications of this section.

D. Notwithstanding section 35-155, in lieu of the bond described in this section, an applicant for a license or renewal of a license may deposit with the deputy director a deposit in the form of cash or alternatives to cash in the amount prescribed under section 32-1021. The deputy director may accept any of the following as an alternative to cash:

1. Certificates of deposit or investment certificates that are payable or assigned to the state treasurer, issued by banks doing business in this state and fully insured by the federal deposit insurance corporation or any successor institution.

2. Certificates of deposit, investment certificates or share accounts that are payable or assigned to the state treasurer, issued by a savings and loan association or savings bank doing business in this state and fully insured by the federal deposit insurance corporation or any successor institution.

3. Certificates of deposit, investment certificates or share accounts that are payable or assigned to the state treasurer, issued by a credit union doing business in this state and fully insured by the national credit union administration or any successor institution.

E. The deputy director shall deposit the cash or alternative to cash received under this section with the state treasurer. The state treasurer shall hold the cash or alternatives to cash in the name of this state to guarantee the faithful performance of all legal obligations of the person required to post bond pursuant to section 32-1021, subsection B. The person is entitled to receive any accrued interest earned from the alternatives to cash. The state treasurer may impose a fee to reimburse the state treasurer for administrative expenses. The fee shall not exceed $10 for each cash or alternative to cash deposit and shall be paid by the applicant for a license or renewal of a license. The state treasurer may prescribe rules relating to the terms and conditions of each type of security provided by this section.

F. In addition to such other terms and conditions as the deputy director prescribes by rule or order, the principal amount of the deposit shall be released only on written authorization of the deputy director or on the order of a court of competent jurisdiction. The principal amount of the deposit shall not be released before the expiration of three years after the first to occur of any of the following:

1. The date of substitution of a bond for a cash alternative.

2. The surrender of the license.

3. The revocation of the license.

4. The expiration of the license.

G. A suit may not be commenced on a bond or cash or alternatives to cash later than three years following the act or acts on which the suit is based, except that for claims of fraud or mistake, the period of limitations shall be measured as prescribed in section 12-543, paragraph 3.

32-1023. Qualifications of applicants

A. An applicant for a license issued under this chapter shall:

1. Be a citizen of the United States.

2. Not have been convicted of a crime involving moral turpitude.

3. Not have defaulted on payment of money collected or received for another.

4. Not have been a former licensee under this chapter whose license was suspended or revoked and not subsequently reinstated.

B. If the applicant for a license is a firm, partnership, association or corporation, the qualifications required by subsection A of this section shall be required of the individual in active management of the firm, partnership, association or corporation.

C. When a licensed agency ceases to be under the active management of a qualified person, as defined in rules, notice of this fact shall be given to the deputy director within ten days. The licensee shall have ninety days after the termination of the services of the acting manager to replace the qualified person and notify the deputy director of the qualified replacement. If the agency is not placed under the active management of a new qualified person and notice is not given to the deputy director within the ninety-day period, the license of the agency expires unless a provisional license has been granted under section 32-1027.

32-1024. Licensing out-of-state collection agents

The deputy director shall issue a license to operate a collection agency to a person who holds and presents with the person's application a valid and subsisting license to operate a collection agency issued by another state or an agency of another state if:

1. Requirements for securing the license were, at the time of issuance, substantially the same or equal to requirements imposed by this chapter.

2. The state concerned extends reciprocity under similar circumstances to licensed collection agents of this state.

3. The application is accompanied by the fees and financial and bonding requirements set forth in this chapter.

32-1027. Issuance of provisional license for limited purposes

In the event of the death of an individual licensee, dissolution of a licensee partnership by death or operation of law, or termination of employment of the active manager if the licensee is a firm, partnership, association or corporation, if it is shown that the financial and bonding requirements of this chapter have been met, the deputy director shall issue without fee a provisional license to the personal representative of the deceased or the deceased's appointee, to the surviving partners, or to the firm, association or corporation, as the case may be, which shall be valid for the following purposes only and expire at the following times:

1. A provisional license issued to a personal representative or the personal representative's appointee shall expire one year from the date of issuance and shall not be subject to renewal. Authority of the provisional licensee shall be limited to those activities deemed necessary to wind up the business of the former licensee.

2. Other provisional licenses shall expire three months after the date of issuance unless the provisional licensee within such period can qualify for a full license.

32-1028. Fees

Every original or renewal application shall be accompanied by the fees prescribed in section 6-126.

32-1051. Duties of licensees

An individual, firm, partnership, association or corporation to whom a license is to be issued under this chapter shall:

1. Meet the financial responsibility and bonding requirements of this chapter.

2. Not have been a former licensee under this chapter whose license was suspended or revoked and not subsequently reinstated.

3. Except for attorneys licensed to practice law, not attempt to collect any collection fee, attorney fee, court cost or expenses unless the fees, charges or expenses are justly due from and legally chargeable against the debtor or have been judicially determined. A licensee may not engage in any unfair or misleading practices or resort to any oppressive, vindictive or illegal means or methods of collection.

4. Except for attorneys licensed to practice law, not give or send to any debtor, or cause to be given or sent to any debtor, any notice, letter, message or form that:

(a) Simulates any legal process.

(b) Is ambiguous as to or misrepresents the character, extent or amount of the obligation of the debtor.

(c) Represents or implies that the existing obligation of the debtor may be increased by the addition of attorney fees, investigation fees, service fees or any other fees or charges when in fact these fees or charges may not legally be added to the existing obligation of the debtor.

(d) Threatens to sell the obligation of the debtor to any person, firm or group.

(e) Uses or sets forth the name of or purports to be from any attorney at law or legal firm.

5. Except for attorneys licensed to practice law, not use any letterhead or literature bearing any heading, slogan or statement representing or implying that the licensee practices law, renders legal services or advice or maintains a legal department.

6. Not use any letterhead, advertisement, agreement, form, circular or other printed matter, or otherwise, to convey the impression that the individual, firm, partnership, association or corporation is vouched for or is an instrumentality of this state, a political subdivision of this state or the department.

32-1055. Unlawful acts

A. It is unlawful for a person to conduct a collection agency in this state without having first applied for and obtained a license under this chapter.

B. A collection agency licensed under this chapter shall not directly or indirectly aid, abet or receive compensation from an unlicensed person. Nothing in this chapter shall prevent a licensed agency from accepting, as forwardee, claims for collection from a collection agency or attorney whose place of business is outside this state.

C. A licensee shall not advertise a claim for sale or threaten to so advertise a claim as a means of endeavoring to enforce payment, nor shall a licensee agree to do so for the purpose of soliciting claims. This subsection shall not be deemed to affect a licensee acting as assignee for the benefit of a creditor or acting under a court order.

D. It is unlawful for a person conducting a collection agency in this state to:

1. Fail to render an account of and pay to the client for whom collection has been made the proceeds collected, less collection charges as agreed to by the person and the client, within thirty days from the last day of the month in which the proceeds were collected. If the amount due the client is less than five dollars, payment may be deferred for an additional thirty days.

2. Fail to deposit with a local depository all monies collected by the person and due to the person's clients, and to fail to keep these monies deposited until these monies or equivalent amounts are remitted to the person's clients. Notwithstanding this paragraph, if a person conducting a collection agency does not maintain an office in this state, the person may deposit and keep these monies in a depository in a state where the person maintains the person's principal office.

3. Fail to keep a record of monies collected and the remittance of these monies.

4. Fail to notify the department within ten days of any change of name under which the person does business as a collection agency or address at which the person conducts business.

5. Aid or abet, directly or indirectly, any person, persons or organizations in evading or violating any of the provisions of this chapter.

32-1056. Violation; classification

A. A person operating a collection agency without a license shall be guilty of a class 1 misdemeanor.

B. A licensee violating the provisions of section 32-1055 or the rules and regulations adopted pursuant to this chapter shall be subject to revocation of license and shall be guilty of a class 1 misdemeanor.

DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS
Title 20, Chapter 4, Article 2

Amend: R20-4-201, R20-4-202, R20-4-206, R20-4-207, R20-4-209, R20-4-211, R20-4-214, R20-4-215

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: August 1, 2023

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

FROM: Council Staff

DATE: July 13, 2023

SUBJECT: **DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS**
Title 20, Chapter 4, Article 2

Amend: R20-4-201, R20-4-202, R20-4-206, R20-4-207, R20-4-209, R20-4-211, R20-4-214, R20-4-215

Summary:

This regular rulemaking from the Department of Insurance and Financial Institutions seeks to amend eight (8) rules in Title 20, Chapter 4, Article 2 related to Bank Organization and Regulation. Specifically, the Department is proposing amendments to reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions on July 1, 2020. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article. Additionally, the Department is endeavoring to update some of the current requirements since most recent rulemaking for this Article was in 2001. For example, the Department is removing the requirement for a stamped copy from the Arizona Corporation Commission for each amendment to the licensee's Articles of Incorporation, and is updating the chart for basic blanket bond coverage and increasing the amount of an excess fidelity bond. In addition, the Department is allowing electronic recordkeeping and moving lists into tables for readability.

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

The Department 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?

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

4. Summary of the agency's economic impact analysis:

The Department states that the changes the Department is making will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions, on July 1, 2020. The former Department of Financial Institutions became a division of the new agency. The Department indicates that as a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article. The Department is also intending to modernize the current rules, but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to applicants and licensees.

Stakeholders include the Department and any entity that holds a banking permit issued by the Department.

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 believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of the regulation of banks holding a banking permit in Arizona.

6. What are the economic impacts on stakeholders?

The Department does not anticipate any costs or benefits in implementing and enforcing the proposed rulemaking. In addition, no political subdivision of this state is directly affected by the implementation of this rule. The Department indicates that the changes impose a probable cost to licensees because they are now required to carry excess fidelity bond coverage in the amount of $2 million which is an increase of $1 million. The Department believes that licensees

will benefit from the removal of the requirements to notify the Director before using an electronic recordkeeping system and the removal of the requirement to provide an Arizona Corporation Commission stamped copy of amendments to the licensee's articles of incorporation (R20-4-201).

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

Between the Notice of Proposed Rulemaking, which was published in the Administrative Register on January 27, 2023, and the Notice of Final Rulemaking now before the Council, the Department indicates it made one change to R20-4-214(C), underlining the phrase "subsection (C)" to indicate new language. The Department indicates the Notice of Proposed Rulemaking failed to underline this new language.

Council staff does not believe these changes make the final rules substantially different from the proposed rules pursuant to A.R.S. § 41-1025.

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

The Department indicates it received no public 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?

Pursuant to A.R.S. § 41-1037(A), if an agency proposes an amendment to an existing rule that requires the issuance of a regulatory permit, license, or agency authorization, the agency shall use a general permit, as defined by A.R.S. § 41-1001(11), if the facilities, activities or practices in the class are substantially similar in nature unless certain exceptions apply.

The Department indicates, pursuant to A.R.S. § 6-201(A), no person can engage in banking business in Arizona without a banking permit issued by the Department. As such, the banking permit is not a general permit but meets the exceptions under A.R.S. § 41-1037(A)(2) and (3) in that "[t]he issuance of an alternative type of permit, license or authorization is specifically authorized by state statute" and "[t]he issuance of a general permit is not technically feasible or would not meet the applicable statutory requirements."

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

The Department indicates rule R20-4-214 – Preservation of Records, yields to a pre-emptive federal law or regulation even if the federal law requires a shorter or longer retention period than required by the Arizona rule. (*See* R20-4-214(B)). R20-4-214(C) lists the following applicable federal laws:

- Bank Secrecy Act

- Federal Deposit Insurance Corporation
- Federal Housing Administration
- Federal Home Loan Mortgage Corporation
- Federal National Mortgage Association
- Government National Mortgage Association
- U.S. Department of Treasury Internal Revenue Service

The Department indicates rule R20-4-214 is not more stringent than the federal laws listed.

11. Conclusion

This regular rulemaking from the Department seeks to amend eight (8) rules in Title 20, Chapter 4, Article 2 related to Bank Organization and Regulation. Specifically, the Department is proposing amendments to reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions on July 1, 2020. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article. Additionally, the Department is endeavoring to update some of the current requirements since most recent rulemaking for this Article was in 2001. For example, the Department is removing the requirement for a stamped copy from the Arizona Corporation Commission for each amendment to the licensee's Articles of Incorporation, and is updating the chart for basic blanket bond coverage and increasing the amount of an excess fidelity bond. In addition, the Department is allowing electronic recordkeeping and moving lists into tables for readability.

The Department is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A). Council staff recommends approval of this rulemaking.

Arizona Department of Insurance and Financial Institutions
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(602) 364-3100 | difi.az.gov

Katie M. Hobbs, Governor
Barbara D. Richardson, Director

DATE: June 8, 2023

VIA EMAIL: grrc@azdoa.gov
Nicole Sornsin, Chair
Governor's Regulatory Review Council
100 North 15th Ave., Suite 305
Phoenix, AZ 85007

RE: Arizona Department of Insurance and Financial Institutions
Financial Institutions Division
A.A.C. Title 20, Chapter 4, Article 2 – Bank Organization and Regulation

Dear Chairperson Sornsin:

Please find enclosed the Final Rulemaking for A.A.C. Title 20, Chapter 4, Article 2 – Bank Organization and Regulation, being submitted by the Arizona Department of Insurance and Financial Institutions ("Department").

Pursuant to A.A.C. R1-6-201(A)(1), the Department responds as follows:

a. The Department closed the record on this rulemaking on February 26, 2023.
b. This rulemaking does not relate to a previous five-year review report. The Department of Financial Institutions submitted the previous five-year review report on this Article to the Council which it approved at the Council's April 2, 2019 Council Meeting.
c. The rulemaking does not establish a new fee.
d. The rulemaking does not contain a fee increase.
e. The rulemaking does not request an immediate effective date under A.R.S. § 41-1032.
f. The Department certifies that the preamble discloses a reference to any study relevant to the rule that it reviewed and either did or did not rely on in its evaluation of or justification for the rulemaking. The Department did not review or rely on any study relevant to the rulemaking.
g. No new full-time employees are necessary to implement and enforce the rule.
h. The following documents are also submitted to the Council with this cover letter:
    i. The Notice of Final Rulemaking;
    ii. An economic, small business, and consumer impact statement that contains the information required by A.R.S. § 41-1055;
    iii. The general and specific statutes authorizing the rulemaking.

By this submission, the Department is requesting approval of this rulemaking from the Council.

For questions about this rulemaking, please contact Mary Kosinski at (602) 364-3476 or mary.kosinski@difi.az.gov.

Sincerely,

Barbara D. Richardson

Barbara D. Richardson
Director

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

PREAMBLE

1. Articles, Parts, or Sections Affected (as applicable) **Rulemaking Action**

R20-4-201	Amend
R20-4-202	Amend
R20-4-206	Amend
R20-4-207	Amend
R20-4-209	Amend
R20-4-211	Amend
R20-4-214	Amend
R20-4-215	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. § 6-123(2)
Implementing statute: A.R.S. § 6-181(9)

3. The effective date of the rule:

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 29 A.A.R. 423, January 27, 2023
Notice of Proposed Rulemaking: 29 A.A.R. 267, January 27, 2023

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

Name: Mary E. Kosinski
Address: Department of Insurance and Financial Institutions
100 N. 15th Ave., Suite 261
Phoenix, Arizona 85007-2630
Telephone: (602)364-3476
E-mail: mary.kosinski@difi.az.gov
Web site: https://difi.az.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:

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 2 – Bank Organization and Regulation. The statutory sections governing bank organization and regulation are found at A.R.S. Title 6, Chapter 2 (A.R.S. §§ 6-181 through 6-395.15).

The changes the Department is proposing will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions (the "new agency"), on July 1, 2020. The former Department of Financial Institutions became a division of the new agency.

As a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article.

When reviewing the rules in the Article, the Department also endeavored to modernize the current rules since the most recent rulemaking for this Article was in 2001. The Department is removing the requirement for a stamped copy from the Arizona Corporation Commission for each amendment to the licensee's Articles of Incorporation, and is updating the chart for basic blanket bond coverage and increasing the amount of an excess fidelity bond. In addition, the Department is allowing electronic recordkeeping and moving lists into tables for readability.

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 and does not propose to rely on any study relevant to 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:

The rulemaking updates language and removes some requirements for licensees. The rulemaking does not diminish a previous grant of authority granted to the Department.

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

Pursuant to A.R.S. § 41-1055(A)(1):

- The rulemaking is not designed to change any conduct of licensees because of a perceived harm or to change the frequency of any violative conduct.

Pursuant to A.R.S. § 41-1055(A)(2):

The Department anticipates the following probable costs to licensees:

1. An increase in the amount of an excess fidelity bond that must be carried by a licensee (R20-4-206).

The Department anticipates the following probable benefits to licensees:

1. The removal of the requirement to notify the Director before using an electronic recordkeeping system (R20-4-214); and
2. The removal of the requirement to provide an Arizona Corporation Commission stamped copy of amendments to the licensee's articles of incorporation (R20-4-201).

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures to licensees.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The Department made one change to R20-4-214(C). In this notice, it underlined the phrase "subsection (C)" to indicate new language. The Notice of Proposed Rulemaking failed to underline this new language.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

The Department published the Notice of Proposed Rulemaking for Bank Organization and Regulation on January 27, 2023. (29 A.A.R. 267, January 27, 2023) At that time it also opened a

30-day Comment Period. During the Comment Period, no one submitted a comment to the Department or requested an Oral Proceeding.

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

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

Not applicable. Pursuant to A.R.S. § 6-201(A), no person can engage in banking business in Arizona without a banking permit issued by the Department. A general permit is not applicable to banking business.

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:

Section R20-4-214 – Preservation of Records, yields to a pre-emptive federal law or regulation even if the federal law requires a shorter or longer retention period than required by the Arizona rule. (*See,* subsection (B))
Subsection (C) lists the following applicable federal laws:

- Bank Secrecy Act
- Federal Deposit Insurance Corporation
- Federal Housing Administration
- Federal Home Loan Mortgage Corporation
- Federal National Mortgage Association
- Government National Mortgage Association
- U.S. Department of Treasury Internal Revenue Service

Section R20-4-214 is not more stringent than the federal laws listed.

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

No formal analysis has been submitted to the Department that compares the rule's impact on the competitiveness of business in this state to the impact of business in other states.

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

No materials are incorporated by reference.

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. The rule was not previously made, amended or repealed as an emergency rule.

15. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE
CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS
ARTICLE 2. BANK ORGANIZATION AND REGULATION

Section
R20-4-201. Articles of Incorporation
R20-4-202. Bylaws
R20-4-206. Bankers Blanket Bond Coverage – A.R.S. § 6-188
R20-4-207. Capital Obligations
R20-4-209. Notice of Permanent Closing of Banking Office
R20-4-211. Application for a Banking Permit
R20-4-214. Preservation of Records
R20-4-215. Trust Business

ARTICLE 2. BANK ORGANIZATION AND REGULATION

R20-4-201. Articles of Incorporation

A licensee shall deliver to the ~~Superintendent~~ Director a copy of each amendment to the licensee's articles of incorporation within 30 days after the amendment is filed with the Arizona Corporation Commission. Before delivery to the ~~Superintendent,~~ Director, an officer of the licensee shall~~:~~

1. ~~Certify~~ certify the copy delivered in compliance with this Section, in writing, signed by the certifying officer, attesting to the completeness, accuracy, and authenticity of the certified copy~~; and~~
2. ~~Ensure the copy bears a stamp affixed by the Arizona Corporation Commission to evidence filing with the Commission~~.

R20-4-202. Bylaws

A licensee shall deliver to the ~~Superintendent~~ Director a copy of each amendment to the licensee's bylaws within 30 days after the amendment is adopted. An officer of the licensee shall certify the copy delivered in compliance with this Section, in writing, attesting to the completeness, accuracy, and authenticity of the certified copy.

R20-4-206. Bankers Blanket Bond Coverage -- A.R.S. § 6-188

A. Each bank shall carry at least the following basic blanket bond coverage:

Banks with Deposits of:			Amounts:
Less than ~~$750,000~~ $25,000,000			~~$25,000~~ $300,000
~~$ 750,000~~	~~to~~	~~1,500,000~~	~~50,000~~
~~1,500,000~~	~~to~~	~~2,000,000~~	~~75,000~~
~~2,000,000~~	~~to~~	~~3,000,000~~	~~90,000~~
~~3,000,000~~	~~to~~	~~5,000,000~~	~~120,000~~
~~5,000,000~~	~~to~~	~~7,500,000~~	~~150,000~~
~~7,500,000~~	~~to~~	~~10,000,000~~	~~175,000~~
~~10,000,000~~	~~to~~	~~15,000,000~~	~~200,000~~
~~15,000,000~~	~~to~~	~~20,000,000~~	~~250,000~~
~~20,000,000~~	~~to~~	~~25,000,000~~	~~300,000~~
25,000,000	to	35,000,000	350,000
35,000,000	to	50,000,000	450,000
50,000,000	to	75,000,000	550,000
75,000,000	to	100,000,000	700,000
100,000,000	to	150,000,000	850,000
150,000,000	to	250,000,000	1,200,000
250,000,000	to	500,000,000	1,700,000
500,000,000	to	1,000,000,000	2,500,000
1,000,000,000	to	2,000,000,000	4,000,000
~~Over 2,000,000,000~~			~~6,000,000~~
2,000,000,000	to	5,000,000,000	6,000,000
5,000,000,000	to	20,000,000,000	9,000,000
Over 20,000,000,000			10,000,000

B. Each bank shall supplement the bankers blanket bond coverage with at least a ~~$1,000,000~~ $2,000,000 excess fidelity bond.

~~Effective 8-8-73.~~

R20-4-207. Capital Obligations

A. An applicant for a ~~Superintendent's~~ Director's order of approval to issue a capital obligation shall submit the following documents to the ~~Superintendent,~~ Director and shall not issue any capital obligation before the ~~Superintendent~~ Director issues the order of approval. The required documents are:

1. A certified copy of the resolution adopted by the Board of Directors, or a certified copy of the unanimous written consent of the Board of Directors, authorizing the sale of the capital obligation;
2. A copy of the agreement underlying the capital obligation;
3. A copy of the note or debenture intended to represent the capital obligation; and
4. A copy of the prospectus, if any, proposed for use in the sale of the capital obligation.

B. Each document evidencing a capital obligation shall:

1. Bear on its face, in bold face type, the following: This obligation is not a deposit and is not insured by the Federal Deposit Insurance Corporation.
2. Have a maturity provision that either:
   a. Gives the obligation a maturity of at least five years, or
   b. In the case of an obligation or issue that provides for scheduled repayments of principal, gives an average maturity of at least five years. The restriction on maturity stated in this subsection does not apply to any obligation that otherwise meets all the requirements of this rule if the ~~Superintendent~~ Director determines that exigent circumstances require the issuance of the obligation without regard to any restriction on maturity. The provisions of this subsection do not apply to mandatory convertible debt obligations or issues.
3. State expressly on its face that the obligation:
   a. Is subordinated and junior in right of payment to the issuing bank's obligations to its depositors and to the bank's other obligations to its general and secured creditors, and
   b. Is ineligible as collateral for a loan by the issuing bank, except as provided in A.R.S. § 6-354.
4. Be unsecured.
5. State expressly on its face that the issuing bank may not retire any part of its capital obligation without the ~~Superintendent's~~ Director's prior written order of approval, and the prior written consent of the Federal Deposit Insurance Corporation.
6. Include, if the obligation is issued to a depository institution, a specific waiver of the right of offset by the lending depository institution.
7. State that, in the event of liquidation, all depositors and other creditors of the bank are to be paid in full before any payment of principal or interest is made on a capital obligation.

C. No payment shall be made under an optional right of payment reserved to the bank without the separate authorization of the ~~Superintendent.~~ Director. The ~~Superintendent~~ Director may grant that authority in the initial order of approval or in a later order of approval.

R20-4-209. Notice of Permanent Closing of Banking Office

A bank may close fewer than all of its banking offices. Before closing any office, a bank shall deliver a letter to the ~~Superintendent~~ Director specifying the banking office it plans to close and the closing date. The bank shall ensure that the ~~Superintendent~~ Director receives the letter at least 10 days before the

closing date. Closing the banking office shall terminate the bank's authority to maintain that banking office on the date of the actual closure.

R20-4-211. Application for a Banking Permit

A. Before an application is filed, the representatives of the potential applicant shall meet with the ~~Superintendent of Banks~~ Director to discuss capitalization, location, and management of the proposed bank.

B. After the meeting required by subsection (A), persons who wish to proceed with the application process shall submit an application in the form the ~~Superintendent~~ Director prescribes. The applicant shall support the application with sufficient information to enable the ~~Superintendent~~ Director to make a determination.

R20-4-214. Preservation of Records

A. Every bank shall keep its corporate and business records as originals or as copies of the originals made by reproduction methods that accurately and permanently preserve the records. Copies complying with this subsection, when satisfactorily identified, have the same evidentiary status as an original. A bank may ~~use an electronic recordkeeping system. The Department shall not require a bank to keep a written copy of~~ keep its records as electronic records if the bank can generate all information and copies required by this Section ~~in a timely manner~~ within the timeframe set by the Department for examination or other purposes.

B. A bank shall keep its corporate and business records for the period required by this Section. These periods are measured from the date of the last entry or final action date. A bank shall have and comply with its own record retention schedule that is consistent with this Section. A bank may comply with this Section by complying with a preemptive federal regulation, even if the federal regulation requires a shorter retention period than is listed in this Section. This Section does not prohibit record retention for longer periods than these state-required minimums for any reason, including a retention period established by preemptive federal law or regulation. Likewise, this Section does not prohibit a bank from keeping any type of record not required in subsection (D).

C. Beginning on the effective date of this Section, corporate and business records of a bank operating in the state of Arizona are classified, and their retention periods are prescribed, according to the schedule in subsection (D). Retention periods are listed in subsection (D) using the notations, acronyms, and abbreviations listed in this ~~Section.~~ subsection (C).

1. A numerical designation refers to a period of years unless a shorter period of time is specified in the schedule.
2. "AC" means after closure.
3. "ACH" means automated clearing house.
4. "AE" means after expiration.
5. "ALC" means after last contact.
6. "AP" means after paid.

7. "ATD" means after termination date.
8. "CTR" means a cash transaction report required by the Federal Bank Secrecy Act.
9. "FDIC" means the Federal Deposit Insurance Corporation.
10. "FHA" means the Federal Housing Administration.
11. "FHLMC" means the Federal Home Loan Mortgage Corporation.
12. "FNMA" means the Federal National Mortgage Association.
13. "GNMA" means the Government National Mortgage Association.
14. "IRS" means the United States Department of the Treasury's Internal Revenue Service.
15. "M" means months.
16. "P" means the bank shall keep the record permanently.
17. "PMI" means private mortgage insurance.
18. "SAR" means a suspicious activity report required by the ~~federal~~ Federal Bank Secrecy Act.
19. "TTL" means a treasury, tax, and loan account maintained by a bank.
20. "UCC" means the Uniform Commercial Code as it is in effect in Arizona.

D. Retention Schedule

1. Accounting and Auditing

~~a. Accrual and bond amortization 3~~
~~b. Audit report 6~~
~~c. Audit work papers 3~~
~~d. Bank call, income and dividend report 5~~
~~e. Bill, statement, or invoice - paid 7~~
~~f. Budget work papers 2~~
~~g. Collateral vault "in-and-out" ticket 1~~
~~h. Daily reserve computation 1~~
~~i. Earnings report 7~~
~~j. Expense voucher or invoice 7~~
~~k. Financial statement 7~~
~~l. Interoffice reconciliation 1~~
~~m. Interoffice transaction 1~~
~~n. Periodic statement for account owned by the bank 2~~
~~o. Reconcilement of deposits due to bank 2~~
~~p. Reconcilement register due from bank 2~~
~~q. Return and cash item register 1~~
~~r. Service contract 2~~
~~s. Treasury tax and loan account 2~~
~~t. Unclaimed property record 7~~

a.	Accrual and bond amortization	3
b.	Audit report	6
c.	Audit work papers	3
d.	Bank call, income and dividend report	5
e.	Bill, statement, or invoice – paid	7
f.	Budget work papers	2

g.	Collateral vault “in-and-out” ticket	1
h.	Daily reserve computation	1
i.	Earnings report	7
j.	Expense voucher or invoice	7
k.	Financial statement	7
l.	Interoffice reconciliation	1
m.	Interoffice transaction	1
n.	Periodic statement for account owned by bank	2
o.	Reconcilement of deposits – due to bank	2
p.	Reconcilement register – due from bank	2
q.	Return and cash item register	1
r.	Service contract	2
s.	Treasury tax and loan account	2
t.	Unclaimed property record	5

2. Administration

~~a. Articles of incorporation or association, bylaws, or other record of organization P~~

~~b. Bankers blanket bond-record showing compliance 5 AE~~

~~c. Bank examiner’s report 7~~

~~d. Capital note issuance and transfer record P~~

~~e. Depreciation record-office equipment 3~~

~~f. Dividend check and register 7~~

~~g. Dividend check-outstanding P~~

~~h. Expired policy insuring the bank 3 AE~~

~~i. FDIC assessment base, record 5~~

~~j. FDIC certificate P~~

~~k. Insurance policy number, record of premium paid and amount recovered 3 AE~~

~~l. Legal proceedings when completed 5~~

~~m. Minute book of:~~

~~i. Meetings of the board of directors P~~

~~ii. Meetings of committees of the board of directors P~~

~~iii. Shareholders’ meetings P~~

~~n. Postage meter record book (from date of final entry) 1~~

~~o. Real estate documentation 5 ATD~~

~~p. Report to directors 3~~

~~q. Stock issuance and transfer record P~~

~~r. Required report to supervisory agency 3~~

~~s. Tax controversy or proceeding when completed 7~~

~~t. Tax record not material to any controversy 7~~

~~u. Voting list and proxies 3~~

a.	Articles of incorporation or association, bylaws or other record of organization		P
b.	Bankers blanket bond-record showing compliance		5AE
c.	Bank examiner's report		7
d.	Capital note issuance and transfer record		P
e.	Depreciation record – office equipment		3
f.	Dividend check and register		7
g.	Dividend check – outstanding		P
h.	Expired policy insuring the bank		3 AE
i.	FDIC assessment base, record		5
j.	FDIC certificate		P
k.	Insurance policy number, record of premium paid and amount recovered		3 AE
l.	Legal proceedings when completed		5
m.	Minute book of:		
	i.	Meetings of the board of directors	P
	ii.	Meeting of committees of the board of directors	P
	iii.	Shareholders' meetings	P
n.	Postage meter record book (from date of final entry)		1
o.	Real estate documentation		5 ATD
p.	Report to directors		3
q.	Stock issuance and transfer record		P
r.	Required report to supervisory agency		3
s.	Tax controversy or proceeding when completed		7
t.	Tax record not material to any controversy		7
u.	Voting list and proxies		3

3. Collections

~~a. Collection payment record 1~~

~~b. Collection receipt-carbon 1~~

~~c. Collection register 1~~

~~d. Coupon cash letter-outgoing 1~~

~~e. Coupon envelope 1~~

~~f. Customer file copy 1~~

~~g. Incoming collection letter 1~~

~~h. Incoming contract or note letter 1~~

a.	Collection payment record	1
b.	Collection receipt – carbon	1
c.	Collection register	1

d.	Coupon cash letter – outgoing	1
e.	Coupon envelope	1
f.	Customer file copy	1
g.	Incoming collection letter	1
h.	Incoming contract or note letter	1

4. Customer service

~~a. Broker account holder identification 5~~

~~b. Broker's confirmation 3~~

~~c. Broker's invoice 3~~

~~d. Broker's statement 3~~

~~e. E-Bond application 2~~

~~f. E-Bond sold or redeemed record 2~~

~~g. E-Bond transmittal letter 2~~

~~h. Lock box daily receipts 1~~

~~i. Night depository agreement 1 AC~~

~~j. Night depository daily record 1~~

~~k. Safekeeping record and receipt 5~~

~~l. Securities buy order and sell order 3~~

a.	Broker account holder – identification	5
b.	Broker's confirmation	3
c.	Broker's invoice	3
d.	Broker's statement	3
e.	E-Bond application	2
f.	E-Bond sold or redeemed – record	2
g.	E-Bond transmittal letter	2
h.	Lock box daily receipts	1
i.	Night depository agreement	1 AC
j.	Night depository daily record	1
k.	Safekeeping record and receipt	5
l.	Securities buy order and sell order	3

5. Data processing (management information systems)

~~a. Back-up data (for reconstruction) daily, end of month, quarter, or year 1~~

~~b. Disaster recovery program P~~

~~c. Film copy of every IRS financial reporting form 6~~

~~d. Program change P~~

~~e. System, program and procedure manual P~~

a.	Back-up data (for reconstruction) daily, end of month, quarter, or year	1
b.	Disaster recovery program	P
c.	Film copy of every IRS financial reporting form	6
d.	Program change	P
e.	System, program and procedure manual	P

6. Deposits

~~a. Account opened and account closed report 1~~

~~b. Certificate of deposit purchase record 7~~

~~c. Check paid, withdrawal slip, and other debits to account 7~~

~~d. Club account check register 1~~

~~e. Club account coupon 1~~

~~f. SAR - for suspicious transaction under $10,000 5~~

~~g. CTR - for transaction exceeding $10,000 5~~

~~h. Customer authorization, resolution, and signature card 6 AC~~

~~i. Deposit account record needed to reconstruct 7~~

~~j. Deposit and other credits 7~~

~~k. Dormant account – after closed or escheated 7 ALC~~

~~l. Form 1096, and 1099 reports to IRS 7~~

~~m. Individual retirement account record 7~~

~~n. Interest check or other record of interest payment and reports 7~~

~~o. Internal management reports:~~

~~i. Large balance 1~~

~~ii. Overdraft 1~~

~~iii. Public funds 1~~

~~iv. Service charges 1~~

~~v. Stop payment 1~~

~~vi. Uncollected funds 1~~

~~vii. Unposted item 1~~

~~viii. Zero balance 1~~

~~p. Ledger card 5 AC~~

~~q. Power of attorney document 7 ATD~~

~~r. Receipt for statement held at customer's request 1~~

~~s. Record showing compliance with the following federal regulations. The stated retention period applies unless, and until, it is preempted by federal law:~~

~~i. Regulation CC, Expedited Funds Availability~~

~~Act 2~~

~~ii. Regulation DD, Truth in Savings Act 2~~

~~iii. Regulation E, Electronic Funds Transfer Act 2~~

~~t. Returned statement and cancelled checks 6~~

~~u. Statement 6~~

~~v. Stop payment order 6 AE~~

~~w. Document used to request and receive Tax Identification Number 6~~

~~x. Transaction journal 6~~

~~y. Trial balance 6~~

a.	Account opened and account closed		1
b.	Certificate of deposit purchase record		7
c.	Check paid, withdrawal slip, and other debits to account		7
d.	Club account check register		1
e.	Club account coupon		1
f.	SAR – for suspicious transaction under $10,000		5
g.	CTR – for transaction exceeding $10,000		5
h.	Customer authorization, resolution, and signature card		6 AC
i.	Deposit account record needed to reconstruct		7
j.	Deposit and other credits		7
k.	Dormant account – after closed or escheated		7 ALC
l.	Form 1096 and 1099 reports to IRS		7
m.	Individual retirement account record		7
n.	Interest check or other record of interest payment and reports		7
o.	Internal management reports:		
	i.	Large balance	1
	ii.	Overdraft	1
	iii.	Public funds	1
	iv.	Service charges	1
	v.	Stop payment	1
	vi.	Uncollected funds	1
	vii.	Unposted item	1
	viii.	Zero balance	1
p.	Ledger card		5 AC
q.	Power of attorney document		7 ATD
r.	Receipt for statement held at customer's request		1
s.	Record showing compliance with the following federal regulations. The state retention period applies unless, and until, it is preempted by federal law:		
	i.	Regulation CC, Expedited Funds Availability Act	2
	ii.	Regulation DD, Truth in Savings Act	2
	iii.	Regulation E, Electronic Funds Transfer Act	2

t.	Returned statement and cancelled checks	6
u.	Statement	6
v.	Stop payment order	6 AE
w.	Document used to request and receive Tax Identification Number	6
x.	Transaction journal	6
y.	Trial balance	6

7. Due from banks

~~a. Advice from correspondent bank 1~~

~~b. Bank statement 1~~

~~c. Draft-original 7~~

~~d. Draft register or copy 1 AP~~

~~e. Duplicate check-information and documentation pertaining to issuance 7~~

~~f. Reconcilement register 1~~

a.	Advice from correspondent bank	1
b.	Bank statement	1
c.	Draft – original	7
d.	Draft register or copy	1 AP
e.	Duplicate check – information and documentation pertaining to issuance	7
f.	Reconcilement register	1

8. Due to banks

~~a. Account opened and account closed-reports 1~~

~~b. Advice-copy 1~~

~~c. Incoming cash letter memo for credit 1~~

~~d. Incoming cash letter for remittance 1~~

~~e. Reconcilement register (TTL) 2~~

~~f. Reconcilement verification 1~~

~~g. Resolution 2 AC~~

~~h. Signature card 6 AC~~

~~i. Trial balance (fiche) 7~~

~~j. Undelivered statement, reconstruction available from bank records 1~~

~~k. Undelivered statement, reconstruction not possible 7~~

a.	Account opened and account closed – reports	1
b.	Advice – copy	1
c.	Incoming cash letter memo for credit	1
d.	Incoming cash letter for remittance	1

e.	Reconcilement register (TTL)	2
f.	Reconcilement verification	1
g.	Resolution	2 AC
h.	Signature card	6 AC
i.	Trial balance (fiche)	7
j.	Undelivered statement, reconstruction available from bank records	1
k.	Undelivered statement, reconstruction not possible	7

9. General

~~a. Address change order 1~~

~~b. Affidavit from customer including affidavit of loss, forgery, or non-use of cashier's check 1~~

~~c. Writ of attachment or garnishment 5~~

~~d. Attachment, release 5~~

~~e. Armored car receipt 1~~

~~f. Check book order 1~~

~~g. Check book-receipt 1~~

~~h. Court order memorandum record 5~~

~~i. Notice of Protest 1~~

~~j. Travelers check-application 2~~

~~k. Vault record-opening and closing 1~~

~~l. Wire transfer debit entry and credit entry 7~~

a.	Address change order	1
b.	Affidavit from customer including affidavit of loss, forgery, or non-use of cashier's check	1
c.	Writ of attachment or garnishment	5
d.	Attachment, release	5
e.	Armored car receipt	1
f.	Check book order	1
g.	Check book – receipt	1
h.	Court order memorandum record	5
i.	Notice of Protest	1
j.	Vault record – opening and closing	1
k.	Wire transfer debit entry and credit entry	7

10. General ledger

~~a. Daily statement of condition 3~~

~~b. General journal-if byproduct of posting the general ledger 3~~

~~c. General journal-if used as book of original entry~~

~~with description 3~~

~~d. General ledger 5~~

~~e. General ledger ticket-debit and credit 2~~

a.	Daily statement of condition	3
b.	General journal – if byproduct of posting the general ledger	3
c.	General journal – if used as book of original entry with description	3
d.	General ledger	5
e.	General ledger ticket – debit and credit	2

11. International department

~~a. Broker account holder-identification 5~~

~~b. Cable copy 7~~

~~c. Cable requisition 7~~

~~d. Collection paid 1~~

~~e. Correspondence 2~~

~~f. Draft 7~~

~~g. Foreign collection register 6~~

~~h. Foreign draft application 6~~

~~i. Foreign draft-carbon 2 ATD~~

~~j. Foreign exchange remittance sheet or book 6~~

~~k. Foreign financial account-record 7~~

~~l. Foreign mail transfer application 6~~

~~m. Foreign mail transfer-carbon 2 ATD~~

~~n. Foreign outstanding cash 2~~

~~o. Foreign payment-incoming 2~~

~~p. Letter of credit application 2~~

~~q. Letter of credit ledger sheet 7~~

~~r. Transfer outside of the United States in excess of $10,000 record 5~~

a.	Broker account holder – identification	5
b.	Cable copy	7
c.	Cable requisition	7
d.	Collection paid	1
e.	Correspondence	2
f.	Draft	7
g.	Foreign collection register	6
h.	Foreign draft application	6
i.	Foreign draft – carbon	2 ATD
j.	Foreign exchange remittance sheet or book	6

k.	Foreign financial account – record	7
l.	Foreign mail transfer application	6
m.	Foreign mail transfer – carbon	2 ATD
n.	Foreign outstanding cash	2
o.	Foreign payment – incoming	2
p.	Letter of credit application	2
q.	Letter of credit ledger sheet	7
r.	Transfer outside of the United States in excess of $10,000 – record	5

12. Investments

~~a. Bonds~~

~~i. Amortization record 6~~

~~ii. Confirmation 3~~

~~iii. Safekeeping receipt 2~~

~~b. Broker's securities~~

~~i. Broker's invoice 3~~

~~ii. Broker's statement 3~~

~~iii. Report of lost or stolen securities 3~~

~~iv. Safekeeping advice 2~~

~~v. Taxpayer identification number 5~~

~~c. Commercial paper~~

~~i. Broker's advice 2~~

~~ii. Purchase order 2~~

~~iii. Remittance advice 2~~

~~d. Mortgage-backed securities~~

~~i. Buy-and-sell agreement 3~~

~~ii. Commitment letter 7~~

~~iii. FHLMC and FNMA loan file 7~~

~~iv. GNMA certificate 7~~

~~v. Interest accrual record 7~~

~~vi. Monthly remittance report 7~~

a.	Bonds		
	i.	Amortization record	6
	ii.	Confirmation	3
	iii.	Safekeeping receipt	2
b.	Broker's securities		
	i.	Broker's invoice	3
	ii.	Broker's statement	3
	iii.	Report of lost or stolen securities	3
	iv.	Safekeeping advice	2

	v.	Taxpayer identification number	5
c.	Commercial paper		
	i.	Broker's advice	2
	ii.	Purchase order	2
	iii.	Remittance advice	2
d.	Mortgage-backed securities		
	i.	Buy-and-sell agreement	3
	ii.	Commitment letter	7
	iii.	FHLMC and FNMA loan file	7
	iv.	GNMA certificate	7
	v.	Interest accrual record	7
	vi.	Monthly remittance report	7

13. Loans. A bank shall keep each loan record listed for the period required by this subsection. These periods are measured from the date of final activity. A bank shall have and comply with its own record retention schedule that is consistent with this subsection. A bank may comply with this subsection by complying with a preemptive federal regulation, even if the federal regulation requires a shorter retention period than is listed in this subsection. This subsection does not prohibit record retention for longer periods than these state-required minimums for any reason, including a retention period established by preemptive federal law or regulation. Likewise, this Section does not prohibit a bank from keeping any type of record not required by this subsection.

~~a. All Loans - general~~

~~i. Application for loan approved 6~~

~~ii. Appraisal 6~~

~~iii. Borrower's financial statement 6~~

~~iv. Charge-off record 10~~

~~v. Charged off note 10~~

~~vi. Collateral file 6~~

~~vii. Correspondence 6~~

~~viii. Credit file – all documentation 6~~

~~ix. Credit report 6~~

~~x. Daily proof and record 6~~

~~xi. Loan committee minutes P~~

~~xii. Miscellaneous loan reports including new loan journal, paid loan journal, past due report, and transaction journal as original entry 6~~

~~xiii. Other documentation for reconstruction of loan 2~~

~~b. Commercial loans~~

~~i. Application for loan denied 12 M~~

~~ii. Bill of sale 6~~

~~iii. Borrowing resolution 3~~

iv. Business annual report (fiscal or year end) after date of report 3

v. Business cash-flow analysis report - after date of report 3

vi. Business tax return - after date of return 6

vii. Commitment letter 6

viii. Copy of mortgage note or deed of trust 6

ix. Evidence of insurance 6

x. Guaranty 6

xi. Letter of credit 6

xii. Participation agreement 6

xiii. Promissory note 6

xiv. Purchase and sale agreement 6

xv. Security agreement 6

xvi. Title documentation 6

xvii. UCC filing 6

e. Consumer loans

i. Application for loan denied, including adverse action notice 25 M

ii. Collateral record 6

iii. Hazard insurance record 6

iv. Invoice 6

v. Life and disability insurance record 6

vi. Overdraft loan agreement 6

vii. Promissory note and modification agreement – copy 6

viii. Title documentation 6

ix. UCC filing - copy 6

d. Real estate loans

i. Assignment of escrow 6

ii. Assumption 6

iii. Commitment letter 6

iv. Copy of deed of trust or mortgage note, as it may have been modified 6

v. Escrow analysis and record 6

vi. Evidence of any FHA or PMI insurance required 6

vii. Hazard insurance life of loan

viii. Proof of insurance excluding hazard 6

ix. Sales contract 6

x. Settlement sheet 6

~~xi. Survey 6~~

~~xii. Title documentation 6~~

~~e. Construction loans. In addition to the documents specified in subsection (d), a bank shall keep a record for a construction loan as specified in this subsection:~~

~~i. Certificate of occupancy 6~~

~~ii. Construction progress report 6~~

~~iii. Contractor's cost breakdown 6~~

~~iv. Disbursement documentation 6~~

~~v. Inspection report 6~~

~~vi. Residential construction specifications and material list 6~~

a.	All loans – general		
	i.	Application for loan approval	6
	ii.	Appraisal	6
	iii.	Borrower's financial statement	6
	iv.	Charge-off record	10
	v.	Charged off note	10
	vi.	Collateral file	6
	vii.	Correspondence	6
	viii.	Credit file- all documentation	6
	ix.	Credit report	6
	x.	Daily proof and record	6
	xi.	Loan committee minutes	P
	xii.	Miscellaneous loan reports including new loan journal, paid loan journal, past due report, and transaction journal as original entry	6
	xiii.	Other documentation for reconstruction of loan	2
b.	Commercial loans		
	i.	Application for loan denied	12 M
	ii.	Bill of sale	6
	iii.	Borrowing resolution	3
	iv.	Business annual report (fiscal or year end) – after date of report	3
	v.	Business cash-flow analysis report – after date of report	3
	vi.	Business tax return – after date of return	6
	vii.	Commitment letter	6
	viii.	Copy of mortgage note or deed of trust	6
	ix.	Evidence of insurance	6
	x.	Guaranty	6

	xi.	Letter of credit	6
	xii.	Participation agreement	6
	xiii.	Promissory note	6
	xiv.	Purchase and sale agreement	6
	xv.	Security agreement	6
	xvi.	Title documentation	6
	xvii.	UCC filing	6
c.	Consumer loans		
	i.	Application for loan denied, including adverse action notice	25 M
	ii.	Collateral record	6
	iii.	Hazard insurance record	6
	iv.	Invoice	6
	v.	Life and disability insurance record	6
	vi.	Overdraft loan agreement	6
	vii.	Promissory note and modification agreement – copy	6
	viii.	Title documentation	6
	ix.	UCC filing – copy	6
d.	Real estate loans		
	i.	Assignment of escrow	6
	ii.	Assumption	6
	iii.	Commitment letter	6
	iv.	Copy of deed of trust or mortgage note, as it may have been modified	6
	v.	Escrow analysis record	6
	vi.	Evidence of any FHA or PMI insurance required	6
	vii.	Hazard insurance	life of loan
	viii.	Proof of insurance excluding hazard	6
	ix.	Sales contract	6
	x.	Settlement sheet	6
	xi.	Survey	6
	xii.	Title documentation	6
e.	Construction loans. In addition to the documents specified in subsection (d), a bank shall keep a record for a construction loan as specified in this subsection:		
	i.	Certificate of occupancy	6
	ii.	Construction progress report	6
	iii.	Contractor’s cost breakdown	6
	iv.	Disbursement documentation	6
	v.	Inspection report	6
	vi.	Residential construction specifications and material list	6

14. Official checks and drafts

~~a. Affidavit, bond, indemnity agreement, other documentation supporting the issuance of a duplicate check or draft 7~~

~~b. Bank draft 3~~

~~c. Cashier's check-cancelled 7~~

~~d. Cashier's check register-copy 7~~

~~e. Expense check-cancelled 7~~

~~f. Expense check register-copy 7~~

~~g. Expense voucher or invoice 7~~

~~h. Money order-bank or personal 7~~

~~i. Money order register-copy 7~~

~~j. Official check outstanding P~~

a.	Affidavit, bond, indemnity agreement, other documentation supporting the issuance of a duplicate check or draft	7
b.	Bank draft	3
c.	Cashier's check – cancelled	7
d.	Cashier's check register – copy	7
e.	Expense check – cancelled	7
f.	Expense check register – copy	7
g.	Expense voucher or invoice	7
h.	Money order – bank or personal	7
i.	Money order register – copy	7
j.	Official check outstanding	P

15. Personnel Records

~~a. Attendance record, and time card 3~~

~~b. Authorization for payroll deduction 2~~

~~c. Department of labor report 5~~

~~d. Disability record 5~~

~~e. Employee record and personnel folder 5~~

~~f. Employment application 3 AT~~

~~g. Insurance record 2~~

~~h. Payroll check 2~~

~~i. Pension fund record 10~~

~~j. Profit sharing fund record 10~~

~~k. Rejected employee application 2~~

~~l. Salary ledger or electronic data processing printout 4~~

~~m. Salary receipt 2~~

~~n. W-3 reconciliation of income tax withheld from wages 3~~

~~o. W-4 withholding exemption certificate 3~~

~~p. Wage and tax statement record (W-2) 7~~

~~q. Wage differential documentation (Fair Labor Standards Act) 3~~

a.	Attendance record, and time card	3
b.	Authorization for payroll deduction	2
c.	Department of labor report	5
d.	Disability record	5
e.	Employee record and personnel folder	5
f.	Employment application	3 AT
g.	Insurance record	2
h.	Payroll check	2
i.	Pension fund record	10
j.	Profit sharing fund record	10
k.	Rejected employee application	2
l.	Salary ledger or electronic data processing printout	4
m.	Salary receipt	2
n.	W-3 reconciliation of income tax withheld from wages	3
o.	W-4 withholding exemption certificate	3
p.	Wage and tax statement record (W-2)	7
q.	Wage differential documentation (Fair Labor Standards Act)	3

16. Registered mail

~~a. Marine insurance book 3~~

~~b. Record of incoming and outgoing registered mail 1~~

~~c. Return receipt card 3~~

a.	Marine insurance book	3
b.	Record of incoming and outgoing registered mail	1
c.	Return receipt card	3

17. Safe deposit vault

~~a. Access ticket or card 6~~

~~b. Court order and correspondence 6~~

~~c. Delivery of will, burial plot deed, insurance policy-receipt 6~~

~~d. Forced entry record 6~~

~~e. Lease or contract-closed account 2 AC~~

~~f. Ledger record of account 1~~

~~g. Opened box contents-record and report 7~~

~~h. Rent receipt-copy 1~~

~~i. Sale to satisfy lien-record 7~~

~~j. Signature card, authorization, and resolution 6 AC~~

a.	Access ticket or card	6
b.	Court order and correspondence	6
c.	Delivery of will, burial plot deed, insurance policy – receipt	6
d.	Forced entry record	6
e.	Lease or contract – closed account	2 AC
f.	Ledger record of account	1
g.	Opened box contents – record and report	7
h.	Rent receipt – copy	1
i.	Sale to satisfy lien – record	7
j.	Signature card, authorization, and resolution	6 AC

18. Tellers

~~a. Mail teller envelope 3 M~~

~~b. Teller's balancing recap or recap book 1~~

~~c. Teller's cash ticket-original and carbons 1~~

~~d. Teller's cash shipment record 1~~

~~e. Teller's exchange ticket 1~~

~~f. Teller's machine tape 1~~

a.	Mail teller envelope	3 M
b.	Teller's balancing recap or recap book	1
c.	Teller's cash ticket – original and carbons	1
d.	Teller's cash shipment record	1
e.	Teller's exchange ticket	1
f.	Teller's machine tape	1

19. Transit, proof, and clearing

~~a. ACH entry 6~~

~~b. Advice of correction to deposit 2~~

~~c. Clearinghouse settlement sheet - recapitulation of checks delivered to the clearinghouse or federal reserve 2~~

~~d. Record of items processed 6~~

~~e. Proof machine tape or other record 2~~

~~f. Receipt for transit letter 1~~

~~g. Return item letter 5~~

a.	ACH entry	6
b.	Advice of correction to deposit	2

c.	Clearinghouse settlement sheet – recapitulation of checks delivered to the clearinghouse or federal reserve	2
d.	Record of items processed	6
e.	Proof machine tape or other record	2
f.	Receipt for transit letter	1
g.	Return item letter	5

20. Trust department administration

~~a. Appraisal of real or personal property held as a trust asset 3 AC~~
~~b. Correspondence 3 AC~~
~~c. Decree or receipt and release 3 AC~~
~~d. Fee record and supporting data 3 AC~~
~~e. Intermediate and final account 3 AC~~
~~f. Legal documentation including judgment, court order, and legal opinion 3 AC~~
~~g. Paid bill 3 AP~~
~~h. Real estate insurance policy 1 AE~~
~~i. Real estate and mortgage document 3 AC~~
~~j. Receipt for asset received or delivered 3 AC~~
~~k. Record of asset tax cost 3 AC~~
~~l. Summary card, original instrument, agreement and amendment, and letters of appointment 3 AC~~
~~m. Synopsis sheet 3 AC~~

a.	Appraisal of real or personal property held as a trust asset	3 AC
b.	Correspondence	3 AC
c.	Decree or receipt and release	3 AC
d.	Fee record and supporting data	3 AC
e.	Intermediate and final account	3 AC
f.	Legal documentation including judgment, court order, and legal opinion	3 AC
g.	Paid bill	3 AP
h.	Real estate insurance policy	1 AE
i.	Real estate and mortgage document	3 AC
j.	Receipt for asset received or delivered	3 AC
k.	Record of asset tax cost	3 AC
l.	Summary card, original instrument, agreement and amendment, and letters of appointment	3 AC
m.	Synopsis sheet	3 AC

21. Corporate trust

~~a. Bond registration journal 3 AC~~
~~b. Bond-cancelled 7~~
~~c. Indemnity bond P~~
~~d. Certification 2~~
~~e. Coupon envelope 6 M~~
~~f. Coupon-cancelled 6 M~~
~~g. Customer receipt 7~~
~~h. Dividend and coupon record 3 AC~~
~~i. Dividend and interest disbursement check and list 3 AC~~
~~j. General ledger ticket 2~~
~~k. Legal paper P~~
~~l. Copy of cancelled stock certificate, original returned to customer 1~~
~~m. Stock registration journal 3 AC~~
~~n. Stock transfer memo 1~~
~~o. Stock transfer receipt 1~~
~~p. Tax return 3 AC~~
~~q. Transfer-supporting papers 3 AC~~
~~r. Transfer journal 3 AC~~
~~s. Transfer tax waiver 3 AC~~
~~t. Trust ledger-corporate 7~~

a.	Bond registration journal	3 AC
b.	Bond – cancelled	7
c.	Indemnity bond	P
d.	Certification	2
e.	Coupon envelope	6 M
f.	Coupon – cancelled	6 M
g.	Customer receipt	7
h.	Dividend and coupon record	3 AC
i.	Dividend and interest disbursement check and list	3 AC
j.	General ledger ticket	2
k.	Legal paper	P
l.	Copy of cancelled stock certificate, original returned to customer	1
m.	Stock registration journal	3 AC
n.	Stock transfer memo	1
o.	Stock transfer receipt	1
p.	Tax return	3 AC
q.	Transfer – supporting papers	3 AC
r.	Transfer journal	3 AC

s.	Transfer tax waiver	3 AC
t.	Trust ledger – corporate	7

22. Personal trust

~~a. Record of previously discharged fiduciary~~

~~i. Accounting 3 AC~~

~~ii. Decree 3 AC~~

~~iii. Receipt and release 3 AC~~

~~b. Accounting - recorded 3 AC~~

~~c. Advice of payment - securities department regarding bond and coupon collection 3 AC~~

~~d. Appraisal~~

~~i. Real property 3 AC~~

~~ii. Personal property 3 AC~~

~~e. Asset delivery receipt 3 AC~~

~~f. Authorization~~

~~i. By co-fiduciary P~~

~~ii. By consultant P~~

~~g. Approval~~

~~i. By co-fiduciary P~~

~~ii. By consultant P~~

~~h. Broker's statement 7~~

~~i. Buy and sell order 7~~

~~j. Cash documentation~~

~~i. Customer cash and asset statement 7~~

~~ii. Cash and security journal 7~~

~~iii. Cash trial balance 1~~

~~k. Common trust fund annual report 10~~

~~l. Correspondence~~

~~i. Transfer letter 3 AC~~

~~ii. Claim letter 3 AC~~

~~m. Coupon collection record 7~~

~~n. Court accounting and petition 7~~

~~o. Daily transaction journal 6 M~~

~~p. Debits and credits-daily 1~~

~~q. Documentation necessary to support account decision 3 AC~~

~~r. Tax Documentation~~

~~i. Federal estate tax return 10~~

~~ii. State estate tax return 10~~

~~iii. Tax-related work papers 10~~

~~iv. Federal gift tax return 10~~

~~s. Fee calculations and supporting data 1~~

~~t. Income tax return~~

~~i. Federal 3 AC~~

~~ii. State 3 AC~~

~~u. Inventory 3 AC~~

~~v. Investment review and related material 3 AC~~

~~w. Minutes~~

~~i. Investment committee P~~

~~ii. Trust committee P~~

a.	Record of previously discharged fiduciary		
	i.	Accounting	3 AC
	ii.	Decree	3 AC
	iii.	Receipt and release	3 AC
b.	Accounting – recorded		3 AC
c.	Advice of payment – securities department regarding bond and coupon collection		3 AC
d.	Appraisal		
	i.	Real property	3 AC
	ii.	Personal property	3 AC
e.	Asset delivery receipt		3 AC
f.	Authorization		
	i.	By co-fiduciary	P
	ii.	By consultant	P
g.	Approval		5
	i.	By co-fiduciary	P
	ii.	By consultant	P
h.	Broker’s statement		7
i.	Buy and sell order		7
j.	Cash documentation		
	i.	Customer cash and asset statement	7
	ii.	Cash and security journal	7
	iii.	Cash trial balance	1
k.	Common trust fund annual report		10
l.	Correspondence		
	i.	Transfer letter	3 AC
	ii.	Claim letter	3 AC
m.	Coupon collection letter		7
n.	Court accounting and petition		7
o.	Daily transaction journal		6 M
p.	Debits and credits – daily		1
q.	Documentation necessary to support account decision		3 AC

r.	Tax Documentation		
	i.	Federal estate tax return	10
	ii.	State estate tax return	10
	iii.	Tax-related work papers	10
	iv.	Federal gift tax return	10
s.	Fee calculations and supporting data		1
t.	Income tax return		
	i.	Federal	3 AC
	ii.	State	3 AC
u.	Inventory		3 AC
v.	Investment review and related material		3 AC
w.	Minutes		
	i.	Investment committee	P
	ii.	Trust committee	P

23. Other personal trust records

~~a. Legal opinion 3 AC~~

~~b. Correspondence related to legal opinion 3 AC~~

~~c. Paid bill 7~~

~~d. Review and recommendation 3 AC~~

~~e. Safekeeping record and receipt 3 AC~~

~~f. Security ledger sheet P~~

~~g. Trust check 10~~

~~h. Trust entry-original 3 AC~~

~~i. Trust or agency agreement-original 3 AC~~

~~j. Vault withdrawal and deposit ticket 7~~

~~k. Will-certified copy P~~

~~l. Work papers supporting tax return 7~~

a.	Legal opinion	3 AC
b.	Correspondence related to legal opinion	3 AC
c.	Paid bill	7
d.	Review and recommendation	3 AC
e.	Safekeeping record and receipt	3 AC
f.	Security ledger sheet	P
g.	Trust check	10
h.	Trust entry – original	3 AC
i.	Trust or agency agreement – original	3 AC
j.	Vault withdrawal and deposit ticket	7
k.	Will – certified copy	P
l.	Work papers supporting tax return	7

24. Trust Investments

~~a. Annual report~~

~~i. Common trust fund 10~~

~~ii. Pooled fund 10~~

~~b. Valuation~~

~~i. Common trust fund 10~~

~~ii. Pooled fund 10~~

~~c. Minutes~~

~~i. Investment committee P~~

~~ii. Administrative committee P~~

~~d. Investment order and broker's confirmation 3 AC~~

~~e. investment review and related material 3 AC~~

~~f. Correspondence 3 AC~~

~~g. Summary of annual account activity 3 AC~~

a.	Annual report		
	i.	Common trust fund	10
	ii.	Pooled fund	10
b.	Valuation		
	i.	Common trust fund	10
	ii.	Pooled fund	10
c.	Minutes		
	i.	Investment committee	P
	ii.	Administrative committee	P
d.	Investment order and broker's confirmation		3 AC
e.	Investment review and related material		3 AC
f.	Correspondence		3 AC
g.	Summary of annual account activity		3 AC

25. Wire transfer

~~a. Incoming wire log 1~~

~~b. Outgoing wire log 1~~

~~c. Transmission record 7~~

~~d. Wire transfer request 7~~

a.	Incoming wire log	1
b.	Outgoing wire log	1
c.	Transmission record	7
d.	Wire transfer request	7

R20-4-215. Trust Business

~~All banks~~ Each bank authorized to conduct trust business under their banking permit shall comply with the applicable requirements of R20-4-808 through R20-4-816.

A.R.S. § 41-1055(B) Economic, Small Business, And Consumer Impact Statement

Title 20. Commerce, Financial Institutions and Insurance

Chapter 4. Department of Insurance and Financial Institutions – Financial Institutions

Article 2. Bank Organization and Regulation

A.R.S. § 41-1055(B)(1): An identification of the proposed rulemaking.

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 2 – Bank Organization and Regulation. The statutory sections governing bank organization and regulation are found at A.R.S. Title 6, Chapter 2 (A.R.S. §§ 6-181 through 6-395.15). The changes the Department is proposing will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions (the "new agency"), on July 1, 2020. The former Department of Financial Institutions became a division of the new agency.

As a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article.

When reviewing the rules in the Article, the Department also endeavored to modernize the current rules since the most recent rulemaking for this Article was in 2001. The Department is removing the requirement for a stamped copy from the Arizona Corporation Commission for each amendment to the licensee's Articles of Incorporation, and is updating the chart for basic blanket bond coverage and increasing the amount of an excess fidelity bond. In addition, the Department is allowing electronic recordkeeping and moving lists into tables for readability.

Questions about this Economic Impact Statement can be directed to: Mary E. Kosinski (mary.kosinski@difi.az.gov).

A.R.S. § 41-1055(B)(2): An identification of the persons who will be directly affected by, bear the costs of or directly benefit from the proposed rulemaking.

This Article applies to an entity that holds a banking permit issued by the Department.

A.R.S. § 41-1055(B)(3): A cost benefit analysis of the following:

(a) The probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking. The probable costs to the implementing agency shall include the number of new full-time employees necessary to implement and enforce the proposed rule. The preparer of the economic, small business and consumer impact statement shall notify the joint legislative budget committee of the number of new full-time employees necessary to implement and enforce the rule before the rule is approved by the council.

The Department does not anticipate any costs or benefits in implementing and enforcing the proposed rulemaking. No new full-time employees will be necessary to implement and enforce the proposed rulemaking.

(b) The probable costs and benefits to a political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.

No political subdivision of this state is directly affected by the implementation and enforcement of the proposed rulemaking.

(c) The probable costs and benefits to businesses directly affected by the proposed rulemaking, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the proposed rulemaking.

The Department anticipates the following probable costs to licensees:

1. An increase in the amount of an excess fidelity bond that must be carried by a licensee (R20-4-206).

The Department anticipates the following probable benefits to licensees:

1. The removal of the requirement to notify the Director before using an electronic recordkeeping system (R20-4-214); and

2. The removal of the requirement to provide an Arizona Corporation Commission stamped copy of amendments to the licensee's articles of incorporation (R20-4-201).

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to licensees.

A.R.S. § 41-1055(B)(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 proposed rulemaking.

The Department does not anticipate any impact on the private employment of persons holding banking permits issued by the Department. Likewise, the Department does not anticipate any impact on public employment in the Department.

A.R.S. § 41-1055(B)(5): A statement of the probable impact of the proposed rulemaking on small businesses. The statement shall include:

(a) An identification of the small businesses subject to the proposed rulemaking.

"Small business" is defined as a concern, including its affiliates, which is:

a. Independently owned and operated,

b. Not dominant in its field,

c. Employs fewer than 100 full-time employees, and

d. Had gross annual receipts of less than $4 million in its last fiscal year.

A.R.S. § 41-1001(23).

Three of the nine state-chartered banks in Arizona qualify as small businesses.

(b) The administrative and other costs required for compliance with the proposed rulemaking.

The proposed changes to the Article impose a probable cost to licensees because they are now required to carry excess fidelity bond coverage in the amount of $2 million which is an increase from $1 million.

(c) A description of the methods prescribed in section 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 to use each method.

A.R.S. § 41-1035 lists the following methods to reduce the impact on small businesses:

1. Establish less stringent compliance or reporting requirements in the rule for small businesses.

The Department did not establish less stringent compliance or reporting requirements for small businesses that hold a banking permit in Arizona because the only compliance requirement that is a change from the prior rule is the increase of the amount of an excess fidelity bond that must be carried by a licensee. This requirement is necessary for all banks for consumer protection.

2. Establish less stringent schedules or deadlines in the rule for compliance or reporting requirements for small businesses.

The Department did not establish less stringent schedules or deadlines for small businesses that hold a banking permit in Arizona because the Department did not change any schedules or deadlines from the prior rules in this rulemaking.

3. Consolidate or simplify the rule's compliance or reporting requirements for small businesses.

The Department did not consolidate or simplify compliance or reporting requirements for small businesses that hold a banking permit in Arizona because it applies all compliance and reporting requirements to all licensees. The Department's compliance and reporting requirements are necessary for consumer protection and to align with federal requirements.

4. Establish performance standards for small businesses to replace design or operational standards in the rule.

The Department did not establish performance standards to replace design or operational standards for small businesses that hold a banking permit in Arizona because the rulemaking does not address design or operational standards.

5. Exempt small businesses from any or all requirements of the rule.

The Department did not exempt small businesses that hold a banking permit in Arizona from any or all requirements of the rules because the requirements of the rules are necessary for consumer protections and to align with federal requirements.

(d) The probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.

The Department does not anticipate any cost or benefit to private persons and consumers.

A.R.S. § 41-1055(B)(6): A statement of the probable effect on state revenues.

No impact on state revenues is anticipated.

A.R.S. § 41-1055(B)(7): A 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 Department believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of the regulation of banks holding a banking permit in Arizona.

A.R.S. § 41-1055(B)(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. An agency advocating that any data is acceptable data has the burden of proving that the data is acceptable. For the purposes of this paragraph, "acceptable data" means empirical, replicable and testable data as evidenced in supporting documentation, statistics, reports, studies or research.

The rule is not based on any data.

12	Acquisition of Control of Financial Institution	R20-4-1602, R20-4-1702			
	Initial Application	A.R.S. 6-1104	30	30	60
13	Money Transmitter	A.R.S. § 6-1201, et seq.			
	Initial Application	A.R.S. § 6-1204(A)	60	60	120
14	Advance Fee Loan Broker	A.R.S. § 6-1301, et seq.			
	Initial Application	A.R.S. § 6-1303(A)	30	30	60
15	Premium Finance Co.	A.R.S. § 6-1401, et seq.			
	Initial Application	A.R.S. § 6-1402(C)	60	60	120
16	Collection Agency	A.R.S. § 32-1001, et seq.			
	Initial Application	A.R.S. § 32-1021, R20-4-1502	30	15	45
17	Motor Vehicle Dealer	A.R.S. § 44-281, et seq.			
	Initial Application	A.R.S. § 44-282(B)	30	15	45
18	Sales Finance Co.	A.R.S. § 44-281, et seq.			
	Initial Application	A.R.S. § 44-282(B)	30	15	45
19	Certificate of Exemption	A.R.S. § 6-912			
	Initial Application	A.R.S. § 6-912(B)	45	45	90
20	Loan Originators	A.R.S. § 6-991, et seq.			
	Initial Application	A.R.S. § 6-991.04(A)	60	60	120

Historical Note
Table A adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 8 A.A.R. 145, effective December 10, 2001 (Supp. 01-4). Amended by final rulemaking at 18 A.A.R. 2622, effective December 2, 2012 (Supp. 12-4).

ARTICLE 2. BANK ORGANIZATION AND REGULATION

R20-4-201. Articles of Incorporation
A licensee shall deliver to the Superintendent a copy of each amendment to the licensee's articles of incorporation within 30 days after the amendment is filed with the Arizona Corporation Commission. Before delivery to the Superintendent, an officer of the licensee shall:

1. Certify the copy delivered in compliance with this Section, in writing, signed by the certifying officer, attesting to the completeness, accuracy, and authenticity of the certified copy; and
2. Ensure the copy bears a stamp affixed by the Arizona Corporation Commission to evidence filing with the Commission.

Historical Note
Former Rule 1. R20-4-201 recodified from R4-4-201 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 811, effective January 10, 2001 (Supp. 01-1).

R20-4-202. Bylaws
A licensee shall deliver to the Superintendent a copy of each amendment to the licensee's bylaws within 30 days after the amendment is adopted. An officer of the licensee shall certify the copy delivered in compliance with this Section, in writing, attesting to the completeness, accuracy, and authenticity of the certified copy.

Historical Note
Former Rule 2. R20-4-202 recodified from R4-4-202 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 811, effective January 10, 2001 (Supp. 01-1).

R20-4-203. Repealed

Historical Note
Former Rule 3; Amended subsection (C) effective September 4, 1981 (Supp. 81-5). R20-4-203 recodified from R4-4-203 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-204. Repealed

Historical Note
Former Rule 4. R20-4-204 recodified from R4-4-204 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-205. Repealed

Historical Note
Former Rule 5. R20-4-205 recodified from R4-4-205 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3188, effective August 3, 2000 (Supp. 00-3).

R20-4-206. Bankers Blanket Bond Coverage -- A.R.S. § 6-188
A. Each bank shall carry at least the following basic blanket bond coverage:

Banks with Deposits of:			Amounts:
Less than $750,000			$25,000
$ 750,000	to	1,500,000	50,000
1,500,000	to	2,000,000	75,000

2,000,000	to	3,000,000	90,000
3,000,000	to	5,000,000	120,000
5,000,000	to	7,500,000	150,000
7,500,000	to	10,000,000	175,000
10,000,000	to	15,000,000	200,000
15,000,000	to	20,000,000	250,000
20,000,000	to	25,000,000	300,000
25,000,000	to	35,000,000	350,000
35,000,000	to	50,000,000	450,000
50,000,000	to	75,000,000	550,000
75,000,000	to	100,000,000	700,000
100,000,000	to	150,000,000	850,000
150,000,000	to	250,000,000	1,200,000
250,000,000	to	500,000,000	1,700,000
500,000,000	to	1,000,000,000	2,500,000
1,000,000,000	to	2,000,000,000	4,000,000
Over 2,000,000,000			6,000,000

B. Each bank shall supplement the bankers blanket bond coverage with at least a $1,000,000 excess fidelity bond.

Effective 8-8-73.

Historical Note
Former Rule 6. R20-4-206 recodified from R4-4-206 (Supp. 95-1).

R20-4-207. Capital Obligations

A. An applicant for a Superintendent's order of approval to issue a capital obligation shall submit the following documents to the Superintendent, and shall not issue any capital obligation before the Superintendent issues the order of approval. The required documents are:
1. A certified copy of the resolution adopted by the Board of Directors, or a certified copy of the unanimous written consent of the Board of Directors, authorizing the sale of the capital obligation;
2. A copy of the agreement underlying the capital obligation;
3. A copy of the note or debenture intended to represent the capital obligation; and
4. A copy of the prospectus, if any, proposed for use in the sale of the capital obligation.

B. Each document evidencing a capital obligation shall:
1. Bear on its face, in bold face type, the following: This obligation is not a deposit and is not insured by the Federal Deposit Insurance Corporation.
2. Have a maturity provision that either:
   a. Gives the obligation a maturity of at least five years, or
   b. In the case of an obligation or issue that provides for scheduled repayments of principal, gives an average maturity of at least five years. The restriction on maturity stated in this subsection does not apply to any obligation that otherwise meets all the requirements of this rule if the Superintendent determines that exigent circumstances require the issuance of the obligation without regard to any restriction on maturity. The provisions of this subsection do not apply to mandatory convertible debt obligations or issues.
3. State expressly on its face that the obligation:
   a. Is subordinated and junior in right of payment to the issuing bank's obligations to its depositors and to the bank's other obligations to its general and secured creditors, and
   b. Is ineligible as collateral for a loan by the issuing bank, except as provided in A.R.S. § 6-354.
4. Be unsecured.
5. State expressly on its face that the issuing bank may not retire any part of its capital obligation without the Superintendent's prior written order of approval, and the prior written consent of the Federal Deposit Insurance Corporation.
6. Include, if the obligation is issued to a depository institution, a specific waiver of the right of offset by the lending depository institution.
7. State that, in the event of liquidation, all depositors and other creditors of the bank are to be paid in full before any payment of principal or interest is made on a capital obligation.

C. No payment shall be made under an optional right of payment reserved to the bank without the separate authorization of the Superintendent. The Superintendent may grant that authority in the initial order of approval or in a later order of approval.

Historical Note
Former Rule 7. R20-4-207 recodified from R4-4-207 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 2155, effective May 4, 2001 (Supp. 01-2).

R20-4-208. Repealed

Historical Note
Former Rule 8. R20-4-208 recodified from R4-4-208 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3188, effective August 3, 2000 (Supp. 00-3).

R20-4-209. Notice of Permanent Closing of Banking Office

A bank may close fewer than all of its banking offices. Before closing any office, a bank shall deliver a letter to the Superintendent specifying the banking office it plans to close and the closing date. The bank shall ensure that the Superintendent receives the letter at least 10 days before the closing date. Closing the banking office shall terminate the bank's authority to maintain that banking office on the date of the actual closure.

Historical Note
Former Rule 9. R20-4-209 recodified from R4-4-209 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5388, effective November 9, 2001 (Supp. 01-4).

R20-4-210. Repealed

Historical Note
Former Rule 10. R20-4-210 recodified from R4-4-210 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3188, effective August 3, 2000 (Supp. 00-3).

R20-4-211. Application for a Banking Permit

A. Before an application is filed, the representatives of the potential applicant shall meet with the Superintendent of Banks to discuss capitalization, location, and management of the proposed bank.

B. After the meeting required by subsection (A), persons who wish to proceed with the application process shall submit an application in the form the Superintendent prescribes. The applicant shall support the application with sufficient information to enable the Superintendent to make a determination.

Historical Note
Former Rule 11. R20-4-211 recodified from R4-4-211 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 3188, effective August 3, 2000 (Supp. 00-3).

R20-4-212. Repealed

Historical Note
Former Rule 12. Amended effective September 4, 1981 (Supp. 81-4). R20-4-212 recodified from R4-4-212 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-213. Repealed

Historical Note
Former Rule 13. Repealed effective September 13, 1981 (Supp. 81-5). R20-4-213 recodified from R4-4-213 (Supp. 95-1).

R20-4-214. Preservation of Records

A. Every bank shall keep its corporate and business records as originals or as copies of the originals made by reproduction methods that accurately and permanently preserve the records. Copies complying with this subsection, when satisfactorily identified, have the same evidentiary status as an original. A bank may use an electronic recordkeeping system. The Department shall not require a bank to keep a written copy of its records if the bank can generate all information and copies required by this Section in a timely manner for examination or other purposes.

B. A bank shall keep its corporate and business records for the period required by this Section. These periods are measured from the date of the last entry or final action date. A bank shall have and comply with its own record retention schedule that is consistent with this Section. A bank may comply with this Section by complying with a preemptive federal regulation, even if the federal regulation requires a shorter retention period than is listed in this Section. This Section does not prohibit record retention for longer periods than these state-required minimums for any reason, including a retention period established by preemptive federal law or regulation. Likewise, this Section does not prohibit a bank from keeping any type of record not required in subsection (D).

C. Beginning on the effective date of this Section, corporate and business records of a bank operating in the state of Arizona are classified, and their retention periods are prescribed, according to the schedule in subsection (D). Retention periods are listed in subsection (D) using the notations, acronyms, and abbreviations listed in this Section.

1. A numerical designation refers to a period of years unless a shorter period of time is specified in the schedule.
2. "AC" means after closure.
3. "ACH" means automated clearing house.
4. "AE" means after expiration.
5. "ALC" means after last contact.
6. "AP" means after paid.
7. "ATD" means after termination date.
8. "CTR" means a cash transaction report required by the Federal Bank Secrecy Act.
9. "FDIC" means the Federal Deposit Insurance Corporation.
10. "FHA" means the Federal Housing Administration.
11. "FHLMC" means the Federal Home Loan Mortgage Corporation.
12. "FNMA" means the Federal National Mortgage Association.
13. "GNMA" means the Government National Mortgage Association.
14. "IRS" means the United States Department of the Treasury's Internal Revenue Service.
15. "M" means months.
16. "P" means the bank shall keep the record permanently.
17. "PMI" means private mortgage insurance.
18. "SAR" means a suspicious activity report required by the federal Bank Secrecy Act.
19. "TTL" means a treasury, tax, and loan account maintained by a bank.
20. "UCC" means the Uniform Commercial Code as it is in effect in Arizona.

D. Retention Schedule

1. Accounting and Auditing
   - a. Accrual and bond amortization 3
   - b. Audit report 6
   - c. Audit work papers 3
   - d. Bank call, income and dividend report 5
   - e. Bill, statement, or invoice - paid 7
   - f. Budget work papers 2
   - g. Collateral vault "in-and-out" ticket 1
   - h. Daily reserve computation 1
   - i. Earnings report 7
   - j. Expense voucher or invoice 7
   - k. Financial statement 7
   - l. Interoffice reconciliation 1
   - m. Interoffice transaction 1
   - n. Periodic statement for account owned by the bank 2
   - o. Reconcilement of deposits-due to bank 2
   - p. Reconcilement register-due from bank 2
   - q. Return and cash item register 1
   - r. Service contract 2
   - s. Treasury tax and loan account 2
   - t. Unclaimed property record 7
2. Administration
   - a. Articles of incorporation or association, bylaws, or other record of organization P
   - b. Bankers blanket bond-record showing compliance 5 AE
   - c. Bank examiner's report 7
   - d. Capital note issuance and transfer record P
   - e. Depreciation record-office equipment 3
   - f. Dividend check and register 7
   - g. Dividend check-outstanding P
   - h. Expired policy insuring the bank 3 AE
   - i. FDIC assessment base, record 5
   - j. FDIC certificate P
   - k. Insurance policy number, record of premium paid and amount recovered 3 AE
   - l. Legal proceedings when completed 5
   - m. Minute book of:
     - i. Meetings of the board of directors P
     - ii. Meetings of committees of the board of directors P
     - iii. Shareholders' meetings P
   - n. Postage meter record book (from date of final entry) 1
   - o. Real estate documentation 5 ATD
   - p. Report to directors 3
   - q. Stock issuance and transfer record P
   - r. Required report to supervisory agency 3
   - s. Tax controversy or proceeding when completed 7
   - t. Tax record not material to any controversy 7

u. Voting list and proxies 3

3. Collections
   a. Collection payment record 1
   b. Collection receipt-carbon 1
   c. Collection register 1
   d. Coupon cash letter-outgoing 1
   e. Coupon envelope 1
   f. Customer file copy 1
   g. Incoming collection letter 1
   h. Incoming contract or note letter 1
4. Customer service
   a. Broker account holder-identification 5
   b. Broker's confirmation 3
   c. Broker's invoice 3
   d. Broker's statement 3
   e. E-Bond application 2
   f. E-Bond sold or redeemed-record 2
   g. E-Bond transmittal letter 2
   h. Lock box daily receipts 1
   i. Night depository agreement 1 AC
   j. Night depository daily record 1
   k. Safekeeping record and receipt 5
   l. Securities buy order and sell order 3
5. Data processing (management information systems)
   a. Back-up data (for reconstruction) daily, end of month, quarter, or year 1
   b. Disaster recovery program P
   c. Film copy of every IRS financial reporting form 6
   d. Program change P
   e. System, program and procedure manual P
6. Deposits
   a. Account opened and account closed report 1
   b. Certificate of deposit purchase record 7
   c. Check paid, withdrawal slip, and other debits to account 7
   d. Club account check register 1
   e. Club account coupon 1
   f. SAR - for suspicious transaction under $10,000 5
   g. CTR - for transaction exceeding $10,000 5
   h. Customer authorization, resolution, and signature card 6 AC
   i. Deposit account record needed to reconstruct 7
   j. Deposit and other credits 7
   k. Dormant account – after closed or escheated 7 ALC
   l. Form 1096, and 1099 reports to IRS 7
   m. Individual retirement account record 7
   n. Interest check or other record of interest payment and reports 7
   o. Internal management reports:
      i. Large balance 1
      ii. Overdraft 1
      iii. Public funds 1
      iv. Service charges 1
      v. Stop payment 1
      vi. Uncollected funds 1
      vii. Unposted item 1
      viii. Zero balance 1
   p. Ledger card 5 AC
   q. Power of attorney document 7 ATD
   r. Receipt for statement held at customer's request 1
   s. Record showing compliance with the following federal regulations. The stated retention period applies unless, and until, it is preempted by federal law:
      i. Regulation CC, Expedited Funds Availability Act 2
      ii. Regulation DD, Truth in Savings Act 2
      iii. Regulation E, Electronic Funds Transfer Act 2
   t. Returned statement and cancelled checks 6
   u. Statement 6
   v. Stop payment order 6 AE
   w. Document used to request and receive Tax Identification Number 6
   x. Transaction journal 6
   y. Trial balance 6
7. Due from banks
   a. Advice from correspondent bank 1
   b. Bank statement 1
   c. Draft-original 7
   d. Draft register or copy 1 AP
   e. Duplicate check-information and documentation pertaining to issuance 7
   f. Reconcilement register 1
8. Due to banks
   a. Account opened and account closed-reports 1
   b. Advice-copy 1
   c. Incoming cash letter memo for credit 1
   d. Incoming cash letter for remittance 1
   e. Reconcilement register (TTL) 2
   f. Reconcilement verification 1
   g. Resolution 2 AC
   h. Signature card 6 AC
   i. Trial balance (fiche) 7
   j. Undelivered statement, reconstruction available from bank records 1
   k. Undelivered statement, reconstruction not possible 7
9. General
   a. Address change order 1
   b. Affidavit from customer including affidavit of loss, forgery, or non-use of cashier's check 1
   c. Writ of attachment or garnishment 5
   d. Attachment, release 5
   e. Armored car receipt 1
   f. Check book order 1
   g. Check book-receipt 1
   h. Court order memorandum record 5
   i. Notice of Protest 1
   j. Travelers check-application 2
   k. Vault record-opening and closing 1
   l. Wire transfer debit entry and credit entry 7
10. General ledger
   a. Daily statement of condition 3
   b. General journal-if byproduct of posting the general ledger 3
   c. General journal-if used as book of original entry with description 3
   d. General ledger 5
   e. General ledger ticket-debit and credit 2
11. International department
   a. Broker account holder-identification 5
   b. Cable copy 7
   c. Cable requisition 7
   d. Collection paid 1
   e. Correspondence 2
   f. Draft 7
   g. Foreign collection register 6
   h. Foreign draft application 6
   i. Foreign draft-carbon 2 ATD

j. Foreign exchange remittance sheet or book 6
k. Foreign financial account-record 7
l. Foreign mail transfer application 6
m. Foreign mail transfer-carbon 2 ATD
n. Foreign outstanding cash 2
o. Foreign payment-incoming 2
p. Letter of credit application 2
q. Letter of credit ledger sheet 7
r. Transfer outside of the United States in excess of $10,000 – record 5

12. Investments
a. Bonds
i. Amortization record 6
ii. Confirmation 3
iii. Safekeeping receipt 2
b. Broker's securities
i. Broker's invoice 3
ii. Broker's statement 3
iii. Report of lost or stolen securities 3
iv. Safekeeping advice 2
v. Taxpayer identification number 5
c. Commercial paper
i. Broker's advice 2
ii. Purchase order 2
iii. Remittance advice 2
d. Mortgage-backed securities
i. Buy-and-sell agreement 3
ii. Commitment letter 7
iii. FHLMC and FNMA loan file 7
iv. GNMA certificate 7
v. Interest accrual record 7
vi. Monthly remittance report 7

13. Loans. A bank shall keep each loan record listed for the period required by this subsection. These periods are measured from the date of final activity. A bank shall have and comply with its own record retention schedule that is consistent with this subsection. A bank may comply with this subsection by complying with a preemptive federal regulation, even if the federal regulation requires a shorter retention period than is listed in this subsection. This subsection does not prohibit record retention for longer periods than these state-required minimums for any reason, including a retention period established by preemptive federal law or regulation. Likewise, this Section does not prohibit a bank from keeping any type of record not required by this subsection.
a. All Loans - general
i. Application for loan approved 6
ii. Appraisal 6
iii. Borrower's financial statement 6
iv. Charge-off record 10
v. Charged off note 10
vi. Collateral file 6
vii. Correspondence 6
viii. Credit file – all documentation 6
ix. Credit report 6
x. Daily proof and record 6
xi. Loan committee minutes P
xii. Miscellaneous loan reports including new loan journal, paid loan journal, past due report, and transaction journal as original entry 6
xiii. Other documentation for reconstruction of loan 2
b. Commercial loans
i. Application for loan denied 12 M
ii. Bill of sale 6
iii. Borrowing resolution 3
iv. Business annual report (fiscal or year end) - after date of report 3
v. Business cash-flow analysis report - after date of report 3
vi. Business tax return - after date of return 6
vii. Commitment letter 6
viii. Copy of mortgage note or deed of trust 6
ix. Evidence of insurance 6
x. Guaranty 6
xi. Letter of credit 6
xii. Participation agreement 6
xiii. Promissory note 6
xiv. Purchase and sale agreement 6
xv. Security agreement 6
xvi. Title documentation 6
xvii. UCC filing 6
c. Consumer loans
i. Application for loan denied, including adverse action notice 25 M
ii. Collateral record 6
iii. Hazard insurance record 6
iv. Invoice 6
v. Life and disability insurance record 6
vi. Overdraft loan agreement 6
vii. Promissory note and modification agreement - copy 6
viii. Title documentation 6
ix. UCC filing - copy 6
d. Real estate loans
i. Assignment of escrow 6
ii. Assumption 6
iii. Commitment letter 6
iv. Copy of deed of trust or mortgage note, as it may have been modified 6
v. Escrow analysis and record 6
vi. Evidence of any FHA or PMI insurance required 6
vii. Hazard insurance life of loan
viii. Proof of insurance excluding hazard 6
ix. Sales contract 6
x. Settlement sheet 6
xi. Survey 6
xii. Title documentation 6
e. Construction loans. In addition to the documents specified in subsection (d), a bank shall keep a record for a construction loan as specified in this subsection:
i. Certificate of occupancy 6
ii. Construction progress report 6
iii. Contractor's cost breakdown 6
iv. Disbursement documentation 6
v. Inspection report 6
vi. Residential construction specifications and material list 6

14. Official checks and drafts
a. Affidavit, bond, indemnity agreement, other documentation supporting the issuance of a duplicate check or draft 7
b. Bank draft 3
c. Cashier's check-cancelled 7
d. Cashier's check register-copy 7

e. Expense check-cancelled 7
f. Expense check register-copy 7
g. Expense voucher or invoice 7
h. Money order-bank or personal 7
i. Money order register-copy 7
j. Official check outstanding P

15. Personnel Records
a. Attendance record, and time card 3
b. Authorization for payroll deduction 2
c. Department of labor report 5
d. Disability record 5
e. Employee record and personnel folder 5
f. Employment application 3 AT
g. Insurance record 2
h. Payroll check 2
i. Pension fund record 10
j. Profit sharing fund record 10
k. Rejected employee application 2
l. Salary ledger or electronic data processing printout 4
m. Salary receipt 2
n. W-3 reconciliation of income tax withheld from wages 3
o. W-4 withholding exemption certificate 3
p. Wage and tax statement record (W-2) 7
q. Wage differential documentation (Fair Labor Standards Act) 3

16. Registered mail
a. Marine insurance book 3
b. Record of incoming and outgoing registered mail 1
c. Return receipt card 3

17. Safe deposit vault
a. Access ticket or card 6
b. Court order and correspondence 6
c. Delivery of will, burial plot deed, insurance policy-receipt 6
d. Forced entry record 6
e. Lease or contract-closed account 2 AC
f. Ledger record of account 1
g. Opened box contents-record and report 7
h. Rent receipt-copy 1
i. Sale to satisfy lien-record 7
j. Signature card, authorization, and resolution 6 AC

18. Tellers
a. Mail teller envelope 3 M
b. Teller's balancing recap or recap book 1
c. Teller's cash ticket-original and carbons 1
d. Teller's cash shipment record 1
e. Teller's exchange ticket 1
f. Teller's machine tape 1

19. Transit, proof, and clearing
a. ACH entry 6
b. Advice of correction to deposit 2
c. Clearinghouse settlement sheet - recapitulation of checks delivered to the clearinghouse or federal reserve 2
d. Record of items processed 6
e. Proof machine tape or other record 2
f. Receipt for transit letter 1
g. Return item letter 5

20. Trust department administration
a. Appraisal of real or personal property held as a trust asset 3 AC
b. Correspondence 3 AC
c. Decree or receipt and release 3 AC
d. Fee record and supporting data 3 AC
e. Intermediate and final account 3 AC
f. Legal documentation including judgment, court order, and legal opinion 3 AC
g. Paid bill 3 AP
h. Real estate insurance policy 1 AE
i. Real estate and mortgage document 3 AC
j. Receipt for asset received or delivered 3 AC
k. Record of asset tax cost 3 AC
l. Summary card, original instrument, agreement and amendment, and letters of appointment 3 AC
m. Synopsis sheet 3 AC

21. Corporate trust
a. Bond registration journal 3 AC
b. Bond-cancelled 7
c. Indemnity bond P
d. Certification 2
e. Coupon envelope 6 M
f. Coupon-cancelled 6 M
g. Customer receipt 7
h. Dividend and coupon record 3 AC
i. Dividend and interest disbursement check and list 3 AC
j. General ledger ticket 2
k. Legal paper P
l. Copy of cancelled stock certificate, original returned to customer 1
m. Stock registration journal 3 AC
n. Stock transfer memo 1
o. Stock transfer receipt 1
p. Tax return 3 AC
q. Transfer-supporting papers 3 AC
r. Transfer journal 3 AC
s. Transfer tax waiver 3 AC
t. Trust ledger-corporate 7

22. Personal trust
a. Record of previously discharged fiduciary
i. Accounting 3 AC
ii. Decree 3 AC
iii. Receipt and release 3 AC
b. Accounting - recorded 3 AC
c. Advice of payment - securities department regarding bond and coupon collection 3 AC
d. Appraisal
i. Real property 3 AC
ii. Personal property 3 AC
e. Asset delivery receipt 3 AC
f. Authorization
i. By co-fiduciary P
ii. By consultant P
g. Approval
i. By co-fiduciary P
ii. By consultant P
h. Broker's statement 7
i. Buy and sell order 7
j. Cash documentation
i. Customer cash and asset statement 7
ii. Cash and security journal 7
iii. Cash trial balance 1
k. Common trust fund annual report 10
l. Correspondence
i. Transfer letter 3 AC
ii. Claim letter 3 AC

m.	Coupon collection record	7
n.	Court accounting and petition	7
o.	Daily transaction journal	6 M
p.	Debits and credits-daily	1
q.	Documentation necessary to support account decision	3 AC
r.	Tax Documentation	
i.	Federal estate tax return	10
ii.	State estate tax return	10
iii.	Tax-related work papers	10
iv.	Federal gift tax return	10
s.	Fee calculations and supporting data	1
t.	Income tax return	
i.	Federal	3 AC
ii.	State	3 AC
u.	Inventory	3 AC
v.	Investment review and related material	3 AC
w.	Minutes	
i.	Investment committee	P
ii.	Trust committee	P
23.	Other personal trust records	
a.	Legal opinion	3 AC
b.	Correspondence related to legal opinion	3 AC
c.	Paid bill	7
d.	Review and recommendation	3 AC
e.	Safekeeping record and receipt	3 AC
f.	Security ledger sheet	P
g.	Trust check	10
h.	Trust entry-original	3 AC
i.	Trust or agency agreement-original	3 AC
j.	Vault withdrawal and deposit ticket	7
k.	Will-certified copy	P
l.	Work papers supporting tax return	7
24.	Trust Investments	
a.	Annual report	
i.	Common trust fund	10
ii.	Pooled fund	10
b.	Valuation	
i.	Common trust fund	10
ii.	Pooled fund	10
c.	Minutes	
i.	Investment committee	P
ii.	Administrative committee	P
d.	Investment order and broker's confirmation	3 AC
e.	investment review and related material	3 AC
f.	Correspondence	3 AC
g.	Summary of annual account activity	3 AC
25.	Wire transfer	
a.	Incoming wire log	1
b.	Outgoing wire log	1
c.	Transmission record	7
d.	Wire transfer request	7

Historical Note
Former Rule 14. R20-4-214 recodified from R4-4-214 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4142, effective September 12, 2001 (Supp. 01-3). Missing notation in subsection (D)(1)(j) corrected as proposed at 7 A.A.R. 2491 (Supp. 20-1).

R20-4-215. Trust Business
All banks authorized to conduct trust business under their banking permit shall comply with the applicable requirements of R20-4-808 through R20-4-816.

Historical Note
Adopted effective June 30, 1977 (Supp. 77-3). R20-4-215 recodified from R4-4-215 (Supp. 95-1).

ARTICLE 3. EXPIRED

R20-4-301. Expired

Historical Note
Former Rule 1. R20-4-301 recodified from R4-4-301 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-302. Repealed

Historical Note
Former Rule 2; Repealed effective January 19, 1984 (Supp. 84-1). R20-4-302 recodified from R4-4-302 (Supp. 95-1).

R20-4-303. Expired

Historical Note
Former Rule 3. R20-4-303 recodified from R4-4-303 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-304. Expired

Historical Note
Former Rule 4. R20-4-304 recodified from R4-4-304 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-305. Repealed

Historical Note
Former Rule 5. R20-4-305 recodified from R4-4-305 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-306. Repealed

Historical Note
Former Rule 6. R20-4-306 recodified from R4-4-306 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-307. Repealed

Historical Note
Former Rule 7. R20-4-307 recodified from R4-4-307 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-308. Repealed

Historical Note
Former Rule 8. R20-4-308 recodified from R4-4-308 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-309. Expired

Historical Note
Former Rule 9. R20-4-309 recodified from R4-4-309 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-310. Reserved

R20-4-311. Repealed

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

ARTICLE 2. BANK ORGANIZATION AND REGULATION

Authorizing Statute: A.R.S. § 6-123(2)

6-123. Deputy director; powers

In addition to the other powers, express or implied, the deputy director may:

1. Exercise all powers that are necessary for the administration and enforcement of the laws and rules relating to financial institutions and enterprises.

2. In accordance with title 41, chapter 6, adopt rules that are necessary or appropriate to administer, enforce and accomplish the purposes of this title and adopt rules and issue orders that limit transactions between financial institutions or enterprises and the directors, officers or employees of the financial institutions or enterprises.

3. Require appropriate records, documents, information and reports from any financial institution or enterprise.

4. Submit to the department of public safety, or the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor, the name and fingerprints of any applicant, licensee, active manager or responsible individual or the name and fingerprints of any organizer, director or officer of any corporate applicant or licensee for:

(a) A banking permit.

(b) Permission to organize a savings and loan association or credit union.

(c) Any license.

(d) Any certificate.

(e) Authority to engage in interstate banking and branching in this state.

The department of public safety shall report the criminal record, if any, of such applicant, licensee or organizer, director or officer of such corporate applicant or licensee within ninety days after receipt of the deputy director's request.

5. Employ appraisers to appraise any property that is owned or held as security by any financial institution or enterprise. The reasonable expenses and compensation of such appraisers shall be paid by the financial institution or enterprise.

6. Hold membership in, pay dues to and attend the convention of the national and regional organizations of state officials occupying like offices or performing similar functions.

7. Cooperate with other regulatory agencies and professional associations to promote the efficient, safe and sound operation and regulation of interstate banking and branching activities, including the formulation of interstate examination policies and procedures and the drafting of model rules and agreements.

8. Participate in the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor. The deputy director may allow the system to collect licensing fees on behalf of the deputy director, to collect a processing fee for the services of the system directly from each applicant for a license or licensee and to process and maintain records on behalf of the deputy director, including information collected pursuant to this section and section 6-123.01. This paragraph does not affect the records disclosure requirements and limitations prescribed in section 6-129.01.

Implementing Statutes: A.R.S. § 6-181(9)

6-181. Declaration of purposes

The purposes of this chapter, which shall govern judicial and administrative interpretation and application of the provisions of this chapter, are to provide for:

1. Safe and sound conduct of banks.

2. Conservation of bank assets.

3. Maintenance of public confidence in banks.

4. Protection of the interests of depositors and fiduciary beneficiaries and of the interest of the public in the soundness and preservation of the banking system.

5. Opportunity for banks to remain competitive with each other, with financial institutions existing under other laws of this state and with banking and financial institutions existing under the laws of other states, the United States and foreign countries.

6. Opportunity for banks to serve effectively the convenience and needs of their depositors, borrowers and other customers, to participate in and promote the economic progress of this state and the United States and to improve and expand their services and facilities for those purposes.

7. Opportunity for management of banks to exercise business judgment in conducting banking affairs subject to this chapter.

8. Simplification and modernization of the law governing banking and governing the exercise of fiduciary and other representative powers by banks.

9. Implementation and execution of this chapter by the full utilization of the rulemaking and administrative discretions of the deputy director.

Gmail GRRC - ADOA <grrc@azdoa.gov>

Response to Council Member Thorwald's Question Regarding Title 6, Chap. 4, Article 2 (Bank Organization and Regulation)

1 message

Mary Kosinski <mary.kosinski@difi.az.gov> Fri, Jul 28, 2023 at 10:12 AM
To: GRRC - ADOA <grrc@azdoa.gov>
Cc: Shane Foster <shane.foster@difi.az.gov>

Council Staff,
Here is the Department's response to Council Member Thorwald's questions regarding cryptocurrencies and marijuana proceeds. Please forward to Council Member Thorwald and the other Council Members.

Cryptocurrency:

Through our AZ parity statutes, AZ state-chartered banks can offer cryptocurrency custodial services to customers. However, they will need to notify the federal regulator first before entering this space. The federal (i.e. OCC, FDIC, and FRB) regulators have put forth guidance (not to be confused with law) in this regard.

None of our nine state-chartered banks currently offer cryptocurrency custodial services/products to their clients.

There are roughly 55 other state-chartered banks and national banks that have a physical branch in AZ that AZ DIFI does not supervise, so DIFI's knowledge of what those other banks offer to the public with regard to crypto is limited. Some of the largest firms (ie. Chase, Wells, and B of A), may offer some crypto custodial services to the public.

Is DIFI proposing new legislation with regard to cryptocurrency?

Answer: NO. This is an area that should be championed by the industry, such as the AZ Bankers' Association, etc., Western Bankers Association, Conference of Bank Supervisors, etc.

Some context: The reason why DIFI has not pushed for new crypto legislation is because our AZ state-chartered banks have expressed little interest in us doing so. Furthermore, the Federal regulators, as well as the Federal Trade Commission, the Dept. of the Treasury, Dept. of Justice, and other federal agencies have stated that sweeping federal (uniform) regulations would be forthcoming (this was prompted by the FTX collapse in Nov 2022.)

Since crypto transactions are not limited to a geographical area because crypto transactions can be performed anywhere where an internet connection can be

established, such regulation should be national vs. having each state adopt its own crypto legislation. Adopting such regulation would be logistically unworkable and would likely not be effective for the public, who like uniformity, convenience, etc.

Finally, each individual bank's board determines its own risk appetite and what risk parameters and or products and services the banks should offer the public, not the regulator, DIFI. At this time, none of the nine state-chartered banks are interested in entering the cryptocurrency custodial space. Thus, DIFI sees no impetus to push this agenda.

Please refer to the joint OCC, FRB, and FDIC guidance below.

https://www.occ.treas.gov/news-issuances/news-releases/2023/nr-ia-2023-1a.pdf

https://www.occ.gov/news-issuances/news-releases/2021/nr-ia-2021-120a.pdf

Here is an interesting article about crypto and why we should not propose any state-specific legislation on crypto.

https://cryptonews.com.au/story/house-financial-services-committee-votes-in-favor-of-crypto-blockchain-bills-274643

Marijuana-related businesses:

Offering products and services to marijuana-related businesses is allowed (whether that is a national bank and/or AZ state-chartered bank). State-chartered banks have no more flexibility than national banks in offering marijuana-related products/loans/deposits, etc. to the public.

DIFI has two state-chartered banks that offer such products and services to marijuana-related businesses. DIFI is aware of one national bank headquartered in AZ that offers these same services and products.

(Arizona had a third AZ state-chartered bank that offered products and services to marijuana-related businesses; however, the AZ state-chartered bank was purchased by an out-of-state headquartered national bank. The national bank decided to divest itself from the marijuana-related business.)

Each bank's board determines if the bank wants to cater to such marijuana-related businesses as the due diligence and compliance costs are high, but such fee income can be very profitable.

DIFI has surveyed the 7 other state-chartered banks and none have any interest in offering such products, as the expertise is limited and the ramp-up costs and regulatory scrutiny are high (Ie. FINCEN, OFAC/BSA regulations come into play).

Is DIFI doing anything with regard to AZ marijuana-related business as it relates to reserve deposits needed to be held at banks?

Reserves needed to be held at banks are determined by the FDIC. This federal regulator provides deposit insurance up to $250K; thus, they set the reserve amounts needed to be held. The reserve amount needed to be held is determined by the amount of deposits a bank has vs. what type of deposit is held by the bank (i.e. marijuana-related, regular consumer, a business deposit). The reserve amount required fluctuates as just as deposit amounts ebb and flow on a daily basis.

The more reserve amounts needed to be held does affect the amount of money a bank can lend out. However, normally the reserve amount is a nominal amount compared to the size of the deposits a bank has on any given day. The DIFI does not impose, nor are we planning to impose, any additional regulatory burden on banks as it relates to the daily reserve requirement needed to be held by our AZ state-chartered banks.

DIFI will be available at the August 1 Council Meeting to answer any further questions.
Thank-you,
Mary Kosinski

Mary E. Kosinski

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Phoenix, AZ 85007
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DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS
Title 20, Chapter 4, Article 8

Amend: R20-4-801, R20-4-805, R20-4-806, R20-4-807, R20-4-808, R20-4-809, R20-4-810, R20-4-811, R20-4-812, R20-4-813, R20-4-814, R20-4-815, R20-4-816

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: **Aug 1, 2023**

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

FROM: Council Staff

DATE: **Jul 6, 2023**

SUBJECT: **DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS**
Title 20, Chapter 4, Article 8

Amend: R20-4-801, R20-4-805, R20-4-806, R20-4-807, R20-4-8018, R20-4-809, R20-4-810, R20-4-811, R20-4-812, R20-4-813, R20-4-814, R20-4-815, R20-4-816

Summary:

This regular rulemaking for the Arizona Department of Insurance and Financial Institutions seeks to amend thirteen (13) rules in Title 20, Chapter 4, Article 8, Trust Companies. The purpose of the Department is to execute laws of this state relating to financial institutions and enterprises.

On July 1, 2020, the Department of Financial Institutions merged with the Department of Insurance to form the Department of Insurance and Financial Institutions. The proposed changes in this rulemaking reflect the structural changes of that merger, issues identified in the prior five year review report, and updates to statutory references.

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

The Department cites both general and specific statutory authority for these rules.

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

The Department indicates that the rules do 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?

The Department did not review or rely on any study relevant to the proposed amended rules.

4. Summary of the agency's economic impact analysis:

The Department states that the changes the Department is making will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions, on July 1, 2020. The former Department of Financial Institutions became a division of the new agency. The Department indicates that as a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article. The Department is also intending to modernize the current rules, but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to applicants and licensees.

According to the Department the rulemaking updates language, a requirement for licensees and corrects a statutory reference. Stakeholders include the Department and any entity that holds a certificate issued by the Department to engage in trust business (A.R.S. § 6-853).

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 believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of the regulation of banks holding a banking permit in Arizona.

6. What are the economic impacts on stakeholders?

The Department does not anticipate any costs or benefits in implementing and enforcing the proposed rulemaking. In addition, no political subdivision of this state is directly affected by the implementation of this rule. The Department does not anticipate any additional costs to licensees imposed by the rulemaking.

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

The Department states that there are no changes between the proposed rulemaking and the final rulemaking.

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

The Department did not receive any public or stakeholder comments.

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 that this is not applicable as these rules do not require 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?

The Department indicates that the rules are not more stringent than corresponding federal law.

11. Conclusion

This regular rulemaking for the Arizona Department of Insurance and Financial Institutions seeks to amend thirteen (13) rules in Title 20, Chapter 4, Article 8, Trust Companies. As mentioned above, the amendments will reflect the structural changes of the Department, update and modernize terminology, and make changes identified in the prior Five Year Review Report.

The Department is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A). Council staff recommends approval of this rulemaking.

Arizona Department of Insurance and Financial Institutions
100 N 15th Avenue, Suite 261, Phoenix, Arizona 85007
(602) 364-3100 | difi.az.gov

Katie M. Hobbs, Governor
Barbara D. Richardson, Director

DATE: June 8, 2023

VIA EMAIL: grrc@azdoa.gov
Nicole Sornsin, Chair
Governor's Regulatory Review Council
100 North 15th Ave., Suite 305
Phoenix, AZ 85007

RE: Arizona Department of Insurance and Financial Institutions
Financial Institutions Division
A.A.C. Title 20, Chapter 4, Article 8 – Trust Companies

Dear Chairperson Sornsin:

Please find enclosed the Final Rulemaking for A.A.C. Title 20, Chapter 4, Article 8 – Trust Companies, being submitted by the Arizona Department of Insurance and Financial Institutions ("Department").

Pursuant to A.A.C. R1-6-201(A)(1), the Department responds as follows:

a. The Department closed the record on this rulemaking on February 26, 2023.
b. This rulemaking relates to a previous five-year review report. The Department of Financial Institutions submitted the previous five-year review report on this Article to the Council which it approved at the Council's February 4, 2020 Council Meeting.
c. The rulemaking does not establish a new fee.
d. The rulemaking does not contain a fee increase.
e. The rulemaking does not request an immediate effective date under A.R.S. § 41-1032.
f. The Department certifies that the preamble discloses a reference to any study relevant to the rule that it reviewed and either did or did not rely on in its evaluation of or justification for the rulemaking. The Department did not review or rely on any study relevant to the rulemaking.
g. No new full-time employees are necessary to implement and enforce the rule.
h. The following documents are also submitted to the Council with this cover letter:
    i. The Notice of Final Rulemaking;
    ii. An economic, small business, and consumer impact statement that contains the information required by A.R.S. § 41-1055;
    iii. The general and specific statutes authorizing the rulemaking.

By this submission, the Department is requesting approval of this rulemaking from the Council.

For questions about this rulemaking, please contact Mary Kosinski at (602) 364-3476 or mary.kosinski@difi.az.gov.

Sincerely,

Barbara D. Richardson

Barbara D. Richardson
Director

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS

– financial institutions

PREAMBLE

1. Articles, Parts, or Sections Affected (as applicable) **Rulemaking Action**

R20-4-801	Amend
R20-4-805	Amend
R20-4-806	Amend
R20-4-807	Amend
R20-4-808	Amend
R20-4-809	Amend
R20-4-810	Amend
R20-4-811	Amend
R20-4-812	Amend
R20-4-813	Amend
R20-4-814	Amend
R20-4-815	Amend
R20-4-816	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. § 6-123(2)

Implementing statutes: A.R.S. §§ 6-851, 6-853(A) (trust companies), 6-382 and 6-853(B) (banks), 6-434 and 6-853(C) (savings and loan associations), 6-854, 6-859, 6-861, and 6-865

3. The effective date of the rule:

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening:	29 A.A.R. 424, January 27, 2023
Notice of Proposed Rulemaking:	29 A.A.R. 286, January 27, 2023

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

Name: Mary E. Kosinski
Address: Department of Insurance and Financial Institutions
100 N. 15th Ave., Suite 261
Phoenix, Arizona 85007-2630
Telephone: (602)364-3476
E-mail: mary.kosinski@difi.az.gov
Web site: https://difi.az.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:

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 8 – Trust Companies. The statutory sections governing trust companies can be found at Title 6, Chapter 8 (A.R.S. §§ 6-851 through 6-882).

The changes the Department is proposing will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions (the "new agency"), on July 1, 2020. The former Department of Financial Institutions became a division of the new agency.

As a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article.

When reviewing the rules in the Article, the Department also endeavored to modernize the current rules including allowing for electronic recordkeeping since the most recent rulemaking for this Article was in 2002. In addition, in a commitment made in a 2019 Five-Year Review Report, the Department is correcting a statutory reference.

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 and does not propose to rely on any study relevant to 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:

The rulemaking updates language, a requirement for licensees and corrects a statutory reference. The rulemaking does not diminish a previous grant of authority granted to the Department.

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

Pursuant to A.R.S. § 41-1055(A)(1):

- The rulemaking is not designed to change any conduct of licensees because of a perceived harm or to change the frequency of any violative conduct.

Pursuant to A.R.S. § 41-1055(A)(2):

The Department anticipates no probable costs to licensees imposed by the rulemaking.

The Department anticipates the following probable benefits to licensees:

1. The removal of the requirement to notify the Director before using an electronic recordkeeping system (R20-4-806); and

2. The removal of the requirement to keep originals of certain documents (R20-4-806).

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to licensees.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The Department made no changes to the Notice of Final Rulemaking from the Notice of Proposed 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 published the Notice of Proposed Rulemaking for Bank Organization and Regulation on January 27, 2023. (29 A.A.R. 285, January 27, 2023) At that time it also opened a 30-day Comment Period. During the Comment Period, no one submitted a comment to the Department or requested an Oral Proceeding.

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

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

reasons why a general permit is not used:

Not applicable. Pursuant to A.R.S. § 6-853, no person can engage in trust business in Arizona without first obtaining a certificate from the Director. A general permit is not applicable to trust business.

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:

Section R20-4-807 (Unsafe or Unsound Condition) finds that a trust company may be in unsafe or unsound condition if it violates any federal requirement for maintaining trusts, common trust funds, or other accounts, or if it violates any applicable federal law or regulation regarding corporations or securities. The rule is not more stringent than the federal law.

Section R20-4-810 (Funds Awaiting Investment or Distribution) requires collateral to qualify as the following types of federal securities:

- Direct obligations of the United States or any agency, department, division, or administration of the federal government;
- Any other obligations fully guaranteed by the United States government as to principal and interest;
- Obligations of the Federal Reserve Bank; and
- Readily marketable securities that qualify as investment securities under the Investment Securities regulations of the Comptroller of the Currency, 12 CFR, Chapter 1, Part 1.

No collateral security is required to the extent the Federal Deposit Insurance Corporation, or its successor, insures the deposited trust funds. The rule is not more stringent than the federal law.

Section R20-4-812 (Self-dealing), subsection (C), prohibits a trust department or trust

company from selling or loaning trust property to itself or certain persons unless expressly authorized by federal law. The rule is not more stringent that the federal law.
In the same rule, subsection (F) allows a trust department or trust company to loan trust property held in one account to another of its accounts if the transaction is not prohibited by applicable federal law. The rule is not more stringent than the federal law.
In the same rule, subsection (G), allows a trust department or trust company to make a loan to a trust account, taking trust assets of the borrowing account as security for repayment if the transaction is not prohibited by applicable federal law. The rule is not more stringent than the 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 formal analysis has been submitted to the Department that compares the rule's impact of the competitiveness of business in this state to the impact of business in other states.

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

No materials are incorporated by reference.

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. The rule was not previously made, amended or repealed as an emergency rule.

15. The full text of the rules follows:

Title 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

ARTICLE 8. trust companies

Section

ARTICLE 8. TRUST COMPANIES

R20-4-801. Definitions

~~In this Article, unless the context otherwise requires:~~ In addition to the definitions provided in A.R.S. § 6-851, the following terms apply to this Article unless the context otherwise requires:

"Account" means the trust, estate, or other fiduciary relationship established with a trust department or trust company.

"Affiliate" has the meaning stated at A.R.S. § 6-801.

~~"Certificate" has the meaning stated at A.R.S. § 6-851.~~

"Director" has the meaning stated at A.R.S. § 20-102.

~~"Fiduciary" has the meaning stated at A.R.S. § 6-851.~~

"Governing instrument" means a document, and all its operative amendments, that:

a. Creates a trust and regulates the trustee's conduct,

b. Creates an agency relationship between a trust department or trust company and a client, or

c. Otherwise evidences a fiduciary relationship between a trust department or trust company and a client.

"Investment responsibility" means full and unrestricted discretion to invest trust funds without direction from anyone as to any matter, including the terms of the trade or the identity of the broker.

"Person" has the meaning stated at A.R.S. § ~~1-215.~~ 20-105.

~~"Superintendent" has the meaning stated at A.R.S. § 6-851.~~

"Trust asset" means any property or property right held by a trust department or trust company for the benefit of another.

~~"Trust business" has the meaning stated at A.R.S. § 6-851.~~

~~"Trust company" has the meaning stated at A.R.S. § 6-851.~~

"Trust department" means a permittee under both A.R.S. § 6-201 et seq. and Article 2 of this Chapter that possesses a banking permit authorizing it to engage in trust business.

"Trust funds" means any money held by a trust department or trust company for the benefit of another.

"Trustor" means a person who creates or funds a trust, or both.

R20-4-805. Reports

A. Within 90 days following each December 31, each trust department and trust company shall file an annual report of trust assets with the ~~Superintendent~~ Director on the form prescribed by the ~~Superintendent.~~ Director. The annual report shall include the current market value of

all trust assets held by the trust department or trust company as of December 31. The report shall also identify and briefly describe all transactions conducted in the report period that are regulated by subsections R20-4-812(E) through R20-4-812(G).

B. Each trust company shall deliver a copy of its annual report and certificate of disclosure to the ~~Superintendent~~ Director within 10 days of filing the report and certificate at the Arizona Corporation Commission. A report or certificate covered by this subsection is one filed under the authority of A.R.S. §§ 10-202 or 10-1622. A copy delivered to the ~~Superintendent,~~ Director, as required in this subsection, shall be date-stamped by the Arizona Corporation Commission to confirm the actual filing date.

C. Each trust company shall notify the ~~Superintendent~~ Director of any change in the directors or officers of the company within 10 days of the change. Any trust company with more than 25 officers may, after obtaining the ~~Superintendent's~~ Director's written approval, limit the officers covered by this subsection to those with substantial involvement in the trust company's corporate operations or in the trust company's trust business in this state.

R20-4-806. Records

A. ~~A trust company may use a computer recordkeeping system if the trust company gives the Superintendent advanced written notice that it intends to do so.~~ Every trust company shall keep its records as originals or as copies of the originals made by reproduction methods that accurately and permanently preserve the records. ~~Except for records required by subsections (B)(1)(a) and (B)(1)(b), the Department shall not require a trust company to keep a written copy of~~ A trust company may keep its records as electronic records if the trust company can generate all information and copies required by this Section ~~in a timely manner~~ within the timeframe set by the Department for examination or other purposes. ~~A trust company may add, delete, modify, or customize a computer recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a trust company shall report to the Superintendent any alteration in the computer recordkeeping system's fundamental character, medium, or function if the alteration changes the computer system to a paper-based system.~~

B. A trust department or trust company shall keep books, accounts, and records adequate to provide clear and readily understandable evidence of all business conducted by the trust department or trust company, including the following:

1. A file for each account that includes:
   a. The ~~original of the~~ governing instrument,
   b. ~~The originals of all~~ All contracts and other legal documents,
   c. Copies of all correspondence,
   d. Accounting records disclosing all the financial transactions, and
   e. A listing of all the account's assets and liabilities.
2. An investment file for each account that includes:
   a. All original documentary evidence of the account's assets; or
   b. Copies of the original documentary evidence of the account's assets, together with written evidence of custody or receipt of the originals by an authorized holder; and
   c. A record of the initial and annual investment reviews for the account.
3. The corporate general ledger kept current on a daily basis. This record shall identify and segregate all financial transactions conducted by the trust department or trust company for itself, distinguishing them from those relating to the trust department's or trust company's trust business;
4. Unaudited financial statements. A trust department or trust company shall produce these statements quarterly or more frequently when ~~directed~~ required by the ~~Superintendent.~~ Director. The financial statements shall include at least:
   a. A balance sheet; and
   b. A statement of income, expenses, and retained earnings.
5. Adequate records of all pending litigation that names the trust department or trust company as a party.

C. A trust department shall keep its fiduciary records separate and distinct from the trust department's corporate records.

D. A trust department or trust company shall keep records described in subsections (B)(1) and (B)(2) for at least three years after closing an account. If litigation occurs concerning a

particular account, the trust department or trust company shall keep that account's records, described in subsections (B)(1) and (B)(2), for three years after the litigation is resolved.

R20-4-807. Unsafe or Unsound Condition

For purposes of A.R.S. §§ 6-863 and 6-865, a trust company conducts business in an unsafe manner or its affairs are in an unsound condition if it:

1. Violates any fiduciary duty or obligation, including those listed in Sections R20-4-809 through R20-4-815;
2. Violates any state or federal requirement for operating or maintaining trusts, common trust funds, or other accounts;
3. Violates any applicable federal or state law or regulation regarding corporations or securities;
4. Employs an officer or director who violates a corporate fiduciary duty;
5. Is insolvent; or
6. Engages in any conduct that the ~~Superintendent~~ Director determines constitutes an unsafe or unsound business practice jeopardizing the trust company's financial condition or the interests of a stockholder, creditor, trustor, beneficiary, or trust company's principal.

R20-4-808. Administration of Fiduciary Powers

A. The board of directors and the officers share responsibility for the exercise of fiduciary powers by a trust department or trust company. The board of directors is responsible for determining policy; investing and disposing of trust assets; and directing and reviewing the actions of all directors, officers, and committees of the board that exercise fiduciary powers. The board of directors may delegate the necessary power and authority to perform the trust department's or trust company's duties as a fiduciary to selected directors, officers, employees, or committees of the board if the delegation is consistent with the corporate charter. The minutes of the board's meetings shall duly reflect all those delegations.

B. A trust department or trust company shall not accept a new account without first obtaining the board's approval, or that of the directors, officers, or committees that the board may have authorized to approve new accounts. The trust department or trust company shall keep a written record of each new account approval and of the closing of each account. The trust department or trust company shall conduct an asset review within 60 days after it accepts each new account if it has investment responsibility for that account. The trust department's or trust company's board shall ensure that an annual review of account assets is conducted for ~~any~~ each account in which the trust department or trust company has investment responsibility, to determine whether to retain or dispose of the assets.

C. A trust department or trust company exercising fiduciary powers shall use independent legal counsel admitted to practice in Arizona to advise and inform the trust department or trust company on fiduciary matters and all other legal issues presented to the trust department or trust company by the conduct of its trust business.

R20-4-809. Fiduciary Duties

A trust department or trust company shall perform all fiduciary duties imposed upon it by law, including the following:

1. Administer accounts strictly according to the governing instrument and solely in the account beneficiary's interests;
2. Use reasonable care and skill to make the account productive;
3. Provide complete and accurate information ~~of~~ about the nature and amount of assets held to each account's beneficiary or principal and permit the beneficiary, principal, or any person duly authorized by the beneficiary or principal to inspect the account's records at any time during normal business hours. The information provided in compliance with this subsection shall be delivered at least quarterly, unless:
    a. The trust department or trust company and its account's beneficiary, principal, or authorized person agree otherwise in writing;
    b. The governing instrument provides otherwise; or

c. A different frequency is established by a lawful course of dealing before the effective date of this rule; and

4. Comply with all lawful provisions of the governing instrument.

R20-4-810. Funds Awaiting Investment or Distribution

A. Trust funds held by a trust department or trust company awaiting investment or distribution shall not remain uninvested or undistributed any longer than is reasonable for the account's proper management.

B. A trust department or trust company may keep trust funds in deposit accounts maintained by the trust department or trust company~~,~~ unless prohibited by law or by the governing instrument. The trust department or trust company shall set aside collateral security for all deposited trust funds under a third party's control. The collateral shall be the following types of securities, in any combination:

1. Direct obligations of the United States or any agency, department, division, or administration of the federal government;
2. Any other obligations fully guaranteed by the United States government as to principal and interest;
3. Obligations of a Federal Reserve Bank;
4. Obligations of any state, political subdivision of a state, or public authority organized under the laws of a state; or
5. Readily marketable securities that either:
   a. Qualify as investment securities under the Investment Securities regulations of the Comptroller of the Currency, 12 CFR, Chapter 1, Part 1; or
   b. Satisfy state pledging requirements under A.R.S. § 6-245(C).

C. The securities set aside under subsection (B) shall, at all times, have a market value no less than the amount of trust funds deposited. No collateral security is required to the extent the Federal Deposit Insurance Corporation, or its successor, insures the deposited trust funds.

R20-4-811. Investment of Trust Funds

A. A trust department or trust company shall invest trust funds according to:

1. The governing instrument; and
2. All applicable laws, including A.R.S. §§ 6-862, 14-7402, and ~~14-7601 through 14-7611.~~ 14-7501 through 14-7512

B. A trust department or trust company shall make any collective investment of trust funds exclusively under the terms of Section R20-4-815.

R20-4-812. Self-dealing

A. A trust department or trust company shall not invest trust funds in the following types of property unless expressly authorized by the governing instrument, applicable state or federal law, or court order:

1. Its own securities;
2. Other types of property acquired from the trust department or trust company;
3. Property acquired from the trust department's or trust company's directors, officers, or employees;
4. Property acquired from the trust department's or trust company's affiliates;
5. Property acquired from its affiliates' directors, officers, or employees; or
6. Property acquired from other individuals or organizations with an interest in the trust department or trust company if that interest might affect the trust department's or trust company's exercise of discretion to the detriment of its trust clients.

B. A trust department or trust company may use trust funds to purchase its own securities, or its affiliates' securities:

1. If the trust department or trust company has authority under subsection (A), and
2. If those securities are offered pro rata to all stockholders of the trust department or trust company.

C. A trust department or trust company shall not sell or loan trust property to itself, or to the following types of persons, unless expressly authorized by the governing instrument, applicable state or federal law, or court order:

1. Its directors, officers, or employees;
2. Its affiliates;
3. Its affiliates' directors, officers, or employees; or
4. Other individuals or organizations with an interest in the trust department or trust company if that interest might affect the trust department's or trust company's exercise of discretion to the detriment of its trust clients.

D. However, a trust department or trust company may sell or loan trust property to persons prohibited by subsection (C) if either:

1. Its counsel has advised in writing that, by holding certain property, the trust department or trust company has incurred a contingent or potential liability for breach of fiduciary duty; and
   a. The proposed sale or loan avoids the contingent or potential liability;
   b. Its board of directors authorizes the sale or loan by an action duly noted in the trust department's or trust company's minutes;
   c. Its board of directors' action expressly authorizes reimbursement to the affected account; and
   d. The affected account is reimbursed, in cash, at no loss to that account; or
2. The ~~Superintendent~~ Director requires or approves, in writing, the sale or loan to otherwise prohibited parties.

E. A trust department or trust company may sell trust property held in one account to another of its accounts if:

1. The transaction is fair to both accounts; and
2. The transaction is not prohibited by the governing instruments, applicable state or federal law, or court order.

F. A trust department or trust company may loan trust property held in one account to another of its accounts if:

1. The transaction is fair to both accounts; and
2. The transaction is not prohibited by the governing instruments, applicable state or federal law, or court order.

G. A trust department or trust company may make a loan to a trust account, taking trust assets of the borrowing account as security for repayment, if:

1. The transaction is fair to the borrowing account; and
2. The transaction is not prohibited by the governing instrument, applicable state or federal law, or court order.

R20-4-813. Custody of Investments

A. A trust department or trust company shall keep each account's investments separate from its own assets. ~~It~~ A trust department or trust company shall place each account's assets in the joint control of at least two officers or employees of the trust department or trust company designated in writing for that purpose by:

1. The trust department's or trust company's board of directors, or
2. One or more officers authorized by the trust department's or trust company's board of directors to make the designation.

B. A trust department or trust company shall either:

1. Keep each account's investments separate from all other accounts' investments, except as provided in Section R20-4-815; or
2. Adequately identify each account's property in the trust department's or trust company's records.

R20-4-814. Compensation

A. A trust department or trust company acting as a fiduciary may charge a reasonable fee for its services. ~~It~~ The trust department or trust company shall receive the fee allowed by the court when it is acting under a court appointment. Any agreement as to fees in the governing instrument shall control the fee unless contrary to law, regulation, or court order.

B. A trust department or trust company shall not permit any of its officers or employees to take any compensation for acting as a co-fiduciary with the trust department or trust company in the administration of an account.

R20-4-815. Collective Investments

A. All collective investments made by a trust department or trust company shall be in a common trust fund established under A.R.S. § 6-871~~,~~ and maintained by the trust department or trust company exclusively for the collective investment and reinvestment of funds contributed by the trust department or trust company acting as a fiduciary. A trust department or trust company shall not establish a common trust fund unless it first:

1. Prepares a written plan regarding the common trust fund; and
2. Obtains its board of directors' approval of the plan, evidenced by a duly adopted resolution or the board's unanimous written consent.

B. The plan shall describe the common trust fund's operational details, including a description of:

1. The trust department's or trust company's investment powers and investment policy over all funds deposited in the common trust fund,
2. The manner for allocating the common trust fund's income and losses,
3. The criteria for admission to or withdrawal from participating in the common trust fund, and
4. The method for valuing assets in the common trust fund and the frequency of valuation.

C. A trust department or trust company shall advise all persons having an interest in its common trust fund of the existence of the plan described in subsection (B), and shall provide a copy of the plan upon request.

D. The annual report required under Section R20-4-805(A) shall include all common trust funds operated by the trust department or trust company.

R20-4-816. Termination of Trust or Fiduciary Powers and Duties

A. Any trust department that wants to surrender its trust powers shall file with the ~~Superintendent~~ Director a certified copy of the appropriate resolution of its board of directors or of the board's unanimous written consent. If, after investigation, the ~~Superintendent~~ Director concludes that the trust department has no remaining fiduciary duties, the ~~Superintendent~~ Director shall notify the trust department that it no longer has authority to exercise trust powers.

B. Any trust company that wants to surrender its certificate of authority to conduct trust business and wind up its affairs shall file with the ~~Superintendent~~ Director a certified copy of the appropriate resolution of its board of directors or of the board's unanimous written consent. Upon receipt of the resolution or consent, the ~~Superintendent~~ Director shall cancel the trust company's certificate of authority, and the trust company shall not accept new trust accounts.

C. After winding up its affairs, any trust company that wants to surrender its rights and obligations as a fiduciary and remove itself from the ~~Superintendent's~~ Director's supervision shall file with the ~~Superintendent~~ Director a certified copy of the appropriate resolution of its board of directors or of the board's unanimous written consent. If, after investigation, the ~~Superintendent~~ Director concludes that the trust company has no further fiduciary duties, the ~~Superintendent~~ Director shall notify the trust company that it no longer has authority to exercise fiduciary powers.

D. Any trust department or trust company that surrenders its powers, rights, obligations, or certificate under this Section or that has them cancelled, suspended, or revoked shall continue to be regulated under A.R.S. § 6-864 and this Article until it winds up its affairs. No action under this Section impairs any liability or cause of action, existing or incurred, against any trust department or trust company or its stockholders, directors, or officers.

A.R.S. § 41-1055(B) Economic, Small Business, And Consumer Impact Statement
Title 20. Commerce, Financial Institutions and Insurance
Chapter 4. Department of Insurance and Financial Institutions – Financial Institutions
Article 8. Trust Companies

A.R.S. § 41-1055(B)(1): An identification of the proposed rulemaking.

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 8 – Trust Companies. The statutory sections governing trust companies can be found at Title 6, Chapter 8 (A.R.S. §§ 6-851 through 6-882).

The changes the Department is proposing will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions (the "new agency"), on July 1, 2020. The former Department of Financial Institutions became a division of the new agency.

As a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article.

When reviewing the rules in the Article, the Department also endeavored to modernize the current rules including allowing for electronic recordkeeping since the most recent rulemaking for this Article was in 2002. In addition, in a commitment made in a 2019 Five-Year Review Report, the Department is correcting a statutory reference.

Questions about this Economic Impact Statement can be directed to: Mary E. Kosinski (mary.kosinski@difi.az.gov).

A.R.S. § 41-1055(B)(2): An identification of the persons who will be directly affected by, bear the costs of or directly benefit from the proposed rulemaking.

This Article applies to an entity that holds a certificate issued by the Department to engage in trust business. A.R.S. § 6-853.

A.R.S. § 41-1055(B)(3): A cost benefit analysis of the following:

(a) The probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking. The probable costs to the implementing agency shall include the number of new full-time employees necessary to implement and enforce the proposed rule. The preparer of the economic, small business and consumer impact statement shall notify the joint legislative budget committee of the number of new full-time employees necessary to implement and enforce the rule before the rule is approved by the council.

The Department does not anticipate any costs or benefits in implementing and enforcing the proposed rulemaking. No new full-time employees will be necessary to implement and enforce the proposed rulemaking.

(b) The probable costs and benefits to a political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.

No political subdivision of this state is directly affected by the implementation and enforcement of the proposed rulemaking.

(c) The probable costs and benefits to businesses directly affected by the proposed rulemaking, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the proposed rulemaking.

The Department anticipates no additional probable costs to licensees imposed by the rulemaking.

The Department anticipates the following probable benefits to licensees:

1. The removal of the requirement to notify the Director before using an electronic recordkeeping system (R20-4-806); and
2. The removal of the requirement to maintain originals for certain documents (R20-4-806).

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to licensees.

A.R.S. § 41-1055(B)(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 proposed rulemaking.

The Department does not anticipate any impact on the private employment of persons holding trust company certificates issued by the Department. Likewise, the Department does not anticipate any impact on public employment in the Department.

A.R.S. § 41-1055(B)(5): A statement of the probable impact of the proposed rulemaking on small businesses. The statement shall include:

(a) An identification of the small businesses subject to the proposed rulemaking.

"Small business" is defined as a concern, including its affiliates, which is:

a. Independently owned and operated,

b. Not dominant in its field,

c. Employs fewer than 100 full-time employees, and

d. Had gross annual receipts of less than $4 million in its last fiscal year.

A.R.S. § 41-1001(23).

One of the ten trust companies in Arizona qualifies as a small business. Currently, no Arizona chartered banks have a trust department.

(b) The administrative and other costs required for compliance with the proposed rulemaking.

The proposed changes to the Article impose no probable costs to licensees.

(c) A description of the methods prescribed in section 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 to use each method.

A.R.S. § 41-1035 lists the following methods to reduce the impact on small businesses:

1. Establish less stringent compliance or reporting requirements in the rule for small businesses.

The Department did not establish less stringent compliance or reporting requirements for small businesses that are trust companies because the rulemaking removes compliance requirements for all licensees.

2. Establish less stringent schedules or deadlines in the rule for compliance or reporting requirements for small businesses.

The Department did not establish less stringent schedules or deadlines for small businesses that are trust companies Arizona because the Department did not change any schedules or deadlines from the prior rules in this rulemaking.

3. Consolidate or simplify the rule's compliance or reporting requirements for small businesses.

The Department did not consolidate or simplify compliance or reporting requirements for small businesses that are trust companies because it applies all compliance and reporting requirements to all licensees. The Department's compliance and reporting requirements are necessary for consumer protection and to align with federal requirements.

4. Establish performance standards for small businesses to replace design or operational standards in the rule.

The Department did not establish performance standards to replace design or operational standards for small businesses that are trust companies because the Department applies design and operational standards to all licensees. No changes have been implemented to design or operational standards from the prior rules.

5. Exempt small businesses from any or all requirements of the rule.

The Department did not exempt small businesses that are trust companies from any or all requirements of the rules because the requirements of the rules are necessary for consumer protections and to align with federal requirements.

(d) The probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.

The Department does not anticipate any cost or benefit to private persons and consumers.

A.R.S. § 41-1055(B)(6): A statement of the probable effect on state revenues.

No impact on state revenues is anticipated.

A.R.S. § 41-1055(B)(7): A 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 Department believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of the regulation of trust companies in Arizona.

A.R.S. § 41-1055(B)(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. An agency advocating that any data is acceptable data has the burden of proving that the data is acceptable. For the purposes of this paragraph, "acceptable data" means empirical, replicable and testable data as evidenced in supporting documentation, statistics, reports, studies or research.

The rule is not based on any data.

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

ARTICLE 8. TRUST COMPANIES

Authorizing Statute: A.R.S. § 6-123(2)

6-123. Deputy director; powers

In addition to the other powers, express or implied, the deputy director may:

1. Exercise all powers that are necessary for the administration and enforcement of the laws and rules relating to financial institutions and enterprises.

2. In accordance with title 41, chapter 6, adopt rules that are necessary or appropriate to administer, enforce and accomplish the purposes of this title and adopt rules and issue orders that limit transactions between financial institutions or enterprises and the directors, officers or employees of the financial institutions or enterprises.

3. Require appropriate records, documents, information and reports from any financial institution or enterprise.

4. Submit to the department of public safety, or the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor, the name and fingerprints of any applicant, licensee, active manager or responsible individual or the name and fingerprints of any organizer, director or officer of any corporate applicant or licensee for:

(a) A banking permit.

(b) Permission to organize a savings and loan association or credit union.

(c) Any license.

(d) Any certificate.

(e) Authority to engage in interstate banking and branching in this state.

The department of public safety shall report the criminal record, if any, of such applicant, licensee or organizer, director or officer of such corporate applicant or licensee within ninety days after receipt of the deputy director's request.

5. Employ appraisers to appraise any property that is owned or held as security by any financial institution or enterprise. The reasonable expenses and compensation of such appraisers shall be paid by the financial institution or enterprise.

6. Hold membership in, pay dues to and attend the convention of the national and regional organizations of state officials occupying like offices or performing similar functions.

7. Cooperate with other regulatory agencies and professional associations to promote the efficient, safe and sound operation and regulation of interstate banking and branching activities, including the formulation of interstate examination policies and procedures and the drafting of model rules and agreements.

8. Participate in the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor. The deputy director may allow the system to collect licensing fees on behalf of the deputy director, to collect a processing fee for the services of the system directly from each applicant for a license or licensee and to process and maintain records on behalf of the deputy director, including information collected pursuant to this section and section 6-123.01. This paragraph does not affect the records disclosure requirements and limitations prescribed in section 6-129.01.

Implementing Statutes: A.R.S. §§ 6-851 and 6-853(A) (trust companies), 6-382 and 6-853(B) (banks), 6-434 and 6-853(C) (savings and loan associations), 6-854, 6-859, 6-861, and 6-865

6-851. Definitions

A. In this chapter, unless the context otherwise requires:

1. "Trust business" means the holding out by a person to the public at large by advertising, solicitation or other means that the person is available to act as a fiduciary in this state and accepting and undertaking to perform the duties as such a fiduciary in the regular course of business.

2. "Trust company" means a corporation holding a certificate issued under this article.

B. In this article, unless the context otherwise requires:

1. "Agent" means a person who receives compensation to regularly perform services specifically related to the conduct of the trust business.

2. "Asset" means any property or property right held by a licensee for the benefit of another.

3. "Capital" means the total of outstanding common stock, preferred stock and surplus and undivided profits.

4. "Certificate" means a certificate of authority issued under this chapter to engage in trust business.

5. "Contingency plan" means a document stating a trust company's means of conducting business and preserving records in the event of any power outage, flood or other physical emergency.

6. "Discretionary assets" means those assets in which the trust company has the unilateral authority to determine investment strategies and execute investment transactions without seeking the concurrence, approval or authority from the customer or any other external party.

7. "Fiduciary" means a personal representative, administrator, guardian, conservator, trustee, agent or other person who acts in a fiduciary capacity and who is not exempt by section 6-852.

8. "Impaired" or "insolvent" means the trust company does not possess assets that are at least equal to liabilities, required reserves and total issued and outstanding capital.

9. "Legal tender" means a medium of exchange, including specie, that is authorized by the United States Constitution or Congress for the payment of debts, public charges, taxes and dues.

10. "Liquid capital" means legal tender, capital in the form of certificates of deposit issued by banks, savings banks or savings and loan associations doing business in this state and insured by

the federal deposit insurance corporation or any successor institution, including deposits to a single depository where excess deposit insurance is provided through a reciprocal deposit arrangement by participating banks, or direct obligations of the United States government with maturity of not more than five years.

11. "Nondiscretionary assets" means those assets for which the trust company must obtain from the customer, broker or investment advisor specific direction and instructions regarding both investment strategies and investment executions.

12. "Specie" means coins having precious metal content.

13. "Surplus" means the total amount paid by shareholders in excess of the par or stated value of the shares of capital stock of a trust business in consideration for the shares.

6-853. Certificate required; exceptions

A. A person shall not engage in the trust business without first obtaining a certificate from the deputy director except as provided by subsection B or C of this section, or by section 6-852, subsection C.

B. A bank, if a member of the federal deposit insurance corporation and otherwise authorized under the laws of the United States, this state or any other state to engage in the trust business in this state, may engage in that business as a bank without obtaining a certificate under this chapter, and shall not be subject to this article, except for section 6-859, subsection A and section 6-860.

C. If a savings and loan association or savings bank is a member of the federal deposit insurance corporation and is authorized under the laws of the United States, this state or any other state to engage in the trust business in this state, the savings and loan association or savings bank may engage in that business as a savings and loan association or savings bank without obtaining a certificate under this chapter and is not subject to this article, except for section 6-859, subsection A and section 6-860.

6-382. Powers of bank as fiduciary

The prohibitions, limitations and restrictions on the transactions of a bank in dealing with its general assets shall not be applicable to a bank in the exercise of its powers as a fiduciary over assets held in such capacity or with respect to obligations incurred in such capacity against the credit of the trust.

6-434. Shares and accounts of certain associations as legal investments; deposit of fiduciary monies

A. All accounts of a federal savings and loan association and all accounts of a savings and loan association operating under this chapter, whose accounts are insured by the federal deposit insurance corporation, as provided in title IV of the national housing act, as now or hereafter

amended, are legal investments for the funds of executors, administrators, guardians, receivers and trustees of every kind and nature and insurance companies, and such associations are qualified to act as trustee or custodian within the provisions of the federal self-employed individual's tax retirement act of 1962, as amended.

B. Monies held by a savings and loan association as fiduciary may be deposited to the credit of the savings and loan association on time or demand account with itself or with any bank or other savings and loan association the deposits of which are insured by instrumentalities of, or corporations chartered by, the United States for the purpose of insuring the accounts of banks or savings and loan associations. Unless otherwise provided by the writing creating the trust, if the monies are deposited with itself the savings and loan association shall secure the deposits with securities described in section 6-446, subsection A, paragraphs 1 and 2 or other security approved by the deputy director for such a purpose, in the amount of the deposit, less the amount by which the deposits are insured by the federal deposit insurance corporation or such other instrumentality of, or corporation chartered by, the United States as may be established for the purpose of insuring the accounts of savings and loan associations.

6-854. Application for certificate

A. An application for a certificate shall be in writing, in such form as the deputy director shall prescribe, verified under oath and supported by such information, data and records as the deputy director may require.

B. An application for a certificate shall include the applicant's executed articles of incorporation and the fee prescribed in section 6-126.

6-859. Records; audits; preservation of records; protection; insurance; bond; contingency plan

A. A bank, savings and loan association or trust company shall keep and use in its business any books, accounts and records which will enable the deputy director to determine whether the bank, savings and loan association or trust company is complying with this article and the rules of the deputy director. The deputy director by rule may provide the periods of time and the manner in which such books, accounts and records shall be preserved.

B. A certified public accountant shall audit the corporate records and trust business of each trust company at least once each fiscal year. The trust company shall file a copy of the audit report with the deputy director not more than one hundred twenty days after the end of the trust company's fiscal year. The audit requirement may be satisfied by filing a copy of the audit report of the parent of the trust company if the audit report is prepared by a certified public accountant and includes a detailed examination of the trust company's assets and liabilities and trust business. If the trust company shows good cause the deputy director may extend the time to file the audit report by not more than ninety days.

C. The audit shall include an examination of the trust company's internal control structure over the financial reporting and accounting of the trust business plus any reportable conditions of the trust company's internal control structure. For purposes of this subsection, "reportable

conditions" means significant deficiencies in the design or operation of the internal control structure that would adversely affect the trust company's ability to perform its business activities and carry out its fiduciary duties and responsibilities consistent with the safe, sound and lawful operation of the trust business.

D. The board of directors of a trust company shall require protection and indemnity for the trust company, pursuant to section 6-868, against dishonesty, fraud, defalcation, forgery, theft, embezzlement, and other similar insurable losses, with corporate insurance or surety companies authorized to do business in this state. Coverage against such losses shall include all agents who do not otherwise provide protection and indemnity for the trust company, directors, officers and employees of the trust company acting independently or in collusion or combination with any person or persons whether or not they draw salary or compensation.

E. The board of directors shall require suitable insurance to protect the trust company against burglary, robbery, theft and other insurable hazards to which it may be exposed in the operation of the business.

F. The board of directors shall procure errors and omissions insurance of at least $500,000.

G. At least once each year the board of directors shall review the fidelity bond and the errors and omissions insurance to determine the adequacy of coverage in relation to the exposure. The minimum amount of insurance required in this chapter does not automatically represent adequate bond and insurance coverage in relation to the exposure. The actions by the board of directors shall be recorded in the minutes of the board. Immediately after procuring the bonds, the board of directors shall file them with the deputy director.

H. The board of directors and senior management shall:

1. Establish policies, procedures and responsibilities for comprehensive contingency planning.

2. Annually review and approve the trust company's contingency plans and record the actions in the minutes of the board of directors.

I. If the trust company receives information processing from a service bureau the board of directors and senior management shall:

1. Evaluate the adequacy of contingency plans for its service bureau.

2. Ensure that the trust company's contingency plan is compatible with its service bureau's plan.

6-861. Reports

A. The deputy director may require reports of financial condition and relevant information concerning the business operations of each trust company, shall fix and extend the time for the filing of such reports and shall assess a penalty of $50 for each day the trust company is delinquent.

B. The president, chief executive officer or chief operating officer shall examine the books and accounts of the trust company for the purpose of making the report and shall verify the report by providing an affidavit stating that the information contained in the report is accurate to the best of the president's or officer's knowledge or belief.

C. The report shall contain statements and information regarding the affairs, business conditions, resources and implementation of internal controls as safeguards for the protection of fiduciary beneficiaries, creditors, shareholders and the public.

D. Excluding weekends and holidays, within forty-eight hours after the date of discovery, a trust company that is the victim of a robbery, the shortage of funds of more than $5,000 or the apparent misapplication of trust funds by an officer, director, agent or employee shall issue a written report to the deputy director explaining the loss.

E. Within thirty days after the service of the complaint, the trust company shall issue a written report to the deputy director stating any adverse legal actions involving allegations of fraud, breach of fiduciary duty, breach of contract or misapplication or commingling of trust funds, including complaints that are dismissed within thirty days after service.

6-865. Unsafe condition; receivership

If the deficiency in capital has not been made good or the trust company is in an unsafe or unsound condition that is not remedied within the time prescribed under an order of the deputy director issued pursuant to section 6-137, the deputy director may apply to the superior court to be appointed receiver for the liquidation or rehabilitation of the company. The expense of such receivership shall be paid out of the assets of the trust company.

DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS
Title 20, Chapter 4

Amend: R20-4-401, R20-4-1001, R20-4-1101, R20-4-1601, R20-4-1602, R20-4-1701, R20-4-1702, R20-4-1704

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: August 1, 2023

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

FROM: Council Staff

DATE: **July 13, 2023**

SUBJECT: **Department of Insurance and Financial Institutions**
Title 20, Chapter 4

Amend: R20-4-401, R20-4-1001, R20-4-1101, R20-4-1601, R20-4-1602, R20-4-1701, R20-4-1702, R20-4-1704

Summary:

This regular rulemaking from the Department of Insurance and Financial Institutions seeks to amend rules in Title 20, Chapter 4 regarding Financial Institutions. Specifically, the Department is proposing the amendments to reflect structural changes to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions on July 1, 2020. As a result of the merger, the new agency (DIFI) made statutory changes to eliminate the position of Superintendent. This structural change necessitated replacing references to "Superintendent" or "Superintendent of Banks" with "Director" throughout the Articles. Additionally, the Department is endeavoring to modernize the current rules since the most recent rulemaking for Article 4 was in 2001, for Article 10 was in 2003, for Article 11 was in 1975, for Article 16 was in 2004, and for Article 17 was in 2005. Lastly, the Department is also making changes proposed in a Five-Year-Review Report approved by the Council in 2020.

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

The Department 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?**

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

4. **Summary of the agency's economic impact analysis:**

The rulemaking seeks to modernize and modify references to several articles within A.A.C. Title 20, Chapter 4 following structural changes resulting from the merger of the former Department of Financial Institutions and the Department of Insurance; specifically, references to "Superintendent" and "Superintendent of Banks" will be replaced with "Director". The Department does not anticipate any costs or benefits in implementing and enforcing the proposed rulemaking. No new full-time employees will be necessary to implement and enforce the proposed rulemaking.

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 believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of the proposed rulemaking.

6. **What are the economic impacts on stakeholders?**

Costs associated with the rulemaking are limited to those incurred by requiring applicants to submit a full set of fingerprints for each executive officer and each director. Benefits include the reduction of notices and publisher's affidavits of publication that must be provided to the Department. The rulemaking has no impact on employment, small businesses, and revenues.

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

The Department indicates it made no changes between the Notice of Proposed Rulemaking 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?

The Department indicates it received no public 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?

The Department indicates it received no public comments related to this rulemaking.

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

The Department indicates the rules are not more stringent than federal law; 12 U.S.C. 1831u(a)(5) and (b)(2).

11. Conclusion

As mentioned above, this regular rulemaking seeks to amend rules to reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions on July 1, 2020. This structural change necessitated replacing references to "Superintendent" with "Director" throughout the Article. The Department is also making changes proposed in a Five-Year-Review Report approved by the Council in 2020.

The Department is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A). Council staff recommends approval of this rulemaking.

Arizona Department of Insurance and Financial Institutions
100 N 15th Avenue, Suite 261, Phoenix, Arizona 85007
(602) 364-3100 | difi.az.gov

Katie M. Hobbs, Governor
Barbara D. Richardson, Director

DATE: June 8, 2023

VIA EMAIL: grrc@azdoa.gov
Nicole Sornsin, Chair
Governor's Regulatory Review Council
100 North 15th Ave., Suite 305
Phoenix, AZ 85007

RE: Arizona Department of Insurance and Financial Institutions
Financial Institutions Division
A.A.C. Title 20, Chapter 4, Articles 4 – Credit Unions; 10 – Safe Deposit and Safekeeping Code; 11 – Public Depositories for Public Monies; 16 – Acquiring Control of Financial Institutions; and 17 – Arizona Interstate Bank and Savings and Loan Association Act

Dear Chairperson Sornsin:

Please find enclosed the Final Rulemaking for A.A.C. Title 20, Chapter 4, Articles 4 – Credit Unions; 10 – Safe Deposit and Safekeeping Code; 11 – Public Depositories for Public Monies; 16 – Acquiring Control of Financial Institutions; and 17 – Arizona Interstate Bank and Savings and Loan Association Act, being submitted by the Arizona Department of Insurance and Financial Institutions ("Department").

Pursuant to A.A.C. R1-6-201(A)(1), the Department responds as follows:

a. The Department closed the record on this rulemaking on February 26, 2023.
b. This rulemaking does not relate to a previous five-year review report for Articles 4, 10, and 11. This rulemaking relates to a previous five-year review report for Articles 16 and 17. The Department of Financial Institutions submitted the previous five-year review report on Articles 16 and 17 to the Council which it tabled at its January 5, 2021 Council meeting and subsequently approved at the Council's February 2, 2021 Council Meeting.
c. The rulemaking does not establish a new fee.
d. The rulemaking does not contain a fee increase.
e. The rulemaking does not request an immediate effective date under A.R.S. § 41-1032.
f. The Department certifies that the preamble discloses a reference to any study relevant to the rule that it reviewed and either did or did not rely on in its evaluation of or justification for the rulemaking. The Department did not review or rely on any study relevant to the rulemaking.
g. No new full-time employees are necessary to implement and enforce the rule.
h. The following documents are also submitted to the Council with this cover letter:
    i. The Notice of Final Rulemaking;
    ii. An economic, small business, and consumer impact statement that contains the information required by A.R.S. § 41-1055;
    iii. The general and specific statutes authorizing the rulemaking.

By this submission, the Department is requesting approval of this rulemaking from the Council.

For questions about this rulemaking, please contact Mary Kosinski at (602) 364-3476 or mary.kosinski@difi.az.gov.

Sincerely,

Barbara D. Richardson

Barbara D. Richardson
Director

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

PREAMBLE

1. Articles, Parts, or Sections Affected (as applicable) **Rulemaking Action**

R20-4-401	Amend
R20-4-1001	Amend
R20-4-1101	Amend
R20-4-1601	Amend
R20-4-1602	Amend
R20-4-1701	Amend
R20-4-1702	Amend
R20-4-1704	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. § 6-123(2)
Implementing statutes:	Article 4: A.R.S. §§ 6-537(A)(1), 6-537(C)
	Article 10: A.R.S. § 6-1003
	Article 11: A.R.S. §§ 35-312, 321(3) and (5)
	Article 16: A.R.S. §§ 6-141, 6-145
	Article 17: A.R.S. § 6-327(G)

3. The effective date of the rule:

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1)

through (5):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable. The Department is proposing the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening:	29 A.A.R. 425, January 27, 2023
Notice of Proposed Rulemaking:	29 A.A.R. 291, January 27, 2023

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

Name:	Mary E. Kosinski
Address:	Department of Insurance and Financial Institutions
	100 N. 15th Ave., Suite 261
	Phoenix, Arizona 85007-2630
Telephone:	(602)364-3476
E-mail:	mary.kosinski@difi.az.gov
Web site:	https://difi.az.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:

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 4 – Credit Unions, Article 10 – Safe Deposit and Safekeeping Code, Article 11 – Public Depositories for Public Monies, Article 16 – Acquiring Control of Financial Institutions and Article 17 – Arizona Interstate Bank and Savings and Loan Association Act.

The correlate statutory sections are:

Article 4 – Credit Unions: Title 6, Ch. 4 (A.R.S. §§ 6-501 through 6-595);

Article 10 – Safe Deposit and Safekeeping Code: Title 6, Ch. 10 (A.R.S. §§ 6-1001 through 6-1009);

Article 11 – Public Depositories for Public Monies: Title 35, Ch. 2, Article 2.1 (A.R.S. §§ 35-321 through 35-329);

Article 16 – Acquiring Control of Financial Institutions: Title 6, Ch. 1, Article 4 (A.R.S. §§ 6-141 through 6-153); and

Article 17 – Arizona Interstate Bank and Savings and Loan Association Act: Title 6, Ch. 2, Article 7 (A.R.S. §§ 6-321 through 6-331).

The changes the Department is proposing will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions (the "new agency"), on July 1, 2020. The former Department of Financial Institutions became a division of the new agency.

As a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" or "Superintendent of Banks" with "Director" throughout the Articles.

When reviewing the rules in the Articles, the Department also endeavored to modernize the current rules since the most recent rulemaking for Article 4 was in 2001, for Article 10 was in 2003, for Article 11 was in 1975, for Article 16 was in 2004, and for Article 17 was in 2005.

In addition, the Department is fulfilling commitments made in its 2020 Five Year Review Report to make changes to Articles 16 and 17.

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 and does not propose to rely on any study relevant to 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:

The rulemaking updates the rules, eliminates unnecessary definitions already in statute, corrects a statutory reference, and changes two requirements in Article 16. The rulemaking does not diminish a previous grant of authority granted to the Department.

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

Pursuant to A.R.S. § 41-1055(A)(1):

- The rulemaking is not designed to change any conduct of licensees because of a perceived harm or to change the frequency of any violative conduct. Instead, the rulemaking updates the rules, eliminates unnecessary definitions already in statute, corrects a statutory reference, and changes two requirements in Article 16.

Pursuant to A.R.S. § 41-1055(A)(2):

The Department anticipates the following probable costs to applicants who are subject to Article 16 (Acquiring Control of Financial Institutions):

1. The replacement of the requirement for an applicant under Section R20-4-1602 to provide a fingerprint card for each executive officer and each director with the requirement to provide a full set of fingerprints for each executive officer and each director.

The Department anticipates the following probable benefits to applicants who are subject to Article 16 (Acquiring Control of Financial Institutions):

1. The removal of the requirement for an applicant under Section R20-4-1602 to provide an audited financial statement for each executive officer and director with the replacement of a personal financial statement for each executive officer and director.

The Department anticipates the following probable benefits to applicants who are subject to Article 17 (Arizona Interstate Bank and Savings and Loan Association Act):

1. The reduction of the number of notices and publisher's affidavits of publication required to be provided to the Department under Section R20-4-1704 from two to one.

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to licensees.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The Department has not made any changes from the Notice of Proposed Rulemaking it published. (29 A.A.R. 291, January 27, 2023)

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

The Department published the Notice of Proposed Rulemaking for the Articles on January 27, 2023. (29 A.A.R. 291, January 27, 2023) At that time it also opened a 30-day Comment Period. During the Comment Period, no one submitted a comment to the Department or requested an Oral Proceeding.

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

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

Not applicable. None of the Articles in this rulemaking address licensing or permitting.

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

The specific rules in this Article do not reference any federal laws or regulations directly. R20-4-1602(A) requires an applicant seeking approval to acquire control of a bank, savings and loan association, or controlling person of a bank or savings and loan association, to file with the Director copies of all application documents filed with federal regulatory agencies. The rule is not more stringent than the federal law.
R20-4-1702(A) requires an out-of-state financial institution that intends to acquire control of an in-state financial institution to give written notice to the Director in the form of a courtesy copy of its federal application. The Director may impose conditions on the acquisition under the authority of A.R.S. 6-324, which requires an acquired in-state financial institution being acquired as a branch to be in continuous operation for five years, and under the authority of A.R.S. 6-328, which prescribes deposit concentration limits. The rule, in conjunction with the statutory sections, does not exceed the requirements of federal law. *See,* 12 U.S.C. 1831u(a)(5) and (b)(2).
R20-4-1704(A) requires submission of one copy of each notice and the publisher's affidavit of publication required by the Federal Reserve Board, Federal Deposit Insurance

Corporation, or other regulatory authority that has concurrent jurisdiction. The rule is not more stringent than the federal law.

R20-4-1704(B) requires copies of any protests known to have been received by the Federal Reserve Board, Federal Deposit Insurance Corporation, or other regulatory authority that has concurrent jurisdiction. The rule is not more stringent than the 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 formal analysis has been submitted to the Department that compares the rule's impact of the competitiveness of business in this state to the impact of business in other states.

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

No materials are incorporated by reference.

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 Department did not previously adopt, amend or repeal the rules in Articles 4, 10 and 17 as emergency rules.

The Department previously adopted Article 11 – Public Depositories for Public Monies as an emergency rule, effective July 29, 1975 (*Arizona Administrative Code 1974- Supplement 75-1, Title 4*. Arizona Memory Project, accessed 15/03/2023, https://azmemory.azlibrary.gov/nodes/view/203019)

The Department amended the rules effective December 26, 1975. (*Arizona Administrative Code 1974- Supplement 75-2, Title 4*. Arizona Memory Project, accessed

15/03/2023, https://azmemory.azlibrary.gov/nodes/view/203020).

The Department made one subsequent change to Article 11 when it expired Section R20-4-1102 on February 5, 2020. (26 A.A.R. 382, March 6, 2020)

The Department previously adopted Article 16 – Acquiring Control of Financial Institutions as an emergency rule, valid for only 90 days, effective September 6, 1978. (Arizona Office of Secretary of State, *Arizona Administrative Digest 78, Number 9, September 30, 1978*. Arizona Memory Project, accessed 16/03/2023, https://azmemory.azlibrary.gov/nodes/view/85322)

The Department adopted the emergency rule effective January 12, 1979. (*Arizona Administrative Code 1974- Supplement 79-1, Title 4*. Arizona Memory Project, accessed 16/03/2023, https://azmemory.azlibrary.gov/nodes/view/203037)

Although the record is incomplete, it does not appear that the Department made any changes from the emergency rulemaking to the final rulemaking.

Subsequent changes have been made to Article 16 by the Department in 2003. (9 A.A.R. 5055, November 21, 2003). The Department amended Sections R20-4-1601 and R20-4-1602, and repealed Sections R20-4-1603 and R20-4-1604.

15. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE
CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

ARTICLE 4. CREDIT UNIONS

Section

ARTICLE 10. SAFE DEPOSIT AND SAFEKEEPING CODE

Section

ARTICLE 11. PUBLIC DEPOSITORIES FOR PUBLIC MONIES

Section

ARTICLE 16. ACQUIRING CONTROL OF FINANCIAL INSTITUTIONS

Section

ARTICLE 17. ARIZONA INTERSTATE BANK AND SAVINGS AND LOAN ASSOCIATION ACT

Section

ARTICLE 4. CREDIT UNIONS

R20-4-401. Fidelity Bond Coverage

A. A credit union shall have a fidelity bond in the form and in the amount required to maintain federal insurance on its accounts.

B. A fidelity bond purchased by a credit union to comply with this Section shall include faithful-performance-of-duty coverage.

C. A credit union shall purchase its fidelity bond from an insurer that holds a certificate of authority from the ~~Arizona~~ Director ~~of Insurance~~ to transact surety business in Arizona.

ARTICLE 10. SAFE DEPOSIT AND SAFEKEEPING CODE

R20-4-1001. Notice of Change of Location of Safe Deposit Repository

A. A corporation or association that moves a repository shall give written notice of the location change to the ~~Superintendent~~ Director and to its customers.

1. A corporation or association shall provide notice of the location change to the ~~Superintendent~~ Director by mailing the notice required under this subsection by first class mail no less than 30 days before the scheduled moving date. The corporation or association shall include a copy of the notice to customers required under subsection (B).
2. A corporation or association shall provide notice of the location change to its customers by:
   a. Publishing notice of the change of location in:
      i. An English language newspaper of general circulation in the county where the repository will be closed,
      ii. In a weekly newspaper for two consecutive publications, or
      iii. In a daily newspaper for three consecutive days; and
   b. Publishing the notice no more than 90 days, and no less than 30 days, before the scheduled moving date.

B. The corporation or association shall include all the following information in the notice:

1. The date the corporation or association intends to move the repository,
2. The earliest date a customer can remove contents and transact other business related to the move,
3. The latest date a customer can remove contents and transact other business related to the move,
4. The street address of the repository to be closed, and
5. The street address of the new repository.

ARTICLE 11. PUBLIC DEPOSITORIES FOR PUBLIC MONIES

R20-4-1101. Capital ~~structure of banks; defined~~ Structure of Banks; Defined

"Capital structure" as the term is applied to banks under ~~Article 2,~~ Article 2.1, Chapter 2, Title 35, Arizona Revised Statutes, means the sum of the following reserves and capital accounts of the institution as stated in the institution's report of condition required by the supervisory banking authority for the year end next preceding the institution's bid for deposit:

1. Reserve for bad debt losses on loans~~.~~ ,
2. Other reserves on loans~~.~~ ,
3. Reserves on securities~~.~~ ,
4. Capital notes and debentures~~.~~ ,
5. Preferred stock -- total par value~~.~~ ,
6. Common stock -- total par value~~.~~ ,
7. Surplus~~.~~ ,
8. Undivided profits~~.~~ , and
9. Reserve for contingencies and other capital reserves.

ARTICLE 16. ACQUIRING CONTROL OF FINANCIAL INSTITUTIONS

R20-4-1601. Definitions

~~In this Article, unless the context otherwise requires:~~ In addition to the definitions provided in A.R.S. § 6-141, the following terms apply to this Article unless the context otherwise requires:

"Acquiring party" means a person who intends to acquire control of a bank, trust company, savings and loan association, or controlling person under A.R.S. Title 6, Chapter 1, Article 4.

~~"Acquisition of control" has the meaning stated in A.R.S. § 6-141.~~

"Bank" has the meaning stated in A.R.S. § 6-101.

~~"Control" has the meaning stated in A.R.S. § 6-141.~~

~~"Controlling person" has the meaning stated in A.R.S. § 6-141.~~

"Director" has the meaning stated in A.R.S. § 6-101(7).

~~"Person" has the meaning stated in A.R.S. § 6-141.~~

"Savings and loan association" means a person required to possess a permit issued by the ~~Superintendent~~ Director under A.R.S. Title 6, Chapter 3.

~~"Superintendent" has the meaning stated in A.R.S. § 6-101.~~

"Target company" means a bank, savings and loan association, trust company, or controlling person to be acquired by an acquiring party.

"Trust company" has the meaning stated in A.R.S. § 6-851.

~~"Voting security" has the meaning stated in A.R.S. § 6-141.~~

R20-4-1602. Application for Approval to Acquire Control of Financial Institution

A. An applicant seeking approval to acquire control of a bank, savings and loan association, or controlling person of a bank or savings and loan association, under A.R.S. Title 6, Chapter 1, Article 4, shall file with the ~~Superintendent~~ Director copies of all application documents filed with federal regulatory agencies in connection with the planned acquisition of control.

B. As used in this subsection, "executive officer" includes the chairman of the board, president, each vice president, cashier, secretary, treasurer, and every other person who participates in major policymaking functions of the applicant. Under A.R.S. § 6-145(A), an applicant seeking approval to acquire control of a trust company or controlling person of a trust company, under A.R.S. Title 6, ~~Chapter1,~~ Chapter 1, Article 4 shall supply all information the ~~Superintendent~~ Director requires under this subsection. The ~~Superintendent~~ Director may

require an applicant to supplement or amend its application based on issues raised by the initial submission. The initial application shall consist of the following items:

1. A copy of the signed purchase agreement~~,~~ ;
2. The applicant's audited financial statement~~,~~ ;
3. A personal history statement, on a form supplied by the Department, for each executive officer and each director of the acquiring party~~,~~ ;
4. Each executive officer's and each director's ~~audited~~ personal financial statement~~,~~ ;
5. A ~~fingerprint card~~ full set of fingerprints for each executive officer and each director~~,~~ ; and
6. A copy of each executive officer's and each director's driver's license.

ARTICLE 17. ARIZONA INTERSTATE BANK AND SAVINGS AND LOAN ASSOCIATION ACT

R20-4-1701. Definitions

~~In this Article, unless the context otherwise requires:~~ In addition to the definitions provided in A.R.S. § 6-321, the following terms apply to this Article unless the context otherwise requires:

~~"Acquire" has the meaning stated at A.R.S. § 6-321(1).~~

"Applicant" means an out-of-state financial institution that intends to acquire control of an in-state financial institution.

~~"Control" has the meaning stated at A.R.S. § 6-321(2).~~

"Director" has the meaning stated in A.R.S. § 6-101(7).

~~"In-state financial institution" has the meaning stated at A.R.S. § 6-321(5).~~

~~"Out-of-state financial institution" has the meaning stated at A.R.S. § 6-321(6).~~

R20-4-1702. Notice to the ~~Superintendent~~ Director of Intent to Acquire Control of an In-state Financial Institution; Surrender of an Acquired Financial Institution's Charter

A. An applicant shall give written notice of an acquisition to the ~~Superintendent~~ Director in the form of a courtesy copy of its federal application. The acquiring entity shall ensure that the notice is delivered to the ~~Superintendent~~ Director not less than ten days before the effective

date of the acquisition. No other application is required under the provisions of A.R.S. Title 6, Chapter 2, Article 7, the Arizona Interstate Bank and Savings and Loan Association Act. The ~~Superintendent~~ Director may impose conditions on an acquisition under the authority of A.R.S. §§ 6-324 and 6-328.

B. An acquired in-state financial institution shall surrender, by delivery to the ~~Superintendent,~~ Director, all permits and certificates issued by the ~~Superintendent~~ Director within ten days after the effective date of the acquisition unless the acquired institution intends to continue operating, after the acquisition, as a ~~stand alone~~ stand-alone subsidiary under the authority of its existing Arizona banking permit.

R20-4-1704. Public Notice

A. An applicant shall transmit to the ~~Superintendent of Banks two copies~~ Director one copy of each notice and the publisher's affidavit of publication required by the Federal Reserve Board, ~~Federal Home Loan Bank Board,~~ the Federal Deposit Insurance Corporation, or other regulatory authority that has concurrent jurisdiction.

B. An applicant shall provide the ~~Superintendent of Banks~~ Director copies of any protests known to have been received by the Federal Reserve Board, ~~Federal Home Loan Bank Board,~~ the Federal Deposit Insurance Corporation, or other regulatory authority that has concurrent jurisdiction.

A.R.S. § 41-1055(B) Economic, Small Business, And Consumer Impact Statement

Title 20. Commerce, Financial Institutions and Insurance

Chapter 4. Department of Insurance and Financial Institutions – Financial Institutions

Article 4. Credit Unions

Article 10. Safe Deposit and Safekeeping Code

Article 11. Public Depositories for Public Monies

Article 16. Acquiring Control of Financial Institutions

Article 17. Arizona Interstate Bank and Savings and Loan Association Act

A.R.S. § 41-1055(B)(1): An identification of the proposed rulemaking.

The Arizona Department of Insurance and Financial Institutions – Financial Institutions Division ("Department") is proposing changes to A.A.C. Title 20, Chapter 4, Article 4 – Credit Unions, Article 10 – Safe Deposit and Safekeeping Code, Article 11 – Public Depositories for Public Monies, Article 16 – Acquiring Control of Financial Institutions and Article 17 – Arizona Interstate Bank and Savings and Loan Association Act.

The correlate statutory sections are:

Article 4 – Credit Unions: Title 6, Ch. 4 (A.R.S. §§ 6-501 through 6-595);

Article 10 – Safe Deposit and Safekeeping Code: Title 6, Ch. 10 (A.R.S. §§ 6-1001 through 6-1009);

Article 11 – Public Depositories for Public Monies: Title 35, Ch. 2, Article 2.1 (A.R.S. §§ 35-321 through 35-329);

Article 16 – Acquiring Control of Financial Institutions: Title 6, Ch. 1, Article 4 (A.R.S. §§ 6-141 through 6-153); and

Article 17 – Arizona Interstate Bank and Savings and Loan Association Act: Title 6, Ch. 2, Article 7 (A.R.S. §§ 6-321 through 6-331).

The changes the Department is proposing will reflect the structural change to the former Department of Financial Institutions which merged with the Department of Insurance to form the Department of Insurance and Financial Institutions (the "new agency"), on July 1, 2020. The former Department of Financial Institutions became a division of the new agency.

As a result of the merger, the new agency made statutory changes to eliminate the position of Superintendent. Instead, the Director of the new agency assumed those duties. This structural change necessitated replacing references to "Superintendent" or "Superintendent of Banks" with "Director" throughout the Articles.

When reviewing the rules in the Articles, the Department also endeavored to modernize the current rules since the most recent rulemaking for Article 4 was in 2001, for Article 10 was in 2003, for Article 11 was in 1975, for Article 16 was in 2004, and for Article 17 was in 2005.

In addition, the Department is fulfilling commitments made in its 2020 Five Year Review Report to make changes to Articles 16 and 17.

Questions about this Economic Impact Statement can be directed to: Mary E. Kosinski (mary.kosinski@difi.az.gov).

A.R.S. § 41-1055(B)(2): An identification of the persons who will be directly affected by, bear the costs of or directly benefit from the proposed rulemaking.

This rulemaking impacts various types of entities.

Article 4 (Credit Unions) applies to corporate non-profit associations holding a certificate of approval issued by the Director to operate as a credit union under A.R.S. § 6-507.

Article 10 (Safe Deposit and Safekeeping Code) applies to corporations or associations that do business as a bank, trust company, credit union, or savings and loan association and maintain safe deposit repositories for public use. A "safe deposit repository" means a safe deposit box or other receptacle and includes vault space made available for use to store property or documents. A.R.S. § 6-1001.

Article 11 (Public Depositories for Public Monies) applies to the state, counties, districts, cities or towns receiving bonds or evidence of indebtedness and money. A.R.S. § 35-302.

Article 16 (Acquiring Control of Financial Institutions) applies to persons who intend to acquire control of a bank, trust company, savings and loan association, or controlling person of a bank, trust company, or savings and loan association. A.R.S. 6-141, Section R20-4-1601.

Article 17 (Arizona Interstate Bank and Savings and Loan Association Act) applies to an out-of-state financial institution that intends to acquire control of an in-state financial institution. R20-4-1701. An out-of-state financial institution includes a state or federal bank, savings bank or savings and loan association with its home office in a state other than Arizona, or a holding company with its home office in a state other than Arizona. A.R.S. § 6-321.

A.R.S. § 41-1055(B)(3): A cost benefit analysis of the following:

(a) The probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking. The probable costs to the implementing agency shall include the number of new full-time employees necessary to implement and enforce the proposed rule. The preparer of the economic, small business and consumer impact statement shall notify the joint legislative budget committee of the number of new full-time employees necessary to implement and enforce the rule before the rule is approved by the council.

The Department does not anticipate any costs or benefits in implementing and enforcing the proposed rulemaking. No new full-time employees will be necessary to implement and enforce the proposed rulemaking.

(b) The probable costs and benefits to a political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.

No political subdivision of this state is directly affected by the implementation and enforcement of the proposed rulemaking for Articles 4 (Credit Unions), 10 (Safe Deposit and Safekeeping Code), 16 (Acquiring Control of Financial Institutions) and 17 (Arizona Interstate Bank and Savings and Loan Association Act).

Article 11 (Public Depositories for Public Monies) affects political subdivisions of this state. However, the only substantive change proposed by the Department is to correct a statutory reference. This change is not anticipated to generate either a cost or benefit to a political subdivision of this state.

(c) The probable costs and benefits to businesses directly affected by the proposed rulemaking, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the proposed rulemaking.

The Department anticipates no additional probable costs or benefits to persons imposed by the rulemaking for Articles 4 (Credit Unions), 10 (Safe Deposit and Safekeeping Code), and 11 (Public Depositories for Public Monies).

The Department anticipates the following probable costs to applicants for proposed changes to Article 16 (Acquiring Control of Financial Institutions):

1. The replacement of the requirement for an applicant under Section R20-4-1602 to provide a fingerprint card for each executive officer and each director with the requirement to provide a full set of fingerprints for each executive officer and each director.

The Department anticipates the following probable benefits to applicants for proposed changes to Article 16:

1. The removal of the requirement for an applicant under Section R20-4-1602 to provide an audited financial statement for each executive officer and director with a personal financial statement for each executive officer and director.

The Department anticipates no additional probable costs to applicants for proposed changes to Article 17 (Arizona Interstate Bank and Savings and Loan Association Act).

The Department anticipates the following probable benefits to applicants for proposed changes to Article 17:

1. The reduction of the number of notices and publisher's affidavits of publication required to be provided to the Department under Section R20-4-1704 from two to one.

The Department did not receive any feedback from stakeholders on any potential financial impact of its proposed changes but it anticipates that these changes will produce minimal financial impact, including no anticipated effect on the revenues or payroll expenditures, to licensees who are impacted by the rulemaking.

A.R.S. § 41-1055(B)(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 proposed rulemaking.

The Department does not anticipate any impact on the private employment of persons imposed by the rulemaking. Likewise, the Department does not anticipate any impact on public employment in the Department or any political subdivision.

A.R.S. § 41-1055(B)(5): A statement of the probable impact of the proposed rulemaking on small businesses. The statement shall include:

(a) An identification of the small businesses subject to the proposed rulemaking.

"Small business" is defined as a concern, including its affiliates, which is:

a. Independently owned and operated,

b. Not dominant in its field,

c. Employs fewer than 100 full-time employees, and

d. Had gross annual receipts of less than $4 million in its last fiscal year.

A.R.S. § 41-1001(23).

Not applicable to Article 4 – Credit Unions. Credit unions do not qualify as small businesses because they are member owned.

Not applicable to Article 10 – Safe Deposit and Safekeeping Code. Although some banks and trust companies may qualify as small businesses, the only change made to the Article is to change the title of "Superintendent" to "Director." Therefore, the proposed rulemaking has no probable impact.

Not applicable to Article 11 – Public Depositories for Public Monies. The Article does not apply to small businesses. It applies to government entities.

Not applicable to Article 16 – Acquiring Control of Financial Institutions. Businesses seeking to acquire a bank, trust company or credit union do not typically fall within the definition of a small business.

Not applicable to Article 17 – Arizona Interstate Bank and Savings and Loan Association Act. The Article applies to out-of-state financial institutions.

(b) The administrative and other costs required for compliance with the

proposed rulemaking.

The rulemaking is not applicable to any small businesses.

(c) A description of the methods prescribed in section 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 to use each method.

A.R.S. § 41-1035 lists the following methods to reduce the impact on small businesses:

1. Establish less stringent compliance or reporting requirements in the rule for small businesses.

Not applicable.

2. Establish less stringent schedules or deadlines in the rule for compliance or reporting requirements for small businesses.

Not applicable.

3. Consolidate or simplify the rule's compliance or reporting requirements for small businesses.

Not applicable.

4. Establish performance standards for small businesses to replace design or operational standards in the rule.

Not applicable.

5. Exempt small businesses from any or all requirements of the rule.

Not applicable.

(d) The probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.

The Department does not anticipate any cost or benefit to private persons and consumers.

A.R.S. § 41-1055(B)(6): A statement of the probable effect on state revenues.

No impact on state revenues is anticipated.

A.R.S. § 41-1055(B)(7): A 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 Department believes that the current rulemaking offers the least intrusive and least costly alternative method to achieve the purpose of the proposed rulemaking.

A.R.S. § 41-1055(B)(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. An agency advocating that any data is acceptable data has the burden of proving that the data is acceptable. For the purposes of this paragraph, "acceptable data" means empirical, replicable and testable data as evidenced in supporting documentation, statistics, reports, studies or research.

The rule is not based on any data.

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ADMINISTRATIVE RULES DIVISION

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS - FINANCIAL INSTITUTIONS

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 October 1, 2022 through December 31, 2022

Questions about these rules? Contact:

Department:	Department of Insurance and Financial Institutions Financial Institutions Division
Address:	100 N. 15th Ave., Ste. 261 Phoenix, AZ 85007
Website:	https://difi.az.gov/laws/rulemaking-process
Name:	Mary E. Kosinski
Telephone:	(602) 364-3476
Email:	mary.kosinski@difi.az.gov

The release of this Chapter in Supp. 22-4 replaces Supp. 22-2, 1-48 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. § 41-5505.

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.

PERSONAL USE/COMMERCIAL USE

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Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS - FINANCIAL INSTITUTIONS

Authority: A.R.S. § 20-124

Supp. 22-4

Editor's Note: The name of the Arizona Department of Financial Institutions was changed to the Department of Insurance and Financial Institutions under Laws 2019, Ch. 252, effective July 1, 2020 (Supp. 22-2).

Editor's Note: The Banking Department's name was changed to the Arizona Department of Financial Institutions under the authority of A.R.S. § 6-110, originally enacted as Laws 2004, Ch. 188, effective January 1, 2006 (Supp. 06-1).

Editor's Note: Title 20, formerly Commerce, Banking, and Insurance, is now Commerce, Financial Institutions, and Insurance. This change became effective when the Banking Department changed its name to the Department of Financial Institutions, effective January 1, 2006 (Supp. 06-1).

20 A.A.C. 4, consisting of R20-4-101 through R20-4-106, R20-4-201 through R20-4-215, R20-4-301 through R20-4-331, R20-4-401 through R20-4-402, R20-4-501 through R20-4-536, R20-4-601 through R20-4-620, R20-4-701 through R20-4-707, R20-4-801 through R20-4-816, R20-4-901 through R20-4-924, R20-4-1001, R20-4-1101 through R20-4-1102, R20-4-1201 through R20-4-1220, R20-4-1401 through R20-4-1410, R20-4-1501 through R20-4-1530, R20-4-1601 through R20-4-1604, and R20-4-1701 through R20-4-1706, recodified from 4 A.A.C. 4, consisting of R4-4-101 through R4-4-106, R4-4-201 through R4-4-215, R4-4-301 through R4-4-331, R4-4-401 through R4-4-402, R4-4-501 through R4-4-536, R4-4-601 through R4-4-620, R4-4-701 through R4-4-707, R4-4-801 through R4-4-816, R4-4-901 through R4-4-924, R4-4-1001, R4-4-1101 through R4-4-1102, R4-4-1201 through R4-4-1220, R4-4-1401 through R4-4-1410, R4-4-1501 through R4-4-1530, R4-4-1601 through R4-4-1604, and R4-4-1701 through R4-4-1706, pursuant to R1-1-102 (Supp. 95-1).

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ARTICLE 1. GENERAL

R20-4-101. Scope of Article

The rules in this Article apply to all activities of the Superintendent and to the interpretation of all Arizona statutes and rules administered by the Superintendent.

Historical Note

Former Rule 1. Former R4-4-101 repealed, new R4-4-101 adopted effective August 16, 1991 (Supp. 91-3). R20-4-101 recodified from R4-4-101 (Supp. 95-1).

R20-4-102. Definitions

In this Chapter, unless otherwise specified:

1. "Active management" means directing a licensee's activities by a responsible individual, who:
   a. Is knowledgeable about the licensee's Arizona activities;
   b. Supervises compliance with:
      i. The laws enforced by the Department of Financial Institutions as they relate to the licensee, and
      ii. Other applicable laws and rules; and
   c. Has sufficient authority to ensure compliance.
2. "Affiliate" has the meaning stated at A.R.S. § 6-901.
3. "Attorney General" means the Attorney General or an assistant Attorney General of the state of Arizona.
4. "Branch office" means any location within or outside Arizona, including a personal residence, but not including a licensee's principal place of business in Arizona, where the licensee holds out to the public that the licensee acts as a licensee.
5. "Business of a savings and loan association or savings bank" means receiving money on deposit subject to payment by check or any other form of order or request or on presentation of a certificate of deposit or other evidence of debt.
6. "Compensation" means, in applying that term's definition in A.R.S. §§ 6-901, 6-941, and 6-971, anything received in advance, after repayment, or at any time during a loan's life. This subsection expressly excludes the following items from those definitions of compensation:
   a. Charges or fees customarily received after a loan's closing including prepayment penalties, termination fees, reinvestment fees, late fees, default interest, transfer fees, impound account interest and fees, extension fees, and modification fees. However, extension fees and modification fees are compensation if the lender advances additional funds or increases the credit limit on an open-end mortgage as part of the extension or modification;
   b. Out-of-pocket expenses paid to independent third parties including appraisal fees, credit report fees, legal fees, document preparation fees, title insurance premiums, recording, filing, and statutory fees, collection fees, servicing fees, escrow fees, and trustee's fees;
   c. Insurance commissions;
   d. Contingent or additional interest, including interest based on net operating income; or
   e. Equity participation.
7. "Commercial finance transaction," as that term is used in this Section's definitions of the terms "Engaged in the business of making mortgage loans" and "Engaged in the business of making mortgage loans or mortgage banking loans," means a loan made primarily for other than personal, family, or household purposes.
8. "Control of a licensee," as used in A.R.S. §§ 6-903, 6-944, or 6-978, does not include acquiring additional fractional equity interests in a licensee by any person who already has the power to vote 51% or more of the licensee's outstanding voting equity interests.
9. "Correspondent contract," as that term is used in A.R.S. §§ 6-941, 6-943, 6-971, or 6-973, means an agreement between a lender and a funding source under which the funding source may fund, or is required to fund, loans originated by the lender.
10. "Cushion," as that term is used in R20-4-1811 or R20-4-1908, means funds that a servicer or lender may require a borrower to pay into an escrow or impound account before the borrower's periodic payments are available in the account to cover unanticipated disbursements.
11. "Directly or indirectly makes, negotiates, or offers to make or negotiate" and "Directly or indirectly making, negotiating, or offering to make or negotiate," as those phrases are used in A.R.S. §§ 6-901, 6-941, or 6-971, mean:
    a. Providing consulting or advisory services in connection with a mortgage loan transaction, mortgage banking loan transaction, or commercial mortgage loan transaction;
       i. To an investor, concerning the location or identity of potential borrowers, regardless of whether the person providing consulting or advisory services directly contacts any potential borrowers; or
       ii. To a borrower, concerning the location or identity of potential investors or lenders; or
    b. Providing assistance in preparing an application for a mortgage loan transaction, mortgage banking loan transaction, or commercial mortgage banking loan transaction, regardless of whether the person providing assistance directly contacts any potential investor or lender; and
    c. Processing a loan; but
    d. "Directly or indirectly makes, negotiates, or offers to make or negotiate" and "Directly or indirectly making, negotiating, or offering to make or negotiate" do not include:
       i. Providing clerical, mechanical, or word processing services to prepare papers or documents associated with a mortgage loan transaction, mortgage banking loan transaction, or commercial mortgage banking loan transaction;
       ii. Purchasing, selling, negotiating to purchase or sell, or offering to purchase or sell a mortgage loan, mortgage banking loan, or commercial mortgage banking loan already funded;
       iii. Making, negotiating, or offering to make additional advances on an existing open-ended mortgage loan, mortgage banking loan, or commercial mortgage loan including revolving credit lines;
       iv. Modifying, renewing, or replacing a mortgage loan, a mortgage banking loan, or a commercial mortgage loan already funded, if the parties to and security for the loan are the same as the original loan immediately before the modifica-

tion, renewal, or replacement, and if no additional funds are advanced and no increase is made in the credit limit on an open-ended loan. Replacing a loan means making a new loan simultaneously with terminating an existing loan.

12. "Electronic record" has the meaning stated at A.R.S. § 44-7002(7).
13. "Employee" means a natural person who has an employment relationship with a licensee that is acknowledged by both the person and the licensee, and:
    a. The person is entitled to payment, or is paid, by the licensee;
    b. The licensee withholds and remits, or is liable for withholding and remitting, payroll deductions for all applicable federal and state payroll taxes;
    c. The licensee has the right to hire and fire the employee and the employee's assistants;
    d. The licensee directs the methods and procedures for performing the employee's job;
    e. The licensee supervises the employee's business conduct and the employee's compliance with applicable laws and rules; and
    f. The rights and duties under subsections (13)(a) through (e) belong to the licensee regardless of whether another person also shares those rights and duties.
14. "Engaged in the business of making mortgage loans," as that phrase is used in A.R.S. § 6-902, and "engaged in the business of making mortgage loans or mortgage banking loans," as that phrase is used in A.R.S. § 6-942, mean the direct or indirect making of a total of more than five mortgage banking loans or mortgage loans, or both in a calendar year. Each loan counts only once as of its closing date. A person is not "engaged in the business of making mortgage loans or mortgage banking loans" if the person makes loans solely in commercial finance transactions in which no more than 35% of the aggregate value of all security taken by the investor on the closing date is a lien, or liens, on real property.
15. "Exclusive contract," as that term is used in A.R.S. §§ 6-912 and 6-991.02, means a written agreement in which a loan originator agrees to perform services as a loan originator subject to supervision and control by a person holding a certificate of exemption issued under A.R.S. § 6-912 on an exclusive basis. The agreement provides that the loan originator is expressly prohibited from performing loan origination or modification services for any other person during the time the agreement is in effect.
16. "Generally accepted accounting principles" has the meaning used by the Financial Accounting Standards Board or the American Institute of Certified Public Accountants.
17. "Holds out to the public," as used in this Section's definition of "branch office," means advertising or otherwise informing the public that mortgage banking loans, commercial mortgage loans, or mortgage loans are made or negotiated at a location. "Holds out to the public" includes listing a location on business cards, stationery, brochures, rate lists, or other promotional items. "Holds out to the public" does not include a clearly identified home or mobile telephone number on a business card or stationery.
18. "Loan," as that term is used in A.R.S. §§ 6-126(C)(6) and (8), means all loans negotiated or closed, without regard to the location of the real property collateral or type of loan.
19. "Loan Processing" means obtaining a loan application's supporting documents for use in underwriting.
20. "Person" means a natural person or any legal or commercial entity including a corporation, business trust, estate, trust, partnership, limited partnership, joint venture, association, limited liability company, limited liability partnership, or limited liability limited partnership.
21. "Property insurance," as that term is used in A.R.S. §§ 6-909 and 6-947, does not include flood insurance as that term is used in the Flood Disaster Protection Act of 1973, as modified by the National Flood Insurance Reform Act of 1994. 42 U.S.C. 4001, et seq.
22. "Reasonable investigation of the background," as that term is used in A.R.S. §§ 6-903, 6-943, or 6-976 means a licensee, at a minimum:
    a. Collects and reviews all the documents authorized by the Immigration Reform and Control Act of 1986, 8 U.S.C. 1324a;
    b. Obtains a completed Employment Eligibility Verification (Form I-9);
    c. Obtains a completed and signed employment application;
    d. Obtains a signed statement attesting to all of an applicant's felony convictions, including detailed information regarding each conviction;
    e. Consults with the applicant's most recent or next most recent employer, if any;
    f. Inquiries regarding the applicant's qualifications and competence for the position;
    g. If for a loan officer, loan originator, loan processor, branch manager, supervisor, or similar position, obtains a current credit report from a credit reporting agency; and
    h. Investigates further if any information received in the above inquiries raises questions as to the applicant's honesty, truthfulness, integrity, or competence. An inquiry is sufficient after two attempts to contact a person, including at least one written inquiry.
23. "Record" has the meaning stated at A.R.S. § 44-7002(13).
24. "Registered to do business in this state" means:
    a. If an Arizona corporation, it is incorporated under A.R.S. Title 10, Chapter 2, Article 1;
    b. If a foreign corporation, it either transfers its domicile under A.R.S. Title 10, Chapter 2, Article 2, or obtains authority to transact business in Arizona under A.R.S. Title 10, Chapter 15, Article 1;
    c. If a business trust, it obtains authority to transact business in Arizona under A.R.S. Title 10, Chapter 18, Article 4;
    d. If an estate, it acts through a personal representative duly appointed by this state's Superior Court, under the provisions of A.R.S. Title 14, Chapter 3 or 4;
    e. If a trust, it delivers to the Superintendent an executed copy of the trust instrument creating the trust together with:

        All the current amendments, or

A true copy of the trust instrument certified accurate and complete by a trustee of the trust before a notary public;

f. If a general partnership, limited partnership, limited liability company, limited liability partnership, or limited liability limited partnership, it is organized under A.R.S. Title 29;

g. If a foreign general partnership, limited partnership, limited liability company, limited liability partnership, or limited liability limited partnership, it is registered with the Arizona Secretary of State's office under A.R.S. Title 29;

h. If a joint venture, association, or any entity not specified in this subsection, it is organized and conducts its business in compliance with Arizona law; or

i. The entity is exempt from registration.

25. "Registered Exempt Person" means a person who is exempt from licensure pursuant to A.R.S. § 6-912 and A.R.S. Title 6, Chapter 9, Articles 1, 2 and 3 as a federally chartered savings bank that is registered with the nationwide mortgage licensing system and registry and holds a certificate of exemption.

26. "Resident of this state" means a natural person domiciled in Arizona.

27. "Responsible individual" or "responsible person", as those terms are used in A.R.S. §§ 6-903, 6-943, 6-973, and 6-976, means a resident of this state who:

a. Lives in Arizona during the entire period of designation as the responsible individual on a license;

b. Is in active management of a licensee's affairs;

c. Meets the qualifications listed in A.R.S. §§ 6-903, 6-943, or 6-973; and

d. Is an officer, director, member, partner, employee, or trustee of a licensed entity.

Historical Note

Former Rule 2. Former R4-4-102 repealed, new R4-4-102 adopted effective August 16, 1991 (Supp. 91-3). R20-4-102 recodified from R4-4-102 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 2094, effective June 10 (Supp. 99-2). Amended by final rulemaking at 7 A.A.R. 668, effective January 10, 2001 (Supp. 01-1). Amended by final rulemaking at 8 A.A.R. 145, effective December 10, 2001 (Supp. 01-4). Amended by final rulemaking at 18 A.A.R. 2622, effective December 2, 2012 (Supp. 12-4).

R20-4-103. Fingerprints

A. A licensee or applicant shall deliver fingerprints requested or required by the Superintendent on fingerprint cards provided by the Superintendent.

B. A licensee or applicant shall bear any costs incurred in obtaining or submitting fingerprints.

C. A licensee or applicant shall arrange to have fingerprints taken, signed, and dated by:

1. A municipal police department,
2. A local sheriff's office, or
3. Another law enforcement authority recognized by the Superintendent.

Historical Note

Former Rule 3. Former R4-4-103 repealed, new R4-4-103 adopted effective August 16, 1991 (Supp. 91-3). R20-4-103 recodified from R4-4-103 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4670, effective November 14, 2000 (Supp. 00-4).

R20-4-104. Acceptance of Other Forms

If another entity's applications and forms provide all the information required by Arizona law, the Superintendent has the discretion to accept them, even if another provision of this Chapter requires use of a specific Department of Financial Institutions form. The Superintendent's exercise of the discretion to accept alternative forms does not limit the Superintendent's power to require additional information necessary to complete an application or other form.

Historical Note

Former Rule 4. Former R4-4-104 repealed, new R4-4-104 adopted effective August 16, 1991 (Supp. 91-3). R20-4-104 recodified from R4-4-104 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4670, effective November 14, 2000 (Supp. 00-4).

R20-4-105. Claims Against a Deposit in Place of Bond

A. As used in this Section:

1. "Deposit" means cash or alternatives to cash deposited by a licensee with the Superintendent in place of a bond.
2. "Depositor" means licensee or an employee of the licensee who makes a deposit with the Superintendent.
3. "Verified claim" means a claim filed with the Superintendent under subsection (B).
4. "Award" means an amount of money granted under subsection (F).

B. A person may file a claim against a deposit by delivering documentation of the claim to the Superintendent. The claim shall be based on a final judgment in favor of the claimant, entered by a court of competent jurisdiction. To support a claim, the judgment shall be:

1. Against a depositor;
2. For injury caused by the depositor's wrongful act, default, fraud, or misrepresentation committed in the course of the depositor's licensed business activity; and
3. Documented by:
   a. A certified copy of the complaint in the action;
   b. A certified copy of the judgment in the action;
   c. A statement that execution of the judgment has not been stayed, or an explanation of the terms and reason for any stay;
   d. A statement of any amounts recovered on the judgment; and
   e. A sworn and notarized statement that the claim is true and correct to the best of the claimant's knowledge and belief.

C. A claimant shall file a claim with the Superintendent, and all required supporting documentation, not more than six months after entry of the judgment asserted in the claim. However, if execution of the asserted judgment is stayed during the first six months after its entry, the claimant may file a verified claim only during the six months after the stay is lifted. The Department shall process a timely-filed verified claim as a request for hearing under R20-4-1208.

D. The claimant shall notify the depositor of the filing of a verified claim under this Section, and make the depositor a party to all proceedings on the claim. To do so, the claimant shall send the depositor a copy of all documents filed under subsection (B). The claimant shall make this delivery no more than 10 days after the original filing with the Superintendent under subsection (B). The Department considers a proceeding on a

verified claim to be a contested case, governed by the provisions of 20 A.A.C. 4, Article 12.

E. The Superintendent shall, after a hearing, deny a verified claim if the hearing produces evidence of any of the following circumstances:
1. The judgment is not for an injury caused by the depositor and described in subsection (B)(2);
2. The judgment was awarded by default, stipulation, or consent, and no showing is made in the hearing of an injury caused by the depositor and described in subsection (B)(2);
3. The judgment's execution has been stayed for any reason;
4. The judgment was procured through fraud or collusion;
5. The judgment has been satisfied from other sources; or
6. The action that produced the judgment was barred by the applicable statute of limitations at the time it was commenced.

F. If the Superintendent grants a verified claim, the Superintendent shall do so in the amount of the compensatory damages awarded against the depositor in the judgment, exclusive of:
1. Attorney's fees, and
2. Amounts previously paid on the judgment.

G. A person injured by a depositor shall give the Superintendent written notice at the time of filing a civil action if the claims alleged could be made as a verified claim under this Section. The written notice shall include a statement of the amount of compensatory damages sought against the depositor. The injured person shall provide further information about the civil action to the Superintendent upon request.

H. If the Superintendent grants a verified claim under subsection (F), the Superintendent shall authorize the State Treasurer, in writing, to release the deposit to the claimant in the amount stated in subsection (F) if the Superintendent has not received notice of another pending civil action under subsection (G).

I. If given notice under subsection (G), the Superintendent shall determine whether the deposit is sufficient to satisfy all claims under subsection (F). The Superintendent shall determine award amounts for each claim of which the Superintendent has notice, and authorize payment, as follows:
1. If the deposit is sufficient to satisfy all claims under subsection (F), the Superintendent shall authorize its release as described in subsection (H).
2. If the deposit is not sufficient to satisfy all claims under subsection (F), the Superintendent shall calculate the award on each claim as follows:
   a. Each granted claim shall receive a pro rata share of the total deposit.
   b. Each pro rata share shall be a dollar amount calculated by multiplying the total deposit by a fraction.
      i. The numerator of the fraction is the amount of the Superintendent's award for the verified claim.
      ii. The denominator of the fraction is the sum of the amount of the Superintendent's award for the verified claim plus the total compensatory damages sought in all other civil actions against the same depositor disclosed to the Superintendent under subsection (G).
   c. The Superintendent shall authorize the State Treasurer to release the pro rata portion of the deposit calculated for each verified claim.

J. A depositor or former licensee may request return of its deposit if it substitutes a bond for the deposit, or if its license is surrendered, revoked, or expired, and if all statutory conditions for release of the deposit have been satisfied. The Superintendent shall not release any part of a deposit to a depositor or former licensee until the Superintendent determines whether there are any awards on verified claims unsatisfied because of an apportionment under subsection (I). The Superintendent shall use the deposit amount to pay any unsatisfied portion of those awards. If the deposit amount is not sufficient to pay in full all unsatisfied awards, the Superintendent shall pay the remaining amount of the deposit to claimants in the ratio their awards bear to the total of all awards granted against the deposit.

K. The court supervising a licensee in receivership may order the release of a deposit to persons injured by conduct described in subsection (B). In that event, the receiver shall deliver a certified copy of the court's order to the Superintendent. The copy may be uncertified if the receiver is the Superintendent or any other officer or agency of the state of Arizona. The Superintendent shall then authorize the State Treasurer, in writing, to release the deposit to the receiver. The receiver shall distribute the deposit as ordered by the receivership court, rather than under this Section.

Historical Note
Adopted effective August 16, 1991 (Supp. 91-3). R20-4-105 recodified from R4-4-105 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4670, effective November 14, 2000 (Supp. 00-4).

R20-4-106. Bankruptcy

An enterprise licensee or consumer lender licensee shall immediately deliver written notice to the Superintendent if it files a voluntary bankruptcy petition, or if its creditors name the licensee a debtor in an involuntary bankruptcy petition. On the date of each of the following documents' filing with the bankruptcy court, the licensee shall deliver to the Superintendent a copy of the:
1. Petition for relief,
2. Schedule of assets and liabilities,
3. Statement of financial affairs,
4. List of creditors, and
5. Plan of reorganization.

Historical Note
Adopted effective August 16, 1991 (Supp. 91-3). R20-4-106 recodified from R4-4-106 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 145, effective December 10, 2001 (Supp. 01-4).

R20-4-107. Licensing Time-frames

A. As used in this Section, "application" means a document specified or described in this Title, or in any statute enforced by the Department, requesting any permit, certificate, approval, registration, charter, or similar permission described in Table A, together with all supporting documentation required by statute or rule.

B. The time-frames in Table A apply solely to applications received by the Department after the effective date of this Section. Each overall time-frame consists of an administrative completeness review time-frame, and a substantive review time-frame. The administrative completeness review time-frame begins to run upon receipt of an application by the Department.
1. Within the administrative completeness review time-frame in Table A, the Department shall notify the applicant in writing whether the application is complete. If the application is incomplete, the notice shall specify the missing information or component.

2. An applicant whose application is incomplete shall supply the missing information within 60 days after the date of the notice. If an applicant shows good cause in writing before the expiration of the 60 day time limit, the Superintendent shall extend the period for administrative completion of an application. The administrative completeness review time-frame stops running on the postmark date of the Department's written notice of an incomplete application, and resumes when the Department receives a complete application. If the applicant fails to submit a complete application within the specified time limit, the Department shall reject the application and close the file. An applicant may reapply.
3. The substantive review time-frame begins to run on the postmark date of the Department's written notice that the application is administratively complete.
4. Within the overall time-frame set forth in Table A the Department shall send the applicant written notice of its decision to approve, conditionally approve, or deny a license, unless the time-frame is extended by mutual agreement under A.R.S. § 41-1075. If the Department denies an application, it shall provide written justification for the denial and a written explanation of the applicant's right to a hearing or appeal in the form required by A.R.S. § 41-1076.
5. The Department shall calculate time limits prescribed in this Section under R2-19-107.

C. The time-frames in this Section apply solely to actions taken by the Department. Nothing in this Section relieves a licensee or applicant of a duty to fulfill any other legal or regulatory requirement that is a condition of its power and authority to engage in business.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).
Amended by final rulemaking at 8 A.A.R. 145, effective December 10, 2001 (Supp. 01-4).

Table A. Licensing Time-frames

No.	License Type	Legal Authority	Administrative Completeness Review (Days)	Substantive Review (Days)	Overall Time-Frame (Days)
1	Bank	A.R.S. § 6-203, et seq.			
	Initial Application	R20-4-211	45	45	90
2	Bank Trust Dept.	A.R.S. § 6-381			
	Initial Application	A.R.S. § 6-203, A.R.S. § 6-204(C)	45	45	90
3	Savings & Loan	A.R.S. § 6-401, et seq.			
	Initial Application	A.R.S. § 6-408, R20-4-327	75	75	150
4	Credit Union	A.R.S. § 6-501, et seq.			
	Initial Application	A.R.S. § 6-506(A)	60	60	120
5	Trust Company	A.R.S. § 6-851, et seq.			
	Initial Application	A.R.S. § 6-854(A)	75	75	150
6	Consumer Lender	A.R.S. § 6-601, et seq.			
	Initial Application	A.R.S. § 6-603(C)	60	60	120
7	Debt Management	A.R.S. § 6-701, et seq.			
	Initial Application	A.R.S. § 6-704(A), R20-4-602(A)	30	30	60
8	Escrow Agent	A.R.S. § 6-801, et seq.			
	Initial Application	A.R.S. § 6-814	60	60	120
9	Mortgage Broker or Commercial Mortgage Broker	A.R.S. § 6-901, et seq.			
	Initial Application	A.R.S. § 6-903(C) & (D)	60	60	120
10	Mortgage Banker	A.R.S. § 6-941, et seq.			
	Initial Application	A.R.S. § 6-943(D)	60	60	120
11	Commercial Mortgage Banker	A.R.S. § 6-971, et seq.			
	Initial Application	A.R.S. § 6-974(A)	60	60	120

12	Acquisition of Control of Financial Institution	R20-4-1602, R20-4-1702			
	Initial Application	A.R.S. 6-1104	30	30	60
13	Money Transmitter	A.R.S. § 6-1201, et seq.			
	Initial Application	A.R.S. § 6-1204(A)	60	60	120
14	Advance Fee Loan Broker	A.R.S. § 6-1301, et seq.			
	Initial Application	A.R.S. § 6-1303(A)	30	30	60
15	Premium Finance Co.	A.R.S. § 6-1401, et seq.			
	Initial Application	A.R.S. § 6-1402(C)	60	60	120
16	Collection Agency	A.R.S. § 32-1001, et seq.			
	Initial Application	A.R.S. § 32-1021, R20-4-1502	30	15	45
17	Motor Vehicle Dealer	A.R.S. § 44-281, et seq.			
	Initial Application	A.R.S. § 44-282(B)	30	15	45
18	Sales Finance Co.	A.R.S. § 44-281, et seq.			
	Initial Application	A.R.S. § 44-282(B)	30	15	45
19	Certificate of Exemption	A.R.S. § 6-912			
	Initial Application	A.R.S. § 6-912(B)	45	45	90
20	Loan Originators	A.R.S. § 6-991, et seq.			
	Initial Application	A.R.S. § 6-991.04(A)	60	60	120

Historical Note
Table A adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 8 A.A.R. 145, effective December 10, 2001 (Supp. 01-4). Amended by final rulemaking at 18 A.A.R. 2622, effective December 2, 2012 (Supp. 12-4).

ARTICLE 2. BANK ORGANIZATION AND REGULATION

R20-4-201. Articles of Incorporation
A licensee shall deliver to the Superintendent a copy of each amendment to the licensee's articles of incorporation within 30 days after the amendment is filed with the Arizona Corporation Commission. Before delivery to the Superintendent, an officer of the licensee shall:

1. Certify the copy delivered in compliance with this Section, in writing, signed by the certifying officer, attesting to the completeness, accuracy, and authenticity of the certified copy; and
2. Ensure the copy bears a stamp affixed by the Arizona Corporation Commission to evidence filing with the Commission.

Historical Note
Former Rule 1. R20-4-201 recodified from R4-4-201 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 811, effective January 10, 2001 (Supp. 01-1).

R20-4-202. Bylaws
A licensee shall deliver to the Superintendent a copy of each amendment to the licensee's bylaws within 30 days after the amendment is adopted. An officer of the licensee shall certify the copy delivered in compliance with this Section, in writing, attesting to the completeness, accuracy, and authenticity of the certified copy.

Historical Note
Former Rule 2. R20-4-202 recodified from R4-4-202 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 811, effective January 10, 2001 (Supp. 01-1).

R20-4-203. Repealed

Historical Note
Former Rule 3; Amended subsection (C) effective September 4, 1981 (Supp. 81-5). R20-4-203 recodified from R4-4-203 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-204. Repealed

Historical Note
Former Rule 4. R20-4-204 recodified from R4-4-204 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-205. Repealed

Historical Note
Former Rule 5. R20-4-205 recodified from R4-4-205 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3188, effective August 3, 2000 (Supp. 00-3).

R20-4-206. Bankers Blanket Bond Coverage -- A.R.S. § 6-188
A. Each bank shall carry at least the following basic blanket bond coverage:

Banks with Deposits of:			Amounts:
Less than $750,000			$25,000
$ 750,000	to	1,500,000	50,000
1,500,000	to	2,000,000	75,000

2,000,000	to	3,000,000	90,000
3,000,000	to	5,000,000	120,000
5,000,000	to	7,500,000	150,000
7,500,000	to	10,000,000	175,000
10,000,000	to	15,000,000	200,000
15,000,000	to	20,000,000	250,000
20,000,000	to	25,000,000	300,000
25,000,000	to	35,000,000	350,000
35,000,000	to	50,000,000	450,000
50,000,000	to	75,000,000	550,000
75,000,000	to	100,000,000	700,000
100,000,000	to	150,000,000	850,000
150,000,000	to	250,000,000	1,200,000
250,000,000	to	500,000,000	1,700,000
500,000,000	to	1,000,000,000	2,500,000
1,000,000,000	to	2,000,000,000	4,000,000
Over 2,000,000,000			6,000,000

B. Each bank shall supplement the bankers blanket bond coverage with at least a $1,000,000 excess fidelity bond.

Effective 8-8-73.

Historical Note
Former Rule 6. R20-4-206 recodified from R4-4-206 (Supp. 95-1).

R20-4-207. Capital Obligations

A. An applicant for a Superintendent's order of approval to issue a capital obligation shall submit the following documents to the Superintendent, and shall not issue any capital obligation before the Superintendent issues the order of approval. The required documents are:
1. A certified copy of the resolution adopted by the Board of Directors, or a certified copy of the unanimous written consent of the Board of Directors, authorizing the sale of the capital obligation;
2. A copy of the agreement underlying the capital obligation;
3. A copy of the note or debenture intended to represent the capital obligation; and
4. A copy of the prospectus, if any, proposed for use in the sale of the capital obligation.

B. Each document evidencing a capital obligation shall:
1. Bear on its face, in bold face type, the following: This obligation is not a deposit and is not insured by the Federal Deposit Insurance Corporation.
2. Have a maturity provision that either:
   a. Gives the obligation a maturity of at least five years, or
   b. In the case of an obligation or issue that provides for scheduled repayments of principal, gives an average maturity of at least five years. The restriction on maturity stated in this subsection does not apply to any obligation that otherwise meets all the requirements of this rule if the Superintendent determines that exigent circumstances require the issuance of the obligation without regard to any restriction on maturity. The provisions of this subsection do not apply to mandatory convertible debt obligations or issues.
3. State expressly on its face that the obligation:
   a. Is subordinated and junior in right of payment to the issuing bank's obligations to its depositors and to the bank's other obligations to its general and secured creditors, and
   b. Is ineligible as collateral for a loan by the issuing bank, except as provided in A.R.S. § 6-354.
4. Be unsecured.
5. State expressly on its face that the issuing bank may not retire any part of its capital obligation without the Superintendent's prior written order of approval, and the prior written consent of the Federal Deposit Insurance Corporation.
6. Include, if the obligation is issued to a depository institution, a specific waiver of the right of offset by the lending depository institution.
7. State that, in the event of liquidation, all depositors and other creditors of the bank are to be paid in full before any payment of principal or interest is made on a capital obligation.

C. No payment shall be made under an optional right of payment reserved to the bank without the separate authorization of the Superintendent. The Superintendent may grant that authority in the initial order of approval or in a later order of approval.

Historical Note
Former Rule 7. R20-4-207 recodified from R4-4-207 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 2155, effective May 4, 2001 (Supp. 01-2).

R20-4-208. Repealed

Historical Note
Former Rule 8. R20-4-208 recodified from R4-4-208 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3188, effective August 3, 2000 (Supp. 00-3).

R20-4-209. Notice of Permanent Closing of Banking Office

A bank may close fewer than all of its banking offices. Before closing any office, a bank shall deliver a letter to the Superintendent specifying the banking office it plans to close and the closing date. The bank shall ensure that the Superintendent receives the letter at least 10 days before the closing date. Closing the banking office shall terminate the bank's authority to maintain that banking office on the date of the actual closure.

Historical Note
Former Rule 9. R20-4-209 recodified from R4-4-209 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5388, effective November 9, 2001 (Supp. 01-4).

R20-4-210. Repealed

Historical Note
Former Rule 10. R20-4-210 recodified from R4-4-210 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3188, effective August 3, 2000 (Supp. 00-3).

R20-4-211. Application for a Banking Permit

A. Before an application is filed, the representatives of the potential applicant shall meet with the Superintendent of Banks to discuss capitalization, location, and management of the proposed bank.

B. After the meeting required by subsection (A), persons who wish to proceed with the application process shall submit an application in the form the Superintendent prescribes. The applicant shall support the application with sufficient information to enable the Superintendent to make a determination.

Historical Note
Former Rule 11. R20-4-211 recodified from R4-4-211 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 3188, effective August 3, 2000 (Supp. 00-3).

R20-4-212. Repealed

Historical Note
Former Rule 12. Amended effective September 4, 1981 (Supp. 81-4). R20-4-212 recodified from R4-4-212 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-213. Repealed

Historical Note
Former Rule 13. Repealed effective September 13, 1981 (Supp. 81-5). R20-4-213 recodified from R4-4-213 (Supp. 95-1).

R20-4-214. Preservation of Records

A. Every bank shall keep its corporate and business records as originals or as copies of the originals made by reproduction methods that accurately and permanently preserve the records. Copies complying with this subsection, when satisfactorily identified, have the same evidentiary status as an original. A bank may use an electronic recordkeeping system. The Department shall not require a bank to keep a written copy of its records if the bank can generate all information and copies required by this Section in a timely manner for examination or other purposes.

B. A bank shall keep its corporate and business records for the period required by this Section. These periods are measured from the date of the last entry or final action date. A bank shall have and comply with its own record retention schedule that is consistent with this Section. A bank may comply with this Section by complying with a preemptive federal regulation, even if the federal regulation requires a shorter retention period than is listed in this Section. This Section does not prohibit record retention for longer periods than these state-required minimums for any reason, including a retention period established by preemptive federal law or regulation. Likewise, this Section does not prohibit a bank from keeping any type of record not required in subsection (D).

C. Beginning on the effective date of this Section, corporate and business records of a bank operating in the state of Arizona are classified, and their retention periods are prescribed, according to the schedule in subsection (D). Retention periods are listed in subsection (D) using the notations, acronyms, and abbreviations listed in this Section.

1. A numerical designation refers to a period of years unless a shorter period of time is specified in the schedule.
2. "AC" means after closure.
3. "ACH" means automated clearing house.
4. "AE" means after expiration.
5. "ALC" means after last contact.
6. "AP" means after paid.
7. "ATD" means after termination date.
8. "CTR" means a cash transaction report required by the Federal Bank Secrecy Act.
9. "FDIC" means the Federal Deposit Insurance Corporation.
10. "FHA" means the Federal Housing Administration.
11. "FHLMC" means the Federal Home Loan Mortgage Corporation.
12. "FNMA" means the Federal National Mortgage Association.
13. "GNMA" means the Government National Mortgage Association.
14. "IRS" means the United States Department of the Treasury's Internal Revenue Service.
15. "M" means months.
16. "P" means the bank shall keep the record permanently.
17. "PMI" means private mortgage insurance.
18. "SAR" means a suspicious activity report required by the federal Bank Secrecy Act.
19. "TTL" means a treasury, tax, and loan account maintained by a bank.
20. "UCC" means the Uniform Commercial Code as it is in effect in Arizona.

D. Retention Schedule

1. Accounting and Auditing
   - a. Accrual and bond amortization 3
   - b. Audit report 6
   - c. Audit work papers 3
   - d. Bank call, income and dividend report 5
   - e. Bill, statement, or invoice - paid 7
   - f. Budget work papers 2
   - g. Collateral vault "in-and-out" ticket 1
   - h. Daily reserve computation 1
   - i. Earnings report 7
   - j. Expense voucher or invoice 7
   - k. Financial statement 7
   - l. Interoffice reconciliation 1
   - m. Interoffice transaction 1
   - n. Periodic statement for account owned by the bank 2
   - o. Reconcilement of deposits-due to bank 2
   - p. Reconcilement register-due from bank 2
   - q. Return and cash item register 1
   - r. Service contract 2
   - s. Treasury tax and loan account 2
   - t. Unclaimed property record 7
2. Administration
   - a. Articles of incorporation or association, bylaws, or other record of organization P
   - b. Bankers blanket bond-record showing compliance 5 AE
   - c. Bank examiner's report 7
   - d. Capital note issuance and transfer record P
   - e. Depreciation record-office equipment 3
   - f. Dividend check and register 7
   - g. Dividend check-outstanding P
   - h. Expired policy insuring the bank 3 AE
   - i. FDIC assessment base, record 5
   - j. FDIC certificate P
   - k. Insurance policy number, record of premium paid and amount recovered 3 AE
   - l. Legal proceedings when completed 5
   - m. Minute book of:
     - i. Meetings of the board of directors P
     - ii. Meetings of committees of the board of directors P
     - iii. Shareholders' meetings P
   - n. Postage meter record book (from date of final entry) 1
   - o. Real estate documentation 5 ATD
   - p. Report to directors 3
   - q. Stock issuance and transfer record P
   - r. Required report to supervisory agency 3
   - s. Tax controversy or proceeding when completed 7
   - t. Tax record not material to any controversy 7

u. Voting list and proxies 3

3. Collections
   a. Collection payment record 1
   b. Collection receipt-carbon 1
   c. Collection register 1
   d. Coupon cash letter-outgoing 1
   e. Coupon envelope 1
   f. Customer file copy 1
   g. Incoming collection letter 1
   h. Incoming contract or note letter 1
4. Customer service
   a. Broker account holder-identification 5
   b. Broker's confirmation 3
   c. Broker's invoice 3
   d. Broker's statement 3
   e. E-Bond application 2
   f. E-Bond sold or redeemed-record 2
   g. E-Bond transmittal letter 2
   h. Lock box daily receipts 1
   i. Night depository agreement 1 AC
   j. Night depository daily record 1
   k. Safekeeping record and receipt 5
   l. Securities buy order and sell order 3
5. Data processing (management information systems)
   a. Back-up data (for reconstruction) daily, end of month, quarter, or year 1
   b. Disaster recovery program P
   c. Film copy of every IRS financial reporting form 6
   d. Program change P
   e. System, program and procedure manual P
6. Deposits
   a. Account opened and account closed report 1
   b. Certificate of deposit purchase record 7
   c. Check paid, withdrawal slip, and other debits to account 7
   d. Club account check register 1
   e. Club account coupon 1
   f. SAR - for suspicious transaction under $10,000 5
   g. CTR - for transaction exceeding $10,000 5
   h. Customer authorization, resolution, and signature card 6 AC
   i. Deposit account record needed to reconstruct 7
   j. Deposit and other credits 7
   k. Dormant account – after closed or escheated 7 ALC
   l. Form 1096, and 1099 reports to IRS 7
   m. Individual retirement account record 7
   n. Interest check or other record of interest payment and reports 7
   o. Internal management reports:
      i. Large balance 1
      ii. Overdraft 1
      iii. Public funds 1
      iv. Service charges 1
      v. Stop payment 1
      vi. Uncollected funds 1
      vii. Unposted item 1
      viii. Zero balance 1
   p. Ledger card 5 AC
   q. Power of attorney document 7 ATD
   r. Receipt for statement held at customer's request 1
   s. Record showing compliance with the following federal regulations. The stated retention period applies unless, and until, it is preempted by federal law:
      i. Regulation CC, Expedited Funds Availability Act 2
      ii. Regulation DD, Truth in Savings Act 2
      iii. Regulation E, Electronic Funds Transfer Act 2
   t. Returned statement and cancelled checks 6
   u. Statement 6
   v. Stop payment order 6 AE
   w. Document used to request and receive Tax Identification Number 6
   x. Transaction journal 6
   y. Trial balance 6
7. Due from banks
   a. Advice from correspondent bank 1
   b. Bank statement 1
   c. Draft-original 7
   d. Draft register or copy 1 AP
   e. Duplicate check-information and documentation pertaining to issuance 7
   f. Reconcilement register 1
8. Due to banks
   a. Account opened and account closed-reports 1
   b. Advice-copy 1
   c. Incoming cash letter memo for credit 1
   d. Incoming cash letter for remittance 1
   e. Reconcilement register (TTL) 2
   f. Reconcilement verification 1
   g. Resolution 2 AC
   h. Signature card 6 AC
   i. Trial balance (fiche) 7
   j. Undelivered statement, reconstruction available from bank records 1
   k. Undelivered statement, reconstruction not possible 7
9. General
   a. Address change order 1
   b. Affidavit from customer including affidavit of loss, forgery, or non-use of cashier's check 1
   c. Writ of attachment or garnishment 5
   d. Attachment, release 5
   e. Armored car receipt 1
   f. Check book order 1
   g. Check book-receipt 1
   h. Court order memorandum record 5
   i. Notice of Protest 1
   j. Travelers check-application 2
   k. Vault record-opening and closing 1
   l. Wire transfer debit entry and credit entry 7
10. General ledger
   a. Daily statement of condition 3
   b. General journal-if byproduct of posting the general ledger 3
   c. General journal-if used as book of original entry with description 3
   d. General ledger 5
   e. General ledger ticket-debit and credit 2
11. International department
   a. Broker account holder-identification 5
   b. Cable copy 7
   c. Cable requisition 7
   d. Collection paid 1
   e. Correspondence 2
   f. Draft 7
   g. Foreign collection register 6
   h. Foreign draft application 6
   i. Foreign draft-carbon 2 ATD

j. Foreign exchange remittance sheet or book 6
k. Foreign financial account-record 7
l. Foreign mail transfer application 6
m. Foreign mail transfer-carbon 2 ATD
n. Foreign outstanding cash 2
o. Foreign payment-incoming 2
p. Letter of credit application 2
q. Letter of credit ledger sheet 7
r. Transfer outside of the United States in excess of $10,000 – record 5

12. Investments
a. Bonds
i. Amortization record 6
ii. Confirmation 3
iii. Safekeeping receipt 2
b. Broker's securities
i. Broker's invoice 3
ii. Broker's statement 3
iii. Report of lost or stolen securities 3
iv. Safekeeping advice 2
v. Taxpayer identification number 5
c. Commercial paper
i. Broker's advice 2
ii. Purchase order 2
iii. Remittance advice 2
d. Mortgage-backed securities
i. Buy-and-sell agreement 3
ii. Commitment letter 7
iii. FHLMC and FNMA loan file 7
iv. GNMA certificate 7
v. Interest accrual record 7
vi. Monthly remittance report 7

13. Loans. A bank shall keep each loan record listed for the period required by this subsection. These periods are measured from the date of final activity. A bank shall have and comply with its own record retention schedule that is consistent with this subsection. A bank may comply with this subsection by complying with a preemptive federal regulation, even if the federal regulation requires a shorter retention period than is listed in this subsection. This subsection does not prohibit record retention for longer periods than these state-required minimums for any reason, including a retention period established by preemptive federal law or regulation. Likewise, this Section does not prohibit a bank from keeping any type of record not required by this subsection.
a. All Loans - general
i. Application for loan approved 6
ii. Appraisal 6
iii. Borrower's financial statement 6
iv. Charge-off record 10
v. Charged off note 10
vi. Collateral file 6
vii. Correspondence 6
viii. Credit file – all documentation 6
ix. Credit report 6
x. Daily proof and record 6
xi. Loan committee minutes P
xii. Miscellaneous loan reports including new loan journal, paid loan journal, past due report, and transaction journal as original entry 6
xiii. Other documentation for reconstruction of loan 2
b. Commercial loans
i. Application for loan denied 12 M
ii. Bill of sale 6
iii. Borrowing resolution 3
iv. Business annual report (fiscal or year end) - after date of report 3
v. Business cash-flow analysis report - after date of report 3
vi. Business tax return - after date of return 6
vii. Commitment letter 6
viii. Copy of mortgage note or deed of trust 6
ix. Evidence of insurance 6
x. Guaranty 6
xi. Letter of credit 6
xii. Participation agreement 6
xiii. Promissory note 6
xiv. Purchase and sale agreement 6
xv. Security agreement 6
xvi. Title documentation 6
xvii. UCC filing 6
c. Consumer loans
i. Application for loan denied, including adverse action notice 25 M
ii. Collateral record 6
iii. Hazard insurance record 6
iv. Invoice 6
v. Life and disability insurance record 6
vi. Overdraft loan agreement 6
vii. Promissory note and modification agreement - copy 6
viii. Title documentation 6
ix. UCC filing - copy 6
d. Real estate loans
i. Assignment of escrow 6
ii. Assumption 6
iii. Commitment letter 6
iv. Copy of deed of trust or mortgage note, as it may have been modified 6
v. Escrow analysis and record 6
vi. Evidence of any FHA or PMI insurance required 6
vii. Hazard insurance life of loan
viii. Proof of insurance excluding hazard 6
ix. Sales contract 6
x. Settlement sheet 6
xi. Survey 6
xii. Title documentation 6
e. Construction loans. In addition to the documents specified in subsection (d), a bank shall keep a record for a construction loan as specified in this subsection:
i. Certificate of occupancy 6
ii. Construction progress report 6
iii. Contractor's cost breakdown 6
iv. Disbursement documentation 6
v. Inspection report 6
vi. Residential construction specifications and material list 6

14. Official checks and drafts
a. Affidavit, bond, indemnity agreement, other documentation supporting the issuance of a duplicate check or draft 7
b. Bank draft 3
c. Cashier's check-cancelled 7
d. Cashier's check register-copy 7

e. Expense check-cancelled 7
f. Expense check register-copy 7
g. Expense voucher or invoice 7
h. Money order-bank or personal 7
i. Money order register-copy 7
j. Official check outstanding P

15. Personnel Records
a. Attendance record, and time card 3
b. Authorization for payroll deduction 2
c. Department of labor report 5
d. Disability record 5
e. Employee record and personnel folder 5
f. Employment application 3 AT
g. Insurance record 2
h. Payroll check 2
i. Pension fund record 10
j. Profit sharing fund record 10
k. Rejected employee application 2
l. Salary ledger or electronic data processing printout 4
m. Salary receipt 2
n. W-3 reconciliation of income tax withheld from wages 3
o. W-4 withholding exemption certificate 3
p. Wage and tax statement record (W-2) 7
q. Wage differential documentation (Fair Labor Standards Act) 3

16. Registered mail
a. Marine insurance book 3
b. Record of incoming and outgoing registered mail 1
c. Return receipt card 3

17. Safe deposit vault
a. Access ticket or card 6
b. Court order and correspondence 6
c. Delivery of will, burial plot deed, insurance policy-receipt 6
d. Forced entry record 6
e. Lease or contract-closed account 2 AC
f. Ledger record of account 1
g. Opened box contents-record and report 7
h. Rent receipt-copy 1
i. Sale to satisfy lien-record 7
j. Signature card, authorization, and resolution 6 AC

18. Tellers
a. Mail teller envelope 3 M
b. Teller's balancing recap or recap book 1
c. Teller's cash ticket-original and carbons 1
d. Teller's cash shipment record 1
e. Teller's exchange ticket 1
f. Teller's machine tape 1

19. Transit, proof, and clearing
a. ACH entry 6
b. Advice of correction to deposit 2
c. Clearinghouse settlement sheet - recapitulation of checks delivered to the clearinghouse or federal reserve 2
d. Record of items processed 6
e. Proof machine tape or other record 2
f. Receipt for transit letter 1
g. Return item letter 5

20. Trust department administration
a. Appraisal of real or personal property held as a trust asset 3 AC
b. Correspondence 3 AC
c. Decree or receipt and release 3 AC
d. Fee record and supporting data 3 AC
e. Intermediate and final account 3 AC
f. Legal documentation including judgment, court order, and legal opinion 3 AC
g. Paid bill 3 AP
h. Real estate insurance policy 1 AE
i. Real estate and mortgage document 3 AC
j. Receipt for asset received or delivered 3 AC
k. Record of asset tax cost 3 AC
l. Summary card, original instrument, agreement and amendment, and letters of appointment 3 AC
m. Synopsis sheet 3 AC

21. Corporate trust
a. Bond registration journal 3 AC
b. Bond-cancelled 7
c. Indemnity bond P
d. Certification 2
e. Coupon envelope 6 M
f. Coupon-cancelled 6 M
g. Customer receipt 7
h. Dividend and coupon record 3 AC
i. Dividend and interest disbursement check and list 3 AC
j. General ledger ticket 2
k. Legal paper P
l. Copy of cancelled stock certificate, original returned to customer 1
m. Stock registration journal 3 AC
n. Stock transfer memo 1
o. Stock transfer receipt 1
p. Tax return 3 AC
q. Transfer-supporting papers 3 AC
r. Transfer journal 3 AC
s. Transfer tax waiver 3 AC
t. Trust ledger-corporate 7

22. Personal trust
a. Record of previously discharged fiduciary
i. Accounting 3 AC
ii. Decree 3 AC
iii. Receipt and release 3 AC
b. Accounting - recorded 3 AC
c. Advice of payment - securities department regarding bond and coupon collection 3 AC
d. Appraisal
i. Real property 3 AC
ii. Personal property 3 AC
e. Asset delivery receipt 3 AC
f. Authorization
i. By co-fiduciary P
ii. By consultant P
g. Approval
i. By co-fiduciary P
ii. By consultant P
h. Broker's statement 7
i. Buy and sell order 7
j. Cash documentation
i. Customer cash and asset statement 7
ii. Cash and security journal 7
iii. Cash trial balance 1
k. Common trust fund annual report 10
l. Correspondence
i. Transfer letter 3 AC
ii. Claim letter 3 AC

m.	Coupon collection record	7
n.	Court accounting and petition	7
o.	Daily transaction journal	6 M
p.	Debits and credits-daily	1
q.	Documentation necessary to support account decision	3 AC
r.	Tax Documentation	
i.	Federal estate tax return	10
ii.	State estate tax return	10
iii.	Tax-related work papers	10
iv.	Federal gift tax return	10
s.	Fee calculations and supporting data	1
t.	Income tax return	
i.	Federal	3 AC
ii.	State	3 AC
u.	Inventory	3 AC
v.	Investment review and related material	3 AC
w.	Minutes	
i.	Investment committee	P
ii.	Trust committee	P
23.	Other personal trust records	
a.	Legal opinion	3 AC
b.	Correspondence related to legal opinion	3 AC
c.	Paid bill	7
d.	Review and recommendation	3 AC
e.	Safekeeping record and receipt	3 AC
f.	Security ledger sheet	P
g.	Trust check	10
h.	Trust entry-original	3 AC
i.	Trust or agency agreement-original	3 AC
j.	Vault withdrawal and deposit ticket	7
k.	Will-certified copy	P
l.	Work papers supporting tax return	7
24.	Trust Investments	
a.	Annual report	
i.	Common trust fund	10
ii.	Pooled fund	10
b.	Valuation	
i.	Common trust fund	10
ii.	Pooled fund	10
c.	Minutes	
i.	Investment committee	P
ii.	Administrative committee	P
d.	Investment order and broker's confirmation	3 AC
e.	investment review and related material	3 AC
f.	Correspondence	3 AC
g.	Summary of annual account activity	3 AC
25.	Wire transfer	
a.	Incoming wire log	1
b.	Outgoing wire log	1
c.	Transmission record	7
d.	Wire transfer request	7

Historical Note
Former Rule 14. R20-4-214 recodified from R4-4-214 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4142, effective September 12, 2001 (Supp. 01-3). Missing notation in subsection (D)(1)(j) corrected as proposed at 7 A.A.R. 2491 (Supp. 20-1).

R20-4-215. Trust Business
All banks authorized to conduct trust business under their banking permit shall comply with the applicable requirements of R20-4-808 through R20-4-816.

Historical Note
Adopted effective June 30, 1977 (Supp. 77-3). R20-4-215 recodified from R4-4-215 (Supp. 95-1).

ARTICLE 3. EXPIRED

R20-4-301. Expired

Historical Note
Former Rule 1. R20-4-301 recodified from R4-4-301 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-302. Repealed

Historical Note
Former Rule 2; Repealed effective January 19, 1984 (Supp. 84-1). R20-4-302 recodified from R4-4-302 (Supp. 95-1).

R20-4-303. Expired

Historical Note
Former Rule 3. R20-4-303 recodified from R4-4-303 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-304. Expired

Historical Note
Former Rule 4. R20-4-304 recodified from R4-4-304 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-305. Repealed

Historical Note
Former Rule 5. R20-4-305 recodified from R4-4-305 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-306. Repealed

Historical Note
Former Rule 6. R20-4-306 recodified from R4-4-306 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-307. Repealed

Historical Note
Former Rule 7. R20-4-307 recodified from R4-4-307 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-308. Repealed

Historical Note
Former Rule 8. R20-4-308 recodified from R4-4-308 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-309. Expired

Historical Note
Former Rule 9. R20-4-309 recodified from R4-4-309 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-310. Reserved

R20-4-311. Repealed

Historical Note
Former Rule 11; Repealed effective January 19, 1984 (Supp. 84-1). R20-4-311 recodified from R4-4-311 (Supp. 95-1).

R20-4-312. Repealed

Historical Note
Former Rule 12. R20-4-312 recodified from R4-4-312 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-313. Reserved

R20-4-314. Repealed

Historical Note
Former Rule 14. R20-4-314 recodified from R4-4-314 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-315. Repealed

Historical Note
Former Rule 15. R20-4-315 recodified from R4-4-315 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-316. Repealed

Historical Note
Former Rule 16. R20-4-316 recodified from R4-4-316 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-317. Repealed

Historical Note
Former Rule 17; Repealed effective January 19, 1984 (Supp. 84-1). R20-4-317 recodified from R4-4-317 (Supp. 95-1).

R20-4-318. Expired

Historical Note
Former Rule 18. R20-4-318 recodified from R4-4-318 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-319. Repealed

Historical Note
Former Rule 19. R20-4-319 recodified from R4-4-319 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-320. Repealed

Historical Note
Former Rule 20. R20-4-320 recodified from R4-4-320 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-321. Repealed

Historical Note
Former Rule 21. R20-4-321 recodified from R4-4-321 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-322. Repealed

Historical Note
Former Rule 22; Repealed effective January 19, 1984 (Supp. 84-1). R20-4-322 recodified from R4-4-322 (Supp. 95-1).

R20-4-323. Repealed

Historical Note
Former Rule 23. R20-4-323 recodified from R4-4-323 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-324. Expired

Historical Note
Former Rule 24. R20-4-324 recodified from R4-4-324 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-325. Expired

Historical Note
Former Rule 25. R20-4-325 recodified from R4-4-325 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-326. Expired

Historical Note
Former Rule 26. R20-4-326 recodified from R4-4-326 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-327. Expired

Historical Note
Former Rule 27. R20-4-327 recodified from R4-4-327 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-328. Expired

Historical Note
Former Rule 28. R20-4-328 recodified from R4-4-328 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-329. Repealed

Historical Note
Former Rule 29. R20-4-329 recodified from R4-4-329 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-330. Expired

Historical Note
Original Rule. R20-4-330 recodified from R4-4-330 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 841, effective March 14, 2017 (Supp. 17-1).

R20-4-331. Repealed

Historical Note
Original Rule. R20-4-331 recodified from R4-4-331 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

ARTICLE 4. CREDIT UNIONS

R20-4-401. Fidelity Bond Coverage

A. A credit union shall have a fidelity bond in the form and in the amount required to maintain federal insurance on its accounts.

B. A fidelity bond purchased by a credit union to comply with this Section shall include faithful-performance-of-duty coverage.

C. A credit union shall purchase its fidelity bond from an insurer that holds a certificate of authority from the Arizona Director of Insurance to transact surety business in Arizona.

Historical Note
Former Rule 1. R20-4-401 recodified from R4-4-401 (Supp. 95-1). Amended effective April 21, 1995 (Supp. 95-2). Amended by final rulemaking at 7 A.A.R. 2229, effective May 3, 2001 (Supp. 01-2).

R20-4-402. Repealed

Historical Note
Former Rule 2. R20-4-402 recodified from R4-4-402 (Supp. 95-1). Repealed effective April 21, 1995 (Supp. 95-2).

ARTICLE 5. SMALL LOANS

R20-4-501. Repealed

Historical Note
Former Rule 1. R20-4-501 recodified from R4-4-501 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-502. Repealed

Historical Note
Former Rule 2. R20-4-502 recodified from R4-4-502 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-503. Adjustments in Precomputed Charges
A licensee shall adjust the total precomputed charges if the first installment period is more or less than one month long. The licensee's records shall reflect the adjustment's collection in one of three ways.

1. In the first installment payment,
2. Amortized over the life of the contract, or
3. As part of the final payment.

Historical Note
Former Rule 3. R20-4-503 recodified from R4-4-503 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-504. Repealed

Historical Note
Former Rule 4. R20-4-504 recodified from R4-4-504 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-505. Repealed

Historical Note
Former Rule 5. R20-4-505 recodified from R4-4-505 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-506. Repealed

Historical Note
Former Rule 6. R20-4-506 recodified from R4-4-506 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-507. Repealed

Historical Note
Former Rule 7. R20-4-507 recodified from R4-4-507 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-508. Cut-off Date for Computing Refunds upon Early Repayment in Full
If a borrower repays a loan before the due date of the final installment, a licensee shall calculate any refund or credit due on the precomputed loan using the following rules:

1. A licensee shall credit any full repayment, made on or before the 15th day following an installment date, as if received on the last previous installment date.
2. A licensee shall credit any full repayment, made on or after the 16th day following an installment date, as if received on the next installment date.

Historical Note
Former Rule 8. R20-4-508 recodified from R4-4-508 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, November 14, 2000 (Supp. 00-4).

R20-4-509. Repealed

Historical Note
Former Rule 9. R20-4-509 recodified from R4-4-509 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-510. Repealed

Historical Note
Former Rule 10. R20-4-510 recodified from R4-4-510 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-511. Repealed

Historical Note
Former Rule 11. R20-4-511 recodified from R4-4-511 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-512. Reserved

R20-4-513. Repealed

Historical Note
Former Rule 13. R20-4-513 recodified from R4-4-513 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-514. Repealed

Historical Note
Former Rule 14. R20-4-514 recodified from R4-4-514 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-515. Repealed

Historical Note
Former Rule 15. R20-4-515 recodified from R4-4-515 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-516. Repealed

Historical Note
Former Rule 16. R20-4-516 recodified from R4-4-516 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-517. Repealed

Historical Note
Former Rule 17. R20-4-517 recodified from R4-4-517 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-518. Deferral Fee

A. A licensee may collect a deferral fee at the time it agrees to a deferment or at any time after the assessment of a deferral fee. If a licensee receives a payment when it agrees to the deferment, it may apply the payment first to the deferral fee. Any remainder of the payment shall be applied to the balance of the loan.

B. If a licensee receives a payment that is large enough to pay in full a delinquent installment and all allowable delinquency fees, the licensee shall apply the payment first to the delinquent installment and fees. The licensee shall not show the paid installment as deferred, and shall not collect a deferral fee.

Historical Note
Former Rule 18. R20-4-518 recodified from R4-4-518 (Supp. 95-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-519. Deferment Statement

A licensee shall give the borrower a statement at the time a deferment is made, and shall retain a copy of the statement in the borrower's credit file. The statement shall contain the following information:

1. The amount of the deferral fee,
2. The date of the borrower's next scheduled payment,
3. The amount of the borrower's next scheduled payment, and
4. The extended maturity date of the loan.

Historical Note
Former Rule 19. R20-4-519 recodified from R4-4-519 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-520. Repealed

Historical Note
Former Rule 20. R20-4-520 recodified from R4-4-520 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-521. Repealed

Historical Note
Former Rule 21. R20-4-521 recodified from R4-4-521 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-522. Repealed

Historical Note
Former Rule 22. R20-4-522 recodified from R4-4-522 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-523. Repealed

Historical Note
Former Rule 23. R20-4-523 recodified from R4-4-523 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-524. Books, Accounts, and Records

A. A licensee may use a computer recordkeeping system if the licensee gives the Superintendent advanced written notice that it intends to do so. The Department shall not require a licensee to keep a written copy of its books, accounts, and records if the licensee can generate all information required by this Section in a timely manner for examination or other purposes. A licensee may modify a computer recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a licensee shall report to the Superintendent any modification that changes a computer system back to a paper-based recordkeeping system;

B. A licensee shall keep its books, accounts, and records of operations licensed under A.R.S. Title 6, Chapter 5 separate from the books, accounts, and records of its other business activities.

C. In addition to any statutory requirements, the books, accounts, and records maintained by a Small Loan Company shall include the following:

1. A file containing a record of all legal actions brought during the fiscal year. A licensee shall keep the file until the Department of Financial Institutions conducts its examination of the licensee.
2. An itemized record of disbursing the proceeds of each loan. The itemized record shall include the amount of refund on each loan that is renewed or refinanced if the licensee makes precomputed loans.
3. A record of the receipt of all allowable fees.
4. A record for each borrower and each loan that contains documentary evidence of filing or recording each instrument of record for the loan.
5. A record of the borrower's voluntary election to purchase any insurance in connection with a loan, if that insurance is sold by the licensee.

Historical Note
Former Rule 24. R20-4-524 recodified from R4-4-524 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-525. Repealed

Historical Note
Former Rule 25. R20-4-525 recodified from R4-4-525 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-526. Repealed

Historical Note
Former Rule 26. R20-4-526 recodified from R4-4-526 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-527. Repealed

Historical Note
Former Rule 27. R20-4-527 recodified from R4-4-527 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-528. Repealed

Historical Note
Former Rule 28. R20-4-528 recodified from R4-4-528 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-529. Repealed

Historical Note
Former Rule 29. R20-4-529 recodified from R4-4-529 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-530. Repealed

Historical Note
Former Rule 30. R20-4-530 recodified from R4-4-530 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-531. Repealed

Historical Note
Former Rule 31. R20-4-531 recodified from R4-4-531 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-532. Repealed

Historical Note
Former Rule 32. R20-4-532 recodified from R4-4-532 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-533. Reserved

R20-4-534. Insurance

A. A licensee shall obtain written evidence of the borrower's voluntary election to purchase insurance in connection with a loan if the licensee's sale of insurance to the borrower is intended to secure repayment of a loan. The licensee shall retain this evidence of voluntary election in its records as required by statute. A document sufficient to comply with this Section shall read as follows:

TO SECURE REPAYMENT OF MY LOAN, I ELECT TO PURCHASE INSURANCE IN THE AMOUNT OF $ _____ .

I UNDERSTAND THAT MY TOTAL LOAN OBLIGATION IS THE SUM OF $ _____ .

B. A licensee shall obtain written evidence of the borrower's voluntary election to purchase property insurance in connection with a loan if the licensee's sale of property insurance to the borrower is intended to secure repayment of a loan. The licensee shall retain this evidence of voluntary election in its records as required by statute. A document sufficient to comply with this Section shall read as follows:

TO SECURE REPAYMENT OF MY LOAN, I ELECT TO PURCHASE PROPERTY INSURANCE IN THE AMOUNT OF $ _____ .

I UNDERSTAND THAT MY TOTAL LOAN OBLIGATION IS THE SUM OF $ _____ .

I ATTEST THAT THE VALUE OF MY PROPERTY INSURED IN CONNECTION WITH THIS LOAN IS THE SUM OF $ _____ .

Historical Note
Former Rule 34. R20-4-534 recodified from R4-4-534 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-535. Reserved

R20-4-536. Repealed

Historical Note
Former Rule 36. R20-4-536 recodified from R4-4-536 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

ARTICLE 6. DEBT MANAGEMENT COMPANIES

Article 6, consisting of Sections R4-4-601 through R4-4-620, adopted effective October 26, 1978, except that Sections R4-4-603, R4-4-604 and R4-4-607 shall become effective January 1, 1979. R20-4-601 through R20-4-620 recodified from R4-4-601 through R4-4-620 (Supp. 95-1).

Former Article 6 consisting of Section R4-4-601 repealed effective October 26, 1978. R20-4-601 recodified from R4-4-601 (Supp. 95-1).

R20-4-601. Repealed

Historical Note
Former Rule 1; Former Section R4-4-601 repealed, new Section R4-4-601 adopted effective October 26, 1978 (Supp. 78-5). R20-4-601 recodified from R4-4-601 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-602. Applications

A. An applicant for a debt management company license shall send the Department an application on the form required by the Superintendent. The Department shall order a credit report from a local credit reporting agency disclosing the credit history of the applicant's principals or managing agents. The Department shall direct the credit reporting agency to send the credit report directly to the Superintendent. The applicant shall pay the cost of obtaining the credit report. A complete application shall include the credit report required by this Section and all of the following:

1. The surety bond required by A.R.S. § 6-704(B);
2. The fidelity bond required by A.R.S. § 6-704(D);
3. The nonrefundable application fee and original license fee described in A.R.S. § 6-706, and specified in A.R.S. § 6-126(A)(14);
4. A sample of the contract intended to be used by the applicant;
5. Current financial statements as described in R20-4-604(A)(5);
6. A certified copy of the current articles of incorporation, by-laws, partnership agreement or other organizing documents used to form the applicant business entity; and
7. Statements of personal history, on the form required by the Superintendent, for each of the applicant's principals, principal officers, trustees, partners, and managing agents.

B. A debt management company applying to operate a branch office or use an agency shall send the Department an application on the form required by the Superintendent.

C. A debt management company applying to renew a license shall deliver, on or before June 15 of each year, an application to the Department on the form required by the Superintendent. A debt management company shall apply separately to renew the license of each authorized business location. With each application for renewal, a debt management company shall include the renewal fee described in A.R.S. § 6-706 and specified in A.R.S. § 6-126(C)(2).

D. The Department may require additional information the Superintendent considers necessary in connection with an application under this Section.

Historical Note

Adopted effective October 26, 1978 (Supp. 78-5). R20-4-602 recodified from R4-4-602 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-603. Reports

A. Each debt management company and each nonprofit corporation or association exempt from licensure under A.R.S. § 6-702(4) and (5), shall send the Department an annual report of its business and operations for each place of business during the previous year beginning July 1 and ending June 30, using the form required by the Superintendent. A debt management company shall deliver its report to the Department on or before August 15.

B. Each debt management company organized as a corporation shall send the Department a copy, date-stamped by the Arizona Corporation Commission, of each annual report and certificate of disclosure filed under the authority of A.R.S. § 10-202 or 10-1622 within ten days of filing the report and certificate with the Arizona Corporation Commission.

C. Each debt management company shall notify the Department of any change in its ownership or in the names of its officers, directors, trustees, partners, or managing agents within ten days of the change.

Historical Note

Adopted effective January 1, 1979 (Supp. 78-5). R20-4-603 recodified from R4-4-603 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-604. Records

A. A debt management company shall keep books, accounts, and records adequate to provide a clear and readily understandable record of all its business activity. A debt management company may use an electronic recordkeeping system. The Department shall not require a debt management company to keep a written copy of its books, accounts, and records if the debt management company can generate all information and documentation required by this Section within three days of the Department's request for production of the records for examination or other purposes. A debt management company's books, accounts, and records shall include:

1. A file for each account containing:
   a. A copy of all correspondence concerning the account;
   b. Evidence of the notice given to creditors of the debt management contract;
   c. A subsidiary ledger disclosing all financial transactions concerning the account;
   d. A copy of each written statement of account given to the debtor;
   e. The original budget analysis required under R20-4-607; and
   f. The original contract between the debt management company and the debtor, including all amendments.
2. A trust account general ledger, kept current daily, that reflects each deposit to and disbursement from the trust account.
3. Each reconciliation of the debt management company's trust account, prepared at least once a month.
4. A general ledger, kept current monthly, that reflects each financial transaction by the debt management company except those recorded in its trust account general ledger.
5. A financial statement produced in accordance with generally accepted accounting principles at least once every three months, or more frequently if directed by the Superintendent, that reflects the financial condition of the debt management company. The financial statement shall include:
   a. A balance sheet,
   b. A statement of income and retained earnings,
   c. A statement of changes in financial condition, and
   d. Appropriate footnotes that either:
      i. Explain entries in the documents listed in subsections (A)(5)(a), (b), and (c);
      ii. Contain material information not required or not reportable in documents listed in subsections (A)(5)(a), (b), or (c); or
      iii. Contain other disclosures required by generally accepted accounting principles.
6. A record of all pending litigation naming the debt management company as a party. The debt management company shall keep, during the pendency of each case, a copy of the complaint, and a copy of any answer or motion filed by the debt management company in response to the complaint.

B. All records required under this Section may be maintained at the debt management company's office in Arizona. A debt management company may keep its records outside this state if it:

1. Makes the records available to the Superintendent, for examination or other purposes, in this state not more than three business days after demand; and
2. Allows its debtor customers to call toll free to obtain information from the records that is not available from the debt management company's office in Arizona.

C. Each debt management company shall preserve its books, accounts, and records for the period required by A.R.S. §§ 6-709(J) and 6-710(1).

Historical Note

Adopted effective January 1, 1979 (Supp. 78-5). R20-4-604 recodified from R4-4-604 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-605. Reserved

R20-4-606. Reserved

R20-4-607. Budget Analysis

A. A debt management company shall not accept an account unless it first concludes that the debtor can reasonably meet the payments agreed upon by the debt management company and the debtor. The debt management company's conclusion shall be supported by a written budget analysis kept in the company's records.

B. The written budget analysis shall either be part of an application form or a separate document. The debtor shall date and sign the written budget analysis before the debt management company draws any conclusions from the budget analysis.

C. The budget analysis shall disclose the disposable income available for payment to the debt management company after the debtor pays its reasonable and necessary living expenses including taxes, insurance, child support, alimony, and residential rent or mortgage payments.

Historical Note
Adopted effective January 1, 1979 (Supp. 78-5). R20-4-607 recodified from R4-4-607 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-608. Reserved

R20-4-609. Repealed

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-609 recodified from R4-4-609 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-610. Repealed

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-610 recodified from R4-4-610 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-611. Advertising

A. A debt management company shall send the Department copies of all advertising, communication, or sales material at least five days before the company uses the advertising, communication, or sales material to promote the sale of the company's services. This requirement applies to every type of promotional material used, whether the company will publish, exhibit, broadcast, or personally distribute the material by any other method or medium.

B. A debt management company shall not use advertising, communication, or sales material that contains:
1. A false, misleading, or deceptive statement about the debt management company's services or charges. A statement is a violation of this Section if the person making the statement does not state a material fact necessary to make the statement true, in light of the circumstances under which it is made;
2. A claim, direct or implied, that the debt management company consolidates debts or makes loans; or
3. A schedule of payments in any form.

C. A debt management company's advertising, communication, and sales material shall contain:
1. The name of the debt management company exactly as it appears on the current license; and
2. The following legend, conspicuously displayed in at least 12 point type and in bold print:
"NOT A LOAN COMPANY."

D. The Department's failure to object to the advertising, communication, or sales material filed with it is not and shall not be represented as an approval of the material or the statements it contains.

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-611 recodified from R4-4-611 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-612. Solvency and Minimum Liquid Assets

A. A debt management company shall not operate if it is insolvent. For purposes of this Section "insolvent" has the same meaning as in A.R.S. § 47-1201(23).

B. To determine compliance with A.R.S. § 6-709(A), a debt management company's liquid assets include funds held in its trust account. Liquid assets do not include goodwill and other intangible assets. A debt management company's total liquid assets shall exceed by $2,500.00 the total of all its current business liabilities together with all balances held for debtors as reflected in the company's subsidiary ledgers.

C. Except as otherwise provided by this Section, or in a specific ruling by the Superintendent, a debt management company shall use generally accepted accounting principles to compute assets and liabilities.

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-612 recodified from R4-4-612 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-613. Reserved

R20-4-614. Reserved

R20-4-615. Reserved

R20-4-616. Reserved

R20-4-617. Reserved

R20-4-618. Reserved

R20-4-619. Reserved

R20-4-620. Repealed

Historical Note
Adopted effective October 26, 1978 (Supp. 78-5). R20-4-620 recodified from R4-4-620 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

ARTICLE 7. ESCROW AGENTS

R20-4-701. Change in Location of Business

An escrow agent shall mail the Superintendent written notice of any change in the location of the escrow agent's business. The escrow agent shall ensure that the Superintendent receives the notice at least five days before the escrow agent conducts business at the new location. The escrow agent shall mail the fee required by A.R.S. § 6-126(A), together with the current escrow license, to the Superintendent with the notice of the location change. The Superintendent shall change the submitted license to reflect the new business location and return it to the escrow agent.

Historical Note
Former Rule 1. R20-4-701 recodified from R4-4-701 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-702. Account Practices and Records

An escrow agent shall maintain records to enable the Superintendent to reconstruct the details of each escrow transaction. The records shall include the following:
1. The seller's name and address;
2. The buyer's name and address;
3. The lender's name and address, if any;
4. The borrower's name and address, if any;
5. The real estate agent's name and address, if any;
6. Complete escrow instructions;
7. Records and supporting documentation for each receipt and disbursement made through the escrow; and
8. A copy of the escrow settlement.

Historical Note

Former Rule 2. R20-4-702 recodified from R4-4-702 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-703. Preservation of Records

An escrow agent shall preserve the records, books, and accounts pertaining to each escrow transaction for at least three years following the final settlement date of the transaction. An escrow agent may use an electronic recordkeeping system. The Department shall not require an escrow agent to keep a written copy of the records, books, and accounts if the escrow agent can generate all information and copies of documents required by A.R.S. § 6-831 in a timely manner for examination or other purposes.

Historical Note

Former Rule 3. R20-4-703 recodified from R4-4-703 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-704. Subsidiary Account Records

An escrow agent shall maintain subsidiary account records that identify the funds deposited in each escrow. The total of all credit balances in the subsidiary accounts shall always equal the balance of the general ledger control account.

Historical Note

Former Rule 4. R20-4-704 recodified from R4-4-704 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-705. Reserved

R20-4-706. Repealed

Historical Note

Former Rule 6. R20-4-706 recodified from R4-4-706 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-707. Expired

Historical Note

Adopted effective June 25, 1993 (Supp. 93-2). R20-4-707 recodified from R4-4-707 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 21 A.A.R. 411, effective September 30, 2014 (Supp. 15-1).

R20-4-708. Financial Condition and Resources

The Superintendent shall consider the following criteria in evaluating an escrow agent's, other escrow agent's, or applicant's financial condition and resources under A.R.S. § 6-817:

1. Amount of positive net worth,
2. Amount of tangible net worth,
3. Amount of liquid assets,
4. Amount of cash provided by operations,
5. Ratio of debt to net worth,
6. Owner's personal financial resources,
7. Outside resources available,
8. Profitability,
9. Projected operating results,
10. Status as agent for a title insurance company, and
11. Sources of new business.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

ARTICLE 8. TRUST COMPANIES

R20-4-801. Definitions

In this Article, unless the context otherwise requires:

"Account" means the trust, estate, or other fiduciary relationship established with a trust department or trust company.

"Affiliate" has the meaning stated at A.R.S. § 6-801.

"Certificate" has the meaning stated at A.R.S. § 6-851.

"Fiduciary" has the meaning stated at A.R.S. § 6-851.

"Governing instrument" means a document, and all its operative amendments, that:

Creates a trust and regulates the trustee's conduct,

Creates an agency relationship between a trust department or trust company and a client, or

Otherwise evidences a fiduciary relationship between a trust department or trust company and a client.

"Investment responsibility" means full and unrestricted discretion to invest trust funds without direction from anyone as to any matter, including the terms of the trade or the identity of the broker.

"Person" has the meaning stated at A.R.S. § 1-215.

"Superintendent" has the meaning stated at A.R.S. § 6-851.

"Trust asset" means any property or property right held by a trust department or trust company for the benefit of another.

"Trust business" has the meaning stated at A.R.S. § 6-851.

"Trust company" has the meaning stated at A.R.S. § 6-851.

"Trust department" means a permittee under both A.R.S. § 6-201 et seq. and Article 2 of this Chapter that possesses a banking permit authorizing it to engage in trust business.

"Trust funds" means any money held by a trust department or trust company for the benefit of another.

"Trustor" means a person who creates or funds a trust, or both.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-801 recodified from R4-4-801 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-802. Reserved

R20-4-803. Reserved

R20-4-804. Repealed

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-804 recodified from R4-4-804 (Supp. 95-1). Repealed by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2).

R20-4-805. Reports

A. Within 90 days following each December 31, each trust department and trust company shall file an annual report of trust assets with the Superintendent on the form prescribed by the Superintendent. The annual report shall include the current market value of all trust assets held by the trust department or trust company as of December 31. The report shall also identify and briefly describe all transactions conducted in the

report period that are regulated by R20-4-812(E) through R20-4-812(G).

B. Each trust company shall deliver a copy of its annual report and certificate of disclosure to the Superintendent within 10 days of filing the report and certificate at the Arizona Corporation Commission. A report or certificate covered by this subsection is one filed under the authority of A.R.S. §§ 10-202 or 10-1622. A copy delivered to the Superintendent, as required in this subsection, shall be date-stamped by the Arizona Corporation Commission to confirm the actual filing date.

C. Each trust company shall notify the Superintendent of any change in the directors or officers of the company within 10 days of the change. Any trust company with more than 25 officers may, after obtaining the Superintendent's written approval, limit the officers covered by this subsection to those with substantial involvement in the trust company's corporate operations or in the trust company's trust business in this state.

Historical Note

Adopted effective September 1, 1977 (Supp. 77-3). R20-4-805 recodified from R4-4-805 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-806. Records

A. A trust company may use a computer recordkeeping system if the trust company gives the Superintendent advanced written notice that it intends to do so. Except for records required by subsections (B)(1)(a) and (B)(1)(b), the Department shall not require a trust company to keep a written copy of its records if the trust company can generate all information required by this Section in a timely manner for examination or other purposes. A trust company may add, delete, modify, or customize a computer recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a trust company shall report to the Superintendent any alteration in the computer recordkeeping system's fundamental character, medium, or function if the alteration changes the computer system to a paper-based system.

B. A trust department or trust company shall keep books, accounts, and records adequate to provide clear and readily understandable evidence of all business conducted by the trust department or trust company, including the following:

1. A file for each account that includes:
   a. The original of the governing instrument,
   b. The originals of all contracts and other legal documents,
   c. Copies of all correspondence,
   d. Accounting records disclosing all the financial transactions, and
   e. A listing of all the account's assets and liabilities.
2. An investment file for each account that includes:
   a. All original documentary evidence of the account's assets; or
   b. Copies of the original documentary evidence of the account's assets, together with written evidence of custody or receipt of the originals by an authorized holder; and
   c. A record of the initial and annual investment reviews for the account.
3. The corporate general ledger kept current on a daily basis. This record shall identify and segregate all financial transactions conducted by the trust department or trust company for itself, distinguishing them from those relating to the trust department's or trust company's trust business;
4. Unaudited financial statements. A trust department or trust company shall produce these statements quarterly or more frequently when directed by the Superintendent. The financial statements shall include at least:
   a. A balance sheet; and
   b. A statement of income, expenses, and retained earnings.
5. Adequate records of all pending litigation that names the trust department or trust company as a party.

C. A trust department shall keep its fiduciary records separate and distinct from the trust department's corporate records.

D. A trust department or trust company shall keep records described in subsections (B)(1) and (B)(2) for at least three years after closing an account. If litigation occurs concerning a particular account, the trust department or trust company shall keep that account's records, described in subsections (B)(1) and (B)(2), for three years after the litigation is resolved.

Historical Note

Adopted effective September 1, 1977 (Supp. 77-3). R20-4-806 recodified from R4-4-806 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-807. Unsafe or Unsound Condition

For purposes of A.R.S. §§ 6-863 and 6-865, a trust company conducts business in an unsafe manner or its affairs are in an unsound condition if it:

1. Violates any fiduciary duty or obligation, including those listed in R20-4-809 through R20-4-815;
2. Violates any state or federal requirement for operating or maintaining trusts, common trust funds, or other accounts;
3. Violates any applicable federal or state law or regulation regarding corporations or securities;
4. Employs an officer or director who violates a corporate fiduciary duty;
5. Is insolvent; or
6. Engages in any conduct that the Superintendent determines constitutes an unsafe or unsound business practice jeopardizing the trust company's financial condition or the interests of a stockholder, creditor, trustor, beneficiary, or trust company's principal.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-807 recodified from R4-4-807 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-808. Administration of Fiduciary Powers

A. The board of directors and the officers share responsibility for the exercise of fiduciary powers by a trust department or trust company. The board of directors is responsible for determining policy; investing and disposing of trust assets; and directing and reviewing the actions of all directors, officers, and committees of the board that exercise fiduciary powers. The board of directors may delegate the necessary power and authority to perform the trust department's or trust company's duties as a fiduciary to selected directors, officers, employees, or committees of the board if the delegation is consistent with

the corporate charter. The minutes of the board's meetings shall duly reflect all those delegations.

B. A trust department or trust company shall not accept a new account without first obtaining the board's approval, or that of the directors, officers, or committees that the board may have authorized to approve new accounts. The trust department or trust company shall keep a written record of each new account approval and of the closing of each account. The trust department or trust company shall conduct an asset review within 60 days after it accepts each new account if it has investment responsibility for that account. The trust department's or trust company's board shall ensure that an annual review of account assets is conducted for any account in which the trust department or trust company has investment responsibility, to determine whether to retain or dispose of the assets.

C. A trust department or trust company exercising fiduciary powers shall use independent legal counsel admitted to practice in Arizona to advise and inform the trust department or trust company on fiduciary matters and all other legal issues presented to the trust department or trust company by the conduct of its trust business.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-808 recodified from R4-4-808 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-809. Fiduciary Duties

A trust department or trust company shall perform all fiduciary duties imposed upon it by law, including the following:

1. Administer accounts strictly according to the governing instrument and solely in the account beneficiary's interests;
2. Use reasonable care and skill to make the account productive;
3. Provide complete and accurate information of the nature and amount of assets held to each account's beneficiary or principal and permit the beneficiary, principal, or any person duly authorized by the beneficiary or principal to inspect the account's records at any time during normal business hours. The information provided in compliance with this subsection shall be delivered at least quarterly, unless:
   a. The trust department or trust company and its account's beneficiary, principal, or authorized person agree otherwise in writing;
   b. The governing instrument provides otherwise; or
   c. A different frequency is established by a lawful course of dealing before the effective date of this rule; and
4. Comply with all lawful provisions of the governing instrument.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-809 recodified from R4-4-809 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-810. Funds Awaiting Investment or Distribution

A. Trust funds held by a trust department or trust company awaiting investment or distribution shall not remain uninvested or undistributed any longer than is reasonable for the account's proper management.

B. A trust department or trust company may keep trust funds in deposit accounts maintained by the trust department or trust company, unless prohibited by law or by the governing instrument. The trust department or trust company shall set aside collateral security for all deposited trust funds under a third party's control. The collateral shall be the following types of securities, in any combination:

1. Direct obligations of the United States or any agency, department, division, or administration of the federal government;
2. Any other obligations fully guaranteed by the United States government as to principal and interest;
3. Obligations of a Federal Reserve Bank;
4. Obligations of any state, political subdivision of a state, or public authority organized under the laws of a state; or
5. Readily marketable securities that either:
   a. Qualify as investment securities under the Investment Securities regulations of the Comptroller of the Currency, 12 CFR, Chapter 1, Part 1; or
   b. Satisfy state pledging requirements under A.R.S. § 6-245(C).

C. The securities set aside under subsection (B) shall, at all times, have a market value no less than the amount of trust funds deposited. No collateral security is required to the extent the Federal Deposit Insurance Corporation, or its successor, insures the deposited trust funds.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-810 recodified from R4-4-810 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-811. Investment of Trust Funds

A. A trust department or trust company shall invest trust funds according to:

1. The governing instrument; and
2. All applicable laws, including A.R.S. §§ 6-862, 14-7402, and 14-7601 through 14-7611.

B. A trust department or trust company shall make any collective investment of trust funds exclusively under the terms of R20-4-815.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-811 recodified from R4-4-811 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-812. Self-dealing

A. A trust department or trust company shall not invest trust funds in the following types of property unless expressly authorized by the governing instrument, applicable state or federal law, or court order:

1. Its own securities;
2. Other types of property acquired from the trust department or trust company;
3. Property acquired from the trust department's or trust company's directors, officers, or employees;
4. Property acquired from the trust department's or trust company's affiliates;

5. Property acquired from its affiliates' directors, officers, or employees; or
6. Property acquired from other individuals or organizations with an interest in the trust department or trust company if that interest might affect the trust department's or trust company's exercise of discretion to the detriment of its trust clients.

B. A trust department or trust company may use trust funds to purchase its own securities, or its affiliates' securities:
1. If the trust department or trust company has authority under subsection (A), and
2. If those securities are offered pro rata to all stockholders of the trust department or trust company.

C. A trust department or trust company shall not sell or loan trust property to itself, or to the following types of persons, unless expressly authorized by the governing instrument, applicable state or federal law, or court order:
1. Its directors, officers, or employees;
2. Its affiliates;
3. Its affiliates' directors, officers, or employees; or
4. Other individuals or organizations with an interest in the trust department or trust company if that interest might affect the trust department's or trust company's exercise of discretion to the detriment of its trust clients.

D. However, a trust department or trust company may sell or loan trust property to persons prohibited by subsection (C) if either:
1. Its counsel has advised in writing that, by holding certain property, the trust department or trust company has incurred a contingent or potential liability for breach of fiduciary duty; and
   a. The proposed sale or loan avoids the contingent or potential liability;
   b. Its board of directors authorizes the sale or loan by an action duly noted in the trust department's or trust company's minutes;
   c. Its board of directors' action expressly authorizes reimbursement to the affected account; and
   d. The affected account is reimbursed, in cash, at no loss to that account; or
2. The Superintendent requires or approves, in writing, the sale or loan to otherwise prohibited parties.

E. A trust department or trust company may sell trust property held in one account to another of its accounts if:
1. The transaction is fair to both accounts; and
2. The transaction is not prohibited by the governing instruments, applicable state or federal law, or court order.

F. A trust department or trust company may loan trust property held in one account to another of its accounts if:
1. The transaction is fair to both accounts; and
2. The transaction is not prohibited by the governing instruments, applicable state or federal law, or court order.

G. A trust department or trust company may make a loan to a trust account, taking trust assets of the borrowing account as security for repayment, if:
1. The transaction is fair to the borrowing account; and
2. The transaction is not prohibited by the governing instrument, applicable state or federal law, or court order.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-812 recodified from R4-4-812 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-813. Custody of Investments

A. A trust department or trust company shall keep each account's investments separate from its own assets. It shall place each account's assets in the joint control of at least two officers or employees of the trust department or trust company designated in writing for that purpose by:
1. The trust department's or trust company's board of directors, or
2. One or more officers authorized by the trust department's or trust company's board of directors to make the designation.

B. A trust department or trust company shall either:
1. Keep each account's investments separate from all other accounts' investments, except as provided in R20-4-815; or
2. Adequately identify each account's property in the trust department's or trust company's records.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-813 recodified from R4-4-813 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-814. Compensation

A. A trust department or trust company acting as a fiduciary may charge a reasonable fee for its services. It shall receive the fee allowed by the court when it is acting under a court appointment. Any agreement as to fees in the governing instrument shall control the fee unless contrary to law, regulation, or court order.

B. A trust department or trust company shall not permit any of its officers or employees to take any compensation for acting as a co-fiduciary with the trust department or trust company in the administration of an account.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-814 recodified from R4-4-814 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-815. Collective Investments

A. All collective investments made by a trust department or trust company shall be in a common trust fund established under A.R.S. § 6-871, and maintained by the trust department or trust company exclusively for the collective investment and reinvestment of funds contributed by the trust department or trust company acting as a fiduciary. A trust department or trust company shall not establish a common trust fund unless it first:
1. Prepares a written plan regarding the common trust fund; and
2. Obtains its board of directors' approval of the plan, evidenced by a duly adopted resolution or the board's unanimous written consent.

B. The plan shall describe the common trust fund's operational details, including a description of:
1. The trust department's or trust company's investment powers and investment policy over all funds deposited in the common trust fund,

2. The manner for allocating the common trust fund's income and losses,
3. The criteria for admission to or withdrawal from participating in the common trust fund, and
4. The method for valuing assets in the common trust fund and the frequency of valuation.

C. A trust department or trust company shall advise all persons having an interest in its common trust fund of the existence of the plan described in subsection (B), and shall provide a copy of the plan upon request.

D. The annual report required under R20-4-805(A) shall include all common trust funds operated by the trust department or trust company.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-815 recodified from R4-4-815 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-816. Termination of Trust or Fiduciary Powers and Duties

A. Any trust department that wants to surrender its trust powers shall file with the Superintendent a certified copy of the appropriate resolution of its board of directors or of the board's unanimous written consent. If, after investigation, the Superintendent concludes that the trust department has no remaining fiduciary duties, the Superintendent shall notify the trust department that it no longer has authority to exercise trust powers.

B. Any trust company that wants to surrender its certificate of authority to conduct trust business and wind up its affairs shall file with the Superintendent a certified copy of the appropriate resolution of its board of directors or of the board's unanimous written consent. Upon receipt of the resolution or consent, the Superintendent shall cancel the trust company's certificate of authority, and the trust company shall not accept new trust accounts.

C. After winding up its affairs, any trust company that wants to surrender its rights and obligations as a fiduciary and remove itself from the Superintendent's supervision shall file with the Superintendent a certified copy of the appropriate resolution of its board of directors or of the board's unanimous written consent. If, after investigation, the Superintendent concludes that the trust company has no further fiduciary duties, the Superintendent shall notify the trust company that it no longer has authority to exercise fiduciary powers.

D. Any trust department or trust company that surrenders its powers, rights, obligations, or certificate under this Section or that has them cancelled, suspended, or revoked shall continue to be regulated under A.R.S. § 6-864 and this Article until it winds up its affairs. No action under this Section impairs any liability or cause of action, existing or incurred, against any trust department or trust company or its stockholders, directors, or officers.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-816 recodified from R4-4-816 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

Appendix A. Repealed

Historical Note

Appendix A repealed by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2).

Appendix B. Repealed

Historical Note

Appendix B repealed by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2).

ARTICLE 9. MORTGAGE BROKERS

R20-4-901. Reserved

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-901 recodified from R4-4-901 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-902. Reserved

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-902 recodified from R4-4-902 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-903. Exemption for an Entity Regulated by an Agency of this State, Other States, or by the United States

A. The exemption under A.R.S. § 6-902 (A)(1) only applies to a person whose offers to make or negotiate a mortgage loan, as defined in A.R.S. § 6-901, and all mortgage loans made or negotiated by the person are regulated directly by an agency of this state, any other state, or the United States.

B. The required regulation of the transactions listed in subsection (A) includes:
1. Rules governing a claimant's accounting and recordkeeping practices;
2. The authority to examine a claimant's books and records relating to its mortgage lending activities; and
3. The ability to place a claimant in a receivership or conservatorship with regard to the claimant's mortgage lending activities.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-903 recodified from R4-4-903 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-904. Reserved

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-904 recodified from R4-4-904 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-905. Repealed

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-905 recodified from R4-4-905 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-906. Equivalent and Related Experience

A. An applicant may satisfy the three years' experience requirement of A.R.S. § 6-903 by the types of lending-related experience listed in this subsection. The Department counts each

month in the following types of work experience toward the three years required for a mortgage broker license, under A.R.S. § 6-903(B), or as a responsible individual, under A.R.S. § 6-903(E). The Department counts a fractional month of experience, at least 15 days long, as a full month.

1. Mortgage broker with an Arizona license, responsible individual, or branch manager for a licensee;
2. Mortgage banker with an Arizona license, responsible individual, or branch manager for a licensee;
3. Loan officer with responsibility primarily for loans secured by lien interests on real property;
4. Lender's branch manager with responsibility primarily for loans secured by lien interests on real property;
5. Mortgage broker with license from another state, or responsible individual for a mortgage broker licensed in another state;
6. Mortgage banker with license from another state, or responsible individual for a mortgage banker licensed in another state;
7. Attorney certified by any state as a real estate specialist.

B. An applicant with insufficient actual experience of the types listed in subsection (A) may satisfy the remainder of the three years' experience requirement of A.R.S. § 6-903 by the types of related experience listed in this subsection. The Department counts each month in the following types of work experience according to the ratio listed below, of actual experience to equivalent experience, credited towards qualifying for a license, under A.R.S. § 6-903(B), or as a responsible individual, under A.R.S. § 6-903(E). The Department counts a fractional month of experience, at least 15 days long, as a full month. An applicant receives credit in only one area listed and for not more than three years' actual experience. The remaining years of experience required to qualify for a license shall be obtained from types of work experiences listed in subsection (A).

1. Attorney without state bar certified real estate specialty...3:2
2. Paralegal with experience in real estate matters...3:2
3. Loan underwriter...3:2
4. Mortgage broker or mortgage banker from another state without license...3:2
5. Real estate broker with an Arizona license or license from a state with substantially equivalent licensing requirements...3:2
6 Escrow officer...3:2
7. Trust officer with a title company...3:2
8. Executive, supervisor, or policy maker involved in administering or operating a mortgage-related business...3:1.5
9. Title officer with a title company...3:1.5
10. Real estate broker, not qualified under subsection (B)(5)...3:1.5
11. Loan processor with responsibility primarily for loans secured by lien interests on real property...3:1.5
12. Lender's branch manager with responsibility primarily for loans not secured by lien interests on real property...3:1.5
13. Real property salesperson with an Arizona license or a license from a state with substantially equivalent licensing requirements...3:1
14. Loan officer, with responsibility primarily for loans not secured by lien interests on real property...3:1

Historical Note
Adopted effective August 14, 1991 (Supp. 91-3). R20-4-906 recodified from R4-4-906 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-907. Course of Study

A. A course of study shall be satisfactorily completed if the applicant has:
1. Attended at least 24 hours of class, and
2. Received a passing grade on the final exam.

B. A course of study shall meet all the following requirements:
1. The following items shall be submitted by the school to the Superintendent on an annual basis:
   a. Course materials;
   b. Class content outlines on a session-by-session basis; and
   c. Sample final exam.
2. The following subjects shall be taught:
   a. Mortgage, deed of trust, and security agreement law;
   b. Negotiable instrument law;
   c. Mortgage broker law;
   d. Escrow agent law;
   e. Recordkeeping requirements of R20-4-917;
   f. Federal Housing Administration, Veterans Administration, Federal National Mortgage Association, Federal Home Loan Mortgage Corporation requirements;
   g. Ethics;
   h. Principal and agent law;
   i. Arithmetical computations common to mortgage brokerage;
   j. Real estate lending principles;
   k. Real estate law;
   l. Real Estate Settlement Procedures Act, 12 U.S.C. 2601 through 2617, and Consumer Credit Protection Act, 15 U.S.C. 1601 through 1666j; and
   m. Securities law.
3. A final exam shall be given that substantially tests the student's knowledge of the subjects described above.

C. The Superintendent shall review the items submitted to the Department and determine within 60 days of submission whether the proposed course of study is satisfactory. The Superintendent may audit a course of study at any time. If the Superintendent finds that a course of study is unsatisfactory, or if the Superintendent has not received the course materials, course content outlines, and sample final exam within the prior 13 months, the Superintendent may withhold or suspend approval.

Historical Note
Adopted effective August 14, 1991 (Supp. 91-3). R20-4-907 recodified from R4-4-907 (Supp. 95-1).

R20-4-908. Reserved

Historical Note
Adopted effective August 14, 1991 (Supp. 91-3). R20-4-908 recodified from R4-4-908 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-909. Reserved

Historical Note
Adopted effective August 14, 1991 (Supp. 91-3). R20-4-909 recodified from R4-4-909 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-910. Reserved

Historical Note
Adopted effective August 14, 1991 (Supp. 91-3). R20-4-910 recodified from R4-4-910 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-911. Qualified Replacement Responsible Individual
If a licensee chooses an individual to serve as a replacement responsible individual and that individual has not satisfactorily completed the course of study required by A.R.S. § 6-903(B)(2) or passed the mortgage broker examination required by A.R.S. § 6-903(B)(3), and is not given the opportunity to do so prior to the expiration of the 90-day time period provided in A.R.S. § 6-903(F), but otherwise meets the requirements of A.R.S. § 6-903(B), the individual shall be qualified as a replacement responsible individual until the next course of study has been held and, if the person successfully completes the course of study, until the mortgage broker examination next following the completion of the course of study has been held and the results of the examination are available. If the individual fails to satisfactorily complete the course of study or fails the mortgage broker examination, the licensee shall then have a new 90-day time period within which to place itself under the active management of a qualified responsible individual. Notwithstanding the foregoing, a licensee shall have no longer than 180 days within which to place the license under the active management of a qualified responsible individual unless the Superintendent grants additional time to the licensee for good cause shown.

Historical Note
Adopted effective August 14, 1991 (Supp. 91-3). R20-4-911 recodified from R4-4-911 (Supp. 95-1).

R20-4-912. Restrictions on the Term of a Cash Alternative
If an applicant or a licensee elects to place with the Superintendent a deposit in the form of a certificate of deposit or investment certificate, in addition to the requirements of A.R.S. § 6-903(J), the certificate of deposit or investment certificate shall not be renewable, nor expire, earlier than 12 months from the date of issuance.

Historical Note
Adopted effective August 14, 1991 (Supp. 91-3). R20-4-912 recodified from R4-4-912 (Supp. 95-1).

R20-4-913. Reserved

Historical Note
Adopted effective August 14, 1991 (Supp. 91-3). R20-4-913 recodified from R4-4-913 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-914. Reserved

Historical Note
Adopted effective August 14, 1991 (Supp. 91-3). R20-4-914 recodified from R4-4-914 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-915. Requirements for a Person Intended to Oversee a Branch Office
A person designated to oversee the operations of a branch office shall be knowledgeable about the branch activities of the licensee, shall supervise compliance by the branch with applicable law and rules, and shall have sufficient authority to ensure such compliance. One person may oversee more than one branch.

Historical Note
Adopted effective August 14, 1991 (Supp. 91-3). R20-4-915 recodified from R4-4-915 (Supp. 95-1).

R20-4-916. Notification of Change of Address
If the address of the principal place of business or of any branch office is changed, the licensee shall notify the Superintendent of the change within five business days after the occurrence of the change of location. Together with such notice, the licensee shall provide to the Department the license for the office changing addresses together with the fee required by A.R.S. § 6-126 for changing the address of an office. A copy of such license shall continue to be displayed at the place of business until a new license is issued.

Historical Note
Adopted effective August 14, 1991 (Supp. 91-3). R20-4-916 recodified from R4-4-916 (Supp. 95-1).

R20-4-917. Recordkeeping Requirements

A. The Superintendent shall approve a licensee's use of a computer or mechanical recordkeeping system if the licensee gives the Superintendent advanced written notice that it intends to do so. The Department shall not require a licensee to keep a written copy of the records if the licensee can generate all information required by this Section in a timely manner for examination or other purposes. A licensee may add, delete, modify, or customize an approved computer or mechanical recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a licensee shall report to the Superintendent any alteration in the approved system's fundamental character, medium, or function if the alteration changes:
1. Any approved computer or mechanical system back to a paper-based system;
2. An approved mechanical system to a computer system; or
3. An approved computer system to a mechanical system.

B. In addition to any statutory requirement regarding records, a record maintained by a mortgage broker shall include the following:
1. A list of all executed loan applications or executed fee agreements that includes the following information:
   a. Applicant's name;
   b. Application date;
   c. Amount of initial loan request;
   d. Final disposition date;
   e. Disposition (funded, denied, etc.); and
   f. Name of loan officer;
2. A record, such as a cash receipts journal, of all money received in connection with a mortgage loan including:
   a. Payor's name;
   b. Date received;
   c. Amount; and
   d. Receipt's purpose, including identification of a related loan, if any;
3. A sequential listing of checks written for each bank account relating to the mortgage broker business, such as a cash disbursement journal, including:
   a. Payee's name;
   b. Amount;
   c. Date; and

d. Payment's purpose, including identification of a related loan, if any;

4. Bank account activity source documents for the mortgage broker business including receipted deposit tickets, numbered receipts for cash, bank account statements, paid checks, and bank advices.
5. A trust subsidiary ledger for each borrower that deposits trust funds showing:
   a. Borrower's name or co-borrowers' names;
   b. Loan number, if any;
   c. Amount received;
   d. Purpose for the amount received;
   e. Date received;
   f. Date deposited into trust account;
   g. Amount disbursed;
   h. Date disbursed;
   i. Disbursement's payee and purpose; and
   j. Balance;
6. A file for each application for a mortgage loan containing:
   a. The agreement with the customer concerning the broker's services, whether as a loan application, fee agreement, or both;
   b. Document showing the application's final disposition, such as a settlement statement, or a denial or withdrawal letter;
   c. Correspondence sent, received, or both by the licensee;
   d. Contract, agreement, and escrow instructions to or with any depository;
   e. Documents showing compliance with the Consumer Credit Protection Act's (15 U.S.C. §§ 1601 through 1666j) and the Real Estate Settlement Procedures Act's (12 U.S.C. §§ 2601 through 2617) disclosure requirements, to the extent applicable;
   f. If the loan is funded by an investor that is not a financial institution, an enterprise, a licensed real estate broker or salesman, a profit sharing or pension trust or, an insurance company, the documents provided to the investor under A.R.S. § 6-907, a copy of the executed note and executed deed of trust or mortgage, and any assignment by the broker to the investor;
   g. If the loan is closed in the mortgage broker's name, a copy of all closing documents including: closing instructions, any applicable rescission notice, HUD-1 settlement statement, final truth-in-lending disclosure, executed note, executed deed of trust or mortgage, and each assignment of beneficial interest by the licensee; and
   h. Itemized list of all fees taken in advance including appraisal fee, credit report fee, and application fee;
7. Samples of every piece of advertising relating to the mortgage broker's business in Arizona;
8. Copies of governmental or regulatory compliance reviews;
9. If the licensee is not a natural person, a file containing:
   a. Organizational documents for the entity;
   b. Minutes;
   c. A record, such as a stock or ownership transfer ledger, showing ownership of all proportional equity interests in the licensee, ascertainable as of any given record date; and
   d. Annual report, if required by law;
10. If the licensee or anyone directly or indirectly owning more than 20% of the licensee has a felony conviction, a copy of the judgment or other record of conviction;
11. If the licensee or anyone directly or indirectly owning more than 20% of the licensee has, in the previous seven years, been named a defendant in any civil suit, a copy of the complaint, any answer filed by the licensee, and any judgment, dismissal, or other final order disposing of the action; and
12. If the Superintendent has granted approval to maintain records outside this state, the specific address where the records are kept, and a person's name to contact for them.

C. If 10 or fewer transactions have occurred during the prior calendar quarter, a licensee shall reconcile and update all records specified in subsection (B) at least once each calendar quarter. A licensee shall reconcile and update all records specified in subsection (B) monthly if more than 10 transactions occurred during the prior calendar quarter. In addition to reconciling each trust bank account, a licensee shall verify each trust balance to each trust subsidiary ledger at each reconciliation.

D. A licensee shall retain the documents described in subsections (B)(1) and (B)(6) for the length of time provided in A.R.S. § 6-906. For the purposes of A.R.S. § 6-906, a mortgage loan's closing date, on a loan application that did not result in the making of a loan, is either:
1. The date a licensee receives a written cancellation notice from an applicant; or
2. The date a licensee mails written notice to an applicant that the application has been denied, as required by federal law.

E. A licensee shall maintain all records described in this Section, and not included in subsection (D), for at least two years.

Historical Note
Adopted effective August 14, 1991 (Supp. 91-3). R20-4-917 recodified from R4-4-917 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-918. Repealed

Historical Note
Adopted effective August 14, 1991 (Supp. 91-3). R20-4-918 recodified from R4-4-918 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-919. Deposit of Monies Received by a Mortgage Broker
All monies received by a mortgage broker which are required to be deposited into an escrow account with an escrow agent licensed pursuant to A.R.S. § 6-801 et seq. shall be so deposited by 5:00 p.m. on the next business day after receipt of the funds.

Historical Note
Adopted effective August 14, 1991 (Supp. 91-3). R20-4-919 recodified from R4-4-919 (Supp. 95-1).

R20-4-920. Requirements for the Testing Committee

A. No licensee shall submit more than five names as nominees to serve on the testing committee. The resumes of the nominees shall be included. The names and resumes shall be submitted to the Superintendent no later than August 1 of each even-numbered year. On or before September 30 of each even-numbered year, the Superintendent shall appoint four persons from the nominees submitted and one employee of the Department as members of the testing committee. A person may

serve more than one two-year term. If the Superintendent does not find at least four persons from the list to be acceptable, the Superintendent shall solicit additional nominees from licensees.

B. In the event of a vacancy on the testing committee, the remaining members of the committee shall submit a list of nominees within 45 days of the vacancy to the Superintendent containing not less than two nominees for each vacancy. The Superintendent shall then appoint a nominee from the list to fill each vacancy for the remainder of the term. If the Superintendent does not find at least one person from the list to be acceptable to fill each vacancy, the remaining members of the committee shall, upon request, submit an additional list of nominees to the Superintendent.

C. The Superintendent may remove any member of the committee at any time without cause.

D. The committee shall review and revise questions on the test not less than once every two years. All questions used on the test shall first be submitted to and approved by the Superintendent.

E. The committee shall inform the applicant of the applicant's score on the test in writing within 30 days of administration of the test.

F. The handbook for mortgage brokers shall be updated by the committee as necessary to reflect changes in the law.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-920 recodified from R4-4-920 (Supp. 95-1).

R20-4-921. Authorizations to Complete Blank Spaces

An authorization, under A.R.S. § 6-909, allowing a licensee or escrow agent to complete certain blank spaces in a document after it is signed by a party to the transaction shall:

1. Specifically identify the document and the blank spaces to be completed;
2. Be in writing, dated, and signed by the authorizing parties; and
3. Contain the following notice, conspicuously printed on its face: YOUR SIGNATURE BELOW AUTHORIZES YOUR MORTGAGE BROKER OR ESCROW AGENT TO FILL IN SPACES YOU LEFT BLANK IN SPECIFIED LOAN DOCUMENTS YOU ARE ABOUT TO SIGN OR MAY HAVE ALREADY SIGNED. UNDER STATE LAW YOU CAN GIVE THIS AUTHORITY, BUT YOU ARE NOT REQUIRED TO DO SO. YOU CAN REFUSE TO SIGN ANY DOCUMENTS UNTIL ALL BLANKS ARE COMPLETELY FILLED IN.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-921 recodified from R4-4-921 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-922. Determining Loan Amounts

In determining the amount of a mortgage loan pursuant to A.R.S. § 6-909(D) or (G), only the principal amount of the loan shall be considered and not any points, interest, finance charges, insurance premiums of any kind, compensation paid to third parties or compensation retained by the mortgage broker or its agents.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-922 recodified from R4-4-922 (Supp. 95-1).

R20-4-923. Delay or Cause Delay

A mortgage broker shall not be deemed to have delayed or caused delay if such delay occurs due to events outside the control of the mortgage broker.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-923 recodified from R4-4-923 (Supp. 95-1).

R20-4-924. Receipt and Disbursement of Monies

A licensee is not receiving or disbursing monies in servicing or arranging a mortgage loan if the licensee, at the request of the lender or servicing agent, on an infrequent basis, assists in the collection or servicing of a mortgage loan by receiving from the borrower a check or draft payable to the lender or servicing agent and forwarding such instrument to the lender or servicing agent not later than 5:00 p.m. on the next business day after receipt by the licensee. For the purposes of this rule, an infrequent basis means, with regard to a particular loan, for not more than 25% of the regularly scheduled payments of the mortgage loan during any calendar year.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-924 recodified from R4-4-924 (Supp. 95-1).

R20-4-925. Waiver of Examination and Course of Study

The Superintendent's waiver of the examination and course of study requirement under A.R.S. § 6-903 extends to a person designated as a responsible individual by either an applicant or a licensee under A.R.S. § 6-903.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-926. Acquisition of Additional Interest in Licensee by Majority Owner

A person that owns 51% or more of a licensee's outstanding voting equity interests, and that acquires the power to vote additional fractional equity interests, shall deliver written notice of the acquisition to the Superintendent. The person shall deliver the notice before completing the acquisition. Within 10 days after completing the acquisition, the person shall deliver documentation evidencing the acquisition to the Superintendent.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-927. Conversion to Commercial Mortgage Broker License

A. Under A.R.S. § 6-913, a mortgage broker licensee shall only be permitted to convert his or her license to a commercial mortgage broker license during the renewal period established by A.R.S. § 6-904.

B. The licensee seeking conversion shall not be subject to the 12 continuing education units as prescribed by A.R.S. § 6-903(V).

C. The licensee seeking conversion shall submit:

1. The renewal fees required by A.R.S. § 6-126 for commercial mortgage brokers, and
2. The information and documents required by A.R.S. § 6-903.

Historical Note

New Section adopted by final rulemaking at 18 A.A.R. 2622, effective December 2, 2012 (Supp. 12-4).

R20-4-928. Certificate of Exemption Application and Renewal

A. Under A.R.S. § 6-912(C), upon application for a certificate of exemption, an applicant shall pay a nonrefundable fee of $300.

B. A person holding a certificate of exemption shall pay a renewal fee of $150.00 on or before December 31 of each year. Certificates of exemption not renewed by December 31 are automatically suspended, and the certificate holder shall not act as a registered exempt person until the certificate is renewed or a new certificate is issued pursuant to A.R.S. § 6-912. While the certificate is suspended, the licensed loan originators sponsored by the registered exempt person may not transact business as a loan originator. A registered exempt person may renew an automatically suspended certificate by paying the renewal fee plus $25.00 for each day after December 31 that a renewal fee is not received by the Superintendent and applying for renewal as prescribed by the Superintendent. A certificate of exemption that is not renewed by January 31 expires. A certificate of exemption shall not be granted to the holder of an expired certificate of exemption except as provided in A.R.S. § 6-912 for the issuance of an original certificate of exemption. Each licensed loan originator that is sponsored by a registered exempt person whose certificate has expired shall have his or her license placed on inactive status and shall not transact business in Arizona as a loan originator pursuant to A.R.S. § 6-991.02(M).

C. In addition to the application fee, on issuance of the certificate of exemption, the Superintendent shall collect the first year's renewal fee prorated according to the number of quarters remaining until the date of the next annual renewal, as required by A.R.S. § 6-126(B).

D. The following fees are payable to the Department:

1. To change the name of the federally chartered savings bank on a certificate of exemption: $250.00.
2. To change the responsible individual for the exempt entity: $250.00.
3. To issue a duplicate or replace a lost certificate of exemption: $100.00.
4. To change the address of the federally chartered savings bank on a certificate of exemption: $50.00.

Historical Note

New Section adopted by final rulemaking at 18 A.A.R. 2622, effective December 2, 2012 (Supp. 12-4).

ARTICLE 10. SAFE DEPOSIT AND SAFEKEEPING CODE

R20-4-1001. Notice of Change of Location of Safe Deposit Repository

A. A corporation or association that moves a repository shall give written notice of the location change to the Superintendent and to its customers.

1. A corporation or association shall provide notice of the location change to the Superintendent by mailing the notice required under this subsection by first class mail no less than 30 days before the scheduled moving date. The corporation or association shall include a copy of the notice to customers required under subsection (B).
2. A corporation or association shall provide notice of the location change to its customers by:
   a. Publishing notice of the change of location in:
      i. An English language newspaper of general circulation in the county where the repository will be closed,
      ii. In a weekly newspaper for two consecutive publications, or
      iii. In a daily newspaper for three consecutive days; and
   b. Publishing the notice no more than 90 days, and no less than 30 days, before the scheduled moving date.

B. The corporation or association shall include all the following information in the notice:

1. The date the corporation or association intends to move the repository,
2. The earliest date a customer can remove contents and transact other business related to the move,
3. The latest date a customer can remove contents and transact other business related to the move,
4. The street address of the repository to be closed, and
5. The street address of the new repository.

Historical Note

Former Rule 1. R20-4-1001 recodified from R4-4-1001 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 5227, effective February 4, 2003 (Supp. 02-4). Preceding Historical Note entry corrected to read 2003 instead of 2002 (Supp. 03-1).

ARTICLE 11. PUBLIC DEPOSITORIES FOR PUBLIC MONIES

R20-4-1101. Capital structure of banks; defined

"Capital structure" as the term is applied to banks under Article 2, Chapter 2, Title 35, Arizona Revised Statutes, means the sum of the following reserves and capital accounts of the institution as stated in the institution's report of condition required by the supervisory banking authority for the year end next preceding the institution's bid for deposit:

1. Reserve for bad debt losses on loans.
2. Other reserves on loans.
3. Reserves on securities.
4. Capital notes and debentures.
5. Preferred stock -- total par value.
6. Common stock -- total par value.
7. Surplus.
8. Undivided profits.
9. Reserve for contingencies and other capital reserves.

Historical Note

Adopted as an emergency effective July 29, 1975 (Supp. 75-1). Amended effective December 26, 1975 (Supp. 75-2). R20-4-1101 recodified from R4-4-1101 (Supp. 95-1).

R20-4-1102. Expired

Historical Note

Adopted as an emergency effective July 29, 1975 (Supp. 75-1). Amended effective December 26, 1975 (Supp. 75-2). R20-4-1102 recodified from R4-4-1102 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 26 A.A.R. 382, effective February 5, 2020 (Supp. 20-1).

ARTICLE 12. RULES OF PRACTICE AND PROCEDURE BEFORE THE DIRECTOR

R20-4-1201. Scope of Article; Definitions

A. Scope. This Article, Title 6, Title 32, Chapters 9 and 36, and Title 44, Chapter 2.1 of the Arizona Revised Statutes govern administrative hearings before the Department. The Department shall use the authority of A.R.S. Title 41, Chapter 6, Article 10, the Office of Administrative Hearings' procedural rules and this Article to govern the initiation and conduct of administrative hearings. In an administrative hearing, special procedural requirements in state statute or another Section in this Article shall also govern the proceedings unless the requirements are inconsistent with either A.R.S. Title 41, Chapter 6,

Article 10, the Office of Administrative Hearings' rules, or this Article. Except as otherwise provided in Section R20-4-1220 for rulemaking petitions, this Article does not apply to rulemaking or to investigative proceedings before the Director. Unless expressly applicable by rule or statute, the Arizona Rules of Civil Procedure do not apply to administrative hearings.

B. In addition to the definitions provided in A.R.S. §§ 41-1001 and 41-1092, the following terms apply to this Article:

"Administrative Hearing" means an appealable agency action as defined by A.R.S. § 41-1092(3) or a contested case as defined by A.R.S. § 41-1001(5) subject to A.R.S. Title 41, Chapter 6, Article 10.

"Attorney General" means the Attorney General of Arizona, and the Attorney General's assistants and special agents.

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

"Director" has the meaning stated at A.R.S. § 20-102.

"Party" has the meaning prescribed at A.R.S. § 41-1001(16) and includes any person or entity subject to the jurisdiction of the Department under A.R.S. Title 6, Title 32 - Chapter 9, Title 32 - Chapter 36, and Title 44 - Chapter 2.1.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1201 recodified from R4-4-1201 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3). Amended by final rulemaking at 28 A.A.R. 3620 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

R20-4-1202. Appearance and Practice before the Director for Administrative Hearings

A. A party may appear on their own behalf or through counsel.

B. When an attorney other than the Attorney General appears or intends to appear before the Director or the Department, they shall promptly disclose their name and contact information and the name and contact information of the party on whose behalf they intend to appear.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1202 recodified from R4-4-1202 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 28 A.A.R. 3620 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

R20-4-1203. Repealed

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1203 recodified from R4-4-1203 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1204. Filing; Service

A. A document filed by a party with the Department is filed on the date it is received by the Department as established by the Department's earliest stamped date on the face of the document or by some other method of affixing a received date by the Department.

B. If a party is represented by an attorney, service is effectuated by service upon the attorney unless additional service upon the represented party is required by an administrative law judge or the Department.

C. A document is served upon a party as provided for under A.R.S. § 41-1092.04 and Section R2-19-108. A party effectuating service is responsible for producing proof of service if requested by the Department.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1204 recodified from R4-4-1204 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3). Amended to correct a typographical error in subsection (B) (Supp. 01-4). Amended by final rulemaking at 28 A.A.R. 3620 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

R20-4-1205. Repealed

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1205 recodified from R4-4-1205 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1206. Repealed

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1206 recodified from R4-4-1206 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1207. Repealed

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1207 recodified from R4-4-1207 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1208. Repealed

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1208 recodified from R4-4-1208 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3). Repealed by final rulemaking at 28 A.A.R. 3620 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

R20-4-1209. Answer to Notice of an Administrative Hearing

A. The Department may, in a notice of hearing, direct one or more parties to file a written answer to the allegations contained in the notice of hearing. Even if not directed to do so, any party to the proceeding may file an answer.

B. A party directed to file an answer shall do so within 20 days after issuance of a notice of hearing, unless the notice of hearing states a different period for the answer. The Department may require any party to answer, in a reasonable time, amendments to the assertions in the notice made after service of the original notice.

C. An answer filed under this Section shall briefly state the party's position or defense to the proceeding and shall specifically admit or deny each of the allegations in the notice of hearing. An answering party who does not have, or cannot easily obtain, knowledge or information sufficient to admit or deny an allegation shall state that inability which shall have the effect of a denial. Any allegation not denied is admitted. A

party who intends to deny only a part of an allegation, shall expressly admit as much of that allegation as is true and shall deny the remainder.

D. A party who fails to file an answer required by this Section within the time allowed is in default. The Director may resolve the proceeding against a defaulting party. In doing so, the Director may regard any allegations in the notice of hearing as admitted by the defaulting party.

E. Defenses not raised in the answer are waived.

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1209 recodified from R4-4-1209 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3). Amended by final rulemaking at 28 A.A.R. 3620 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

R20-4-1210. Stay Pending a Hearing

A person aggrieved by the Department's action or order who files a timely written request for a hearing may ask, in the request for a hearing, that the Director stay an action or any part of an order that will become effective before a hearing. The Director may, in the Director's discretion, stay the legal effectiveness of any action or order until the matter can be heard and finally decided if the aggrieved person's request demonstrates that:

1. The person has a reasonable defense that might prevail on the merits at the hearing,
2. The person will suffer irreparable injury unless the Director grants the stay,
3. The stay would not substantially or irreparably harm other interested persons, and
4. The stay would not jeopardize the public interest or contravene public policy.

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1210 recodified from R4-4-1210 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3). Amended by final rulemaking at 28 A.A.R. 3620 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

R20-4-1211. Repealed

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1211 recodified from R4-4-1211 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3). Repealed by final rulemaking at 28 A.A.R. 3620 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

R20-4-1212. Repealed

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1212 recodified from R4-4-1212 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1213. Repealed

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1213 recodified from R4-4-1213 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1214. Repealed

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1214 recodified from R4-4-1214 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1215. Repealed

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1215 recodified from R4-4-1215 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1216. Repealed

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1216 recodified from R4-4-1216 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1217. Repealed

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1217 recodified from R4-4-1217 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1218. Repealed

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1218 recodified from R4-4-1218 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1219. Request for Rehearing or Review

A. Any party aggrieved by an administrative decision may file with the Director within time limits and other procedural guidelines contained in A.R.S. § 41-1092.09, a written motion for rehearing or review of the decision specifying the particular reason for the request.

B. A party filing a motion under this Section may amend the motion at any time before a response to the motion is filed. An amended motion tolls the time for filing a response and the time for rendering a decision on the motion.

C. A request for rehearing or review which is not timely filed is deemed waived for the purpose of judicial review.

D. A motion for rehearing or review shall specify which of the grounds listed in subsection (G) it is based upon and shall set forth the specific facts and laws in support of the motion. A motion may cite relevant portions of testimony from the hearing if a transcript is provided with the motion and may cite hearing exhibits by reference to the exhibit number. The motion shall specify the relief sought by the request, such as a different finding of fact, conclusion of law or order and may seek multiple forms of relief in the alternative. When a motion for rehearing or review is based on an affidavit, the moving party shall attach the affidavit to the motion.

E. A party may file a separate request for a stay of the Director's decision. Filing a stay request or a motion for rehearing or review does not stay an order filed by the Director. The Direc-

tor may stay an order pending the resolution of a motion for rehearing or review.

F. Each party served with a motion for rehearing or review shall be permitted to file a written response within 15 days after the motion has been filed. Affidavits may be attached to and filed with a response. A response may cite relevant portions of testimony from the hearing if a transcript is provided with the response and may cite hearing exhibits by reference to the exhibit number. The Director has the discretion to hear oral argument to consider a request for rehearing or review.

G. The Director may grant a motion for rehearing or review for any of the following causes:

1. Irregularity in the proceedings before the Department, in any order, or any abuse of discretion that deprives the moving party of a fair hearing;
2. Misconduct by the Department, the administrative law judge, or the prevailing party;
3. Accident or surprise that could not have been prevented by ordinary care;
4. Newly discovered material evidence that could not reasonably have been discovered and produced at the original hearing;
5. Excessive or insufficient penalties;
6. Error in admitting or rejecting evidence or other legal errors occurring at the hearing; and
7. The decision is not justified by the evidence or is contrary to law.

H. The Director may affirm or modify the decision or grant a rehearing as to all or any of the parties and on all or part of the issues for any reason listed in subsection (G). An order granting a rehearing shall specify the reason for granting the rehearing, and the rehearing shall cover only those matters specified.

I. The Director, within the time for filing a motion for rehearing, may without a motion for rehearing, order a rehearing for any reason that would allow the granting of a motion for rehearing by a party. The order for rehearing, granted without a motion, shall specify the reason for granting the rehearing.

J. The Director may grant a motion for rehearing, timely served, for a reason not stated in the motion. The order for rehearing, granted for a reason not stated in the motion, shall specify the reason for granting the rehearing.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1219 recodified from R4-4-1219 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3). Amended by final rulemaking at 28 A.A.R. 3620 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

R20-4-1220. Petition for Rulemaking Action

A. The following definitions apply in this Section.

1. "Petitioner" means a person who petitions the Department for Rulemaking action as authorized under A.R.S. § 41-1033(A).
2. "Rule" has the meaning stated at A.R.S. § 41-1001 and is enforceable by the Department.
3. "Rulemaking action" means the process for formulation and finalization of a new rule, or amendment or repeal of an existing rule.
4. "Substantive Policy Statement" has the meaning stated at A.R.S. § 41-1001, is advisory only, and is not enforceable by the Department.

B. Any person may petition the Department under A.R.S. § 41-1033(A) to either:

1. Make, amend, or repeal a final Rule; or
2. Review an existing agency practice or Substantive Policy Statement that the Petitioner alleges to constitute a Rule.

C. A person who files a petition pursuant to A.R.S. § 41-1033(A), shall include the following information in the petition:

1. The Petitioner's name and contact information;
2. The name and address of any organization the Petitioner represents;
3. Whether the Petitioner is petitioning the Department to:
   a. Make, amend, or repeal a final Rule; or
   b. Review an existing agency practice or Substantive Policy Statement that the Petitioner alleges to constitute a Rule;
4. A detailed explanation of Petitioner's basis for submitting the petition;

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1220 recodified from R4-4-1220 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3). Section repealed; new Section amended by final rulemaking at 28 A.A.R. 3620 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

ARTICLE 13. LOAN ORIGINATORS

R20-4-1301. Scope of Article

This Article applies to:

1. All loan originating activities of any person licensed under Arizona law as a loan originator, and
2. The conduct of any applicant for a loan originator license.

Historical Note

New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section renewed by emergency rulemaking and amended at 16 A.A.R. 2165, effective October 24, 2010 for 180 days (Supp. 10-4). Emergency expired April 21, 2011; new Section made by final rulemaking at 16 A.A.R. 2401, effective April 22, 2011 (Supp. 10-4). Since emergency expired, the emergency rulemaking has been removed. (Supp. 15-1).

R20-4-1302. Course of Study to Qualify for Licensure

A. The Superintendent shall, under the authority of A.R.S. § 6-991.03(B)(1), approve a course of study that includes only those courses reviewed and approved by the Nationwide Mortgage Licensing System pursuant to A.R.S. § 6-991.03(E) and (F) and the Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 U.S.C. 5101 through 5116).

B. An applicant for a loan originator license shall satisfactorily complete a course of study by:

1. Attending at least 20 hours of instruction, and
2. Receiving a passing grade of not less than 75 percent correct answers on both the national and Arizona state exam required by A.R.S. § 6-991.07 and the Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 U.S.C. 5101 through 5116).

C. A pre-licensure course of study shall include 20 hours of instruction in the following areas:

1. Federal law and regulation, including the Real Estate Settlement Procedures Act ("RESPA"), the Truth in Lending Act ("TILA"), good faith estimates, federal privacy laws, fair lending laws including the Equal Credit Opportunity

Act ("ECOA") and the Fair Credit Reporting Act ("FCRA"): Three hours;
2. Business ethics, including fraud, consumer protection laws, and fair lending practices: Three hours;
3. Non-traditional mortgage product lending standards: Two hours;
4. Arizona real estate and mortgage lending law, including loan origination and processing, Arizona law relating to agency and the obligations between principal and agent, and state privacy laws: Four hours;
5. The remaining eight hours should be comprised of instruction in:
   a. The obligations between principal and agent;
   b. The statutory and regulatory laws governing loan originators;
   c. Arithmetical computations common to mortgage lending;
   d. Principles of real estate lending;
   e. The purpose and effect of mortgages, deeds of trust, and security agreements;
   f. The terms and conditions of conforming and non-conforming residential mortgages;
   g. Real estate appraisal; and
   h. The principles of appraisal independence.

D. A continuing education course of study shall include eight hours of instruction each year in the following areas:
1. Federal law and regulation, including the Real Estate Settlement Procedures Act ("RESPA"), the Truth in Lending Act ("TILA"), good faith estimates, federal privacy laws, fair lending laws including the Equal Credit Opportunity Act ("ECOA") and the Fair Credit Reporting Act ("FCRA"): Three hours;
2. Business ethics, including fraud, consumer protection laws, and fair lending practices: Two hours;
3. Non-traditional mortgage product lending standards: Two hours;
4. Arizona real estate and mortgage lending law, including loan origination and processing, Arizona law relating to agency and the obligations between principal and agent, and state privacy laws: One hour.

Historical Note
New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section renewed by emergency rulemaking and amended at 16 A.A.R. 2165, effective October 24, 2010 for 180 days (Supp. 10-4). Emergency expired April 21, 2011; new Section made by final rulemaking at 16 A.A.R. 2401, effective April 22, 2011 (Supp. 10-4). Since emergency expired, the emergency rulemaking has been removed. (Supp. 15-1).

R20-4-1303. Financial Responsibility
An applicant for a loan originator license shall demonstrate financial responsibility, as required by A.R.S. § 6-991.03, by either:
1. Depositing with the Superintendent a bond as specified by A.R.S. § 6-991.03(B)(4) and paying to the Superintendent, for deposit into the Mortgage Recovery Fund, the sum of $100 at the time of filing an original or a renewal application pursuant to A.R.S. § 6-991.03(B)(6); or
2. Depositing with the Superintendent a bond as specified by A.R.S. § 6-991.03(B)(4) and depositing with the Superintendent a bond as specified by A.R.S. § 6-991.03(B)(6).

Historical Note
New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section renewed by emergency rulemaking at 16 A.A.R. 2165, effective October 24, 2010 for 180 days (Supp. 10-4). Emergency expired April 21, 2011; new Section made by final rulemaking at 16 A.A.R. 2401, effective April 22, 2011 (Supp. 10-4). Since emergency expired, the emergency rulemaking has been removed. (Supp. 15-1).

R20-4-1304. Fees
Loan Originator program fees:
1. Initial application fee (non-refundable) pursuant to A.R.S. § 6-126(A)(33): $350,
2. Initial license fee (prorated according to the number of quarters remaining until the next annual renewal) pursuant to A.R.S. § 6-126(B): $150,
3. Annual renewal fee pursuant to A.R.S. § 6-126(C)(12) or fee for change to inactive status pursuant to A.R.S. §§ 6-126(C)(13) and 6-991.04(G): $150,
4. Transfer license to new employer fee pursuant to A.R.S. § 6-126(A)(34): $50,
5. Change of residence address fee pursuant to A.R.S. § 6-991.04(J): $50,
6. Examination fee pursuant to A.R.S. § 6-991.07(E): the amount charged by the vendor,
7. Late renewal fee pursuant to A.R.S. § 6-991.04(E): $25 per day after the filing deadline.

Historical Note
New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section renewed by emergency rulemaking and amended at 16 A.A.R. 2165, effective October 24, 2010 for 180 days (Supp. 10-4). Emergency expired April 21, 2011; new Section made by final rulemaking at 16 A.A.R. 2401, effective April 22, 2011 (Supp. 10-4). Since emergency expired, the emergency rulemaking has been removed. (Supp. 15-1).

R20-4-1305. Practice and Procedure
Loan originators shall follow the practice outlined in 20 A.A.C. 4, Article 12 (Rules of Practice and Procedure Before the Superintendent) for challenging information the Superintendent enters into the Nationwide Mortgage Licensing System and Registry pursuant to A.R.S. §§ 6-991.03(K) and 6-991.04(M).

Historical Note
New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section repealed; new Section made by renewed emergency rulemaking at 16 A.A.R. 2165, effective October 24, 2010 for 180 days (Supp. 10-4). Emergency expired April 21, 2011; new Section made by final rulemaking at 16 A.A.R. 2401, effective April 22, 2011 (Supp. 10-4). Since emergency expired, the emergency rulemaking has been removed. (Supp. 15-1).

ARTICLE 14. INVESTIGATIONS

R20-4-1401. Definitions
In this Article, unless the context otherwise requires:
1. "Examination" means reviewing an applicant's or licensee's operations, books, and records for any lawful purpose, including those listed in A.R.S. § 6-124(A).

2. "Investigation" means an inquiry, other than an examination, into the affairs of a licensed or unlicensed entity including a review of the entity's operations, books, and records, conducted by the Superintendent for any lawful purpose, including those listed in A.R.S. § 6-124(A).
3. "Licensee" means a financial institution or enterprise.

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). Former Section R4-4-1401 repealed, new Section R4-4-1401 renumbered from R4-4-1402 and amended effective August 14, 1991 (Supp. 91-3). Amended effective August 14, 1991 (Supp. 91-3). R20-4-1401 recodified from R4-4-1401 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 4653, effective December 6, 2003 (Supp. 03-4).

R20-4-1402. Repealed

Historical Note
Former Section R4-4-1402 renumbered to R4-4-1401, new Section R4-4-1402 adopted effective August 14, 1991 (Supp. 91-3). R20-4-1402 recodified from R4-4-1402 (Supp. 95-1). Section repealed by final rulemaking at 9 A.A.R. 4653, effective December 6, 2003 (Supp. 03-4).

R20-4-1403. Subpoenas: Service; Amendment; Investigation or Examination not a Condition of the Superintendent's Subpoena Power
The Superintendent may serve a subpoena either by personal delivery or by first class, certified, or express mail, or by facsimile transmission. A Department employee, or an attorney or agent of the Attorney General's office, may accomplish service for the Superintendent. The Superintendent may amend a subpoena at any time, and may serve the amended subpoena as provided in this Section. Under A.R.S. §§ 6-123(3), 6-124(B), and 12-2212, the Superintendent may compel testimony or document production, by subpoena or other means, regardless of whether an examination or investigation is in progress.

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). Former Section R4-4-1403 repealed, new Section R4-4-1403 renumbered from R4-4-1407 and amended effective August 14, 1991 (Supp. 91-3). R20-4-1403 recodified from R4-4-1403 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 4653, effective December 6, 2003 (Supp. 03-4).

R20-4-1404. Repealed

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). Repealed effective August 14, 1991 (Supp. 91-3). R20-4-1404 recodified from R4-4-1404 (Supp. 95-1).

R20-4-1405. Fingerprints; Background Information
A. In connection with an examination or investigation, the Superintendent may investigate the following persons' background:
1. An applicant or a licensee, or a person whom the Superintendent reasonably believes may be violating any statute or rule administered by the Superintendent; and
2. An officer, director, agent, employee, partner, joint venturer, affiliate, or other person associated with a person described in subsection (A)(1), if the other person has or had any involvement in or control over the activities of the person described in subsection (A)(1).

B. In connection with an examination or investigation, the Superintendent may require a person described in A.R.S. § 6-123.01(A) or (E) to submit a statement of personal history and fingerprints to the Department.

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). Former Section R4-4-1405 repealed, new Section R4-4-1405 renumbered from R4-4-1409 and amended effective August 14, 1991 (Supp. 91-3). R20-4-1405 recodified from R4-4-1405 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 4653, effective December 6, 2003 (Supp. 03-4).

R20-4-1406. Repealed

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). Repealed effective August 14, 1991 (Supp. 91-3). R20-4-1406 recodified from R4-4-1406 (Supp. 95-1).

R20-4-1407. Renumbered

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). Renumbered to R4-4-1403 effective August 14, 1991 (Supp. 91-3). R20-4-1407 recodified from R4-4-1407 (Supp. 95-1).

R20-4-1408. Repealed

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). Repealed effective August 14, 1991 (Supp. 91-3). R20-4-1408 recodified from R4-4-1408 (Supp. 95-1).

R20-4-1409. Renumbered

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). Renumbered to R4-4-1405 effective August 14, 1991 (Supp. 91-3). R20-4-1409 recodified from R4-4-1409 (Supp. 95-1).

R20-4-1410. Repealed

Historical Note
Adopted effective February 7, 1978 (Supp. 78-1). Repealed effective August 14, 1991 (Supp. 91-3). R20-4-1410 recodified from R4-4-1410 (Supp. 95-1).

ARTICLE 15. COLLECTION AGENCIES

R20-4-1501. Definitions
In this Article, unless the context otherwise requires:
1. "Account" means a contractual arrangement between a client and a collection agency that obligates the collection agency to attempt to collect one or more debts on the client's behalf.
2. "Active Manager" means the person who is in active management of the conduct of the collection agency's business, and who meets the qualifications listed in A.R.S. § 32-1023(A).
3. "Client" means a person who has hired a collection agency to collect a debt.
4. "Collection agency" has the meaning in A.R.S. § 32-1001(A)(2).
5. "Contact" means to communicate with, and includes attempted communications.
6. "Credit bureau" or "credit reporting agency" means any person engaged exclusively in the business of gathering, recording, and disseminating information about the

credit-worthiness, financial responsibility, paying habits, and character of persons being considered for credit extension.

7. "Creditor" means a person who offers or extends credit creating a debt, or to whom a debt is owed. The term does not include a person that receives an assignment or transfer of a defaulted debt solely for use in collecting the debt for someone else.
8. "Debt" means a debtor's actual or claimed obligation to pay money, whether or not the obligation has been reduced to judgment.
9. "Debtor" means a person obligated to pay a debt. The term also means a person claimed to be obligated to pay a debt.
10. "Superintendent" has the meaning in A.R.S. § 6-101.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1501 recodified from R4-4-1501 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1502. Applications

A. An applicant for a license shall complete and file an application, as required by the Department, by delivering the application to the Superintendent, together with the following documents and payment:
1. The bond required by A.R.S. § 32-1021;
2. The nonrefundable investigation fee and original license fee required by A.R.S. § 32-1028 and stated in A.R.S. § 6-126;
3. A current financial statement in the form required by the Department;
4. A certified copy of the current articles of incorporation, by-laws, partnership agreement, or other organizational documents under which the applicant proposes to conduct business; and
5. A statement of personal history for each principal officer, partner, and manager of the applicant, in the form required by the Department.

B. An out-of-state collection agency applying for a license under A.R.S. § 32-1024 shall complete and file the application required by subsection (A), together with a signed statement declaring that:
1. The requirements for securing the out-of-state license were, when issued, substantially the same or equivalent to the requirements imposed under A.R.S. Title 32, Chapter 9, Article 2. The statement shall also contain a complete description of those requirements.
2. The state issuing the out-of-state license extends reciprocity to Arizona licensees under similar circumstances. The statement shall also contain a complete description of the conditions for reciprocity in the other state.

C. A licensee applying for license renewal shall complete and file an application, as required by the Department, by delivering the renewal application to the Superintendent before January 1, together with the renewal fee required by A.R.S. § 32-1028 and stated in A.R.S. § 6-126. An application for renewal shall also include a current financial statement in the form required by the Department.

D. An applicant for a provisional license under A.R.S. § 32-1027 shall complete and file an application as required by the Department, by delivering the application to the Superintendent within 30 days of the event justifying a provisional license. The applicant shall deliver the application together with each of the following:
1. A bond that satisfies the requirements of A.R.S. § 32-1022;
2. A current financial statement as required by the Department;
3. A detailed description of the facts justifying the issuance of a provisional license; and
4. Evidence that the licensee notified the Superintendent as required by A.R.S. § 32-1023, in the event the licensee has terminated its active manager.

E. An applicant for a provisional license shall, in each instance, be appropriate to the circumstances justifying the provisional license, as follows:
1. A licensee's personal representative, or the personal representative's appointee, shall complete and file an application if the licensee, a natural person, has died;
2. The surviving partners shall complete and file an application if the licensee, a partnership, has dissolved;
3. A licensee shall complete and file an application if an active manager's employment was terminated.

F. An applicant for a provisional license shall clearly label the top of the first page with the heading "APPLICATION FOR PROVISIONAL LICENSE UNDER A.R.S. § 32-1027."

G. The Superintendent may require additional information the Superintendent considers necessary in connection with any application under this rule.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1502 recodified from R4-4-1502 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4742, effective November 13, 2000 (Supp. 00-4).

R20-4-1503. Reports

A. A collection agency shall notify the Superintendent in writing of any change in the officers, directors, partners, or active manager of the collection agency not more than ten days after the change. With the notice, the collection agency shall provide the Superintendent with a Statement of Personal History for each new officer, director, partner, or active manager on a form obtained from the Department.

B. A collection agency shall notify the Superintendent in writing of any change in its place of business not more than 10 days after the change.

Historical Note

Adopted effective December 18, 1979 (Supp. 79-6). R20-4-1503 recodified from R4-4-1503 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1504. Records

A. A licensee may use a computer recordkeeping system if the licensee gives the Superintendent advanced written notice that it intends to do so. The Department shall not require a licensee to keep a written copy of its books, accounts, and records if the licensee can generate all information required by this Section in a timely manner for examination or other purposes. A licensee may modify a computer recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a licensee shall report to

the Superintendent any modification that changes a computer system back to a paper-based recordkeeping system;

B. All licensees shall keep and maintain books, accounts, and records adequate to provide a clear and readily understandable record of all business conducted by the collection agency, including:

1. Records or books of account listing all clients' accounts in numerical order, or in alphabetical order according to the clients' names. If a collection agency keeps books of accounting in numerical order, the collection agency shall alphabetically cross-index each client name with the corresponding account's number. Each account shall reflect its true condition at each calendar month's end, and shall include:
   a. The client's name and address;
   b. Each debtor's name worked for collection in that month;
   c. The amount, description, and date of each debit and each credit to the account; and
   d. The balance due to, or owing from, the client.
2. A record and history of each debt for collection that clearly shows:
   a. The debtor's name;
   b. The debt's principal amount;
   c. The interest charged or collected;
   d. The amount, and a description of any other charges;
   e. The amount, and date, of each payment received or collected; and
   f. The current balance due on the debt.
3. An original of each written contract, between the licensee and a client, including any contract amendments.
4. A trust general ledger reflecting all deposits to and payments from a trust account. A licensee shall post transactions to its trust general ledger at least every five business days. A licensee shall bring its trust general ledger current within 24 hours when requested by the Superintendent.
5. The licensee's trust account reconciliation, prepared at least once a month.
6. Books, records, and files maintained so that the Superintendent can easily conduct an unannounced spot check, as well as the examinations and investigations required by A.R.S. §§ 6-122 and 6-124.
7. A copy of all pleadings in pending litigation that names the collection agency as a defendant.
8. A record of fictitious names used by the agency's debt collectors as required by R20-4-1520.

C. A person issuing a receipt for a collection agency shall sign the receipt using that person's true name. Each receipt shall also show the collection agency's name.

D. A licensee shall maintain all records required under this Section and shall make them available for examination, investigation, or audit in Arizona within three working days after the Superintendent demands the records.

E. A licensee shall retain the records required by this Section for the following periods:

1. A licensee shall retain all records described in subsections (B)(1), (B)(3), (B)(4), (B)(5), (B)(6), (B)(7), and (B)(8) for at least six years following their creation.
2. A licensee shall retain all records described in subsection (B)(2) for at least three years from an account's assignment to the licensee. If a licensee collects any money on an account, the licensee shall retain the records described in subsection (B)(2) for at least three years from the last collection date.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). Amended effective December 18, 1979 (Supp. 79-6). R20-4-1504 recodified from R4-4-1504 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4742, effective November 13, 2000 (Supp. 00-4).

R20-4-1505. Trust Account

A. A licensee that maintains an office in Arizona shall deposit all funds collected for a client in a trust account with an Arizona bank or savings and loan association. A licensee that does not maintain an office in Arizona shall deposit all funds collected for a client in a trust account at a depository in the state where the licensee maintains its principal office. A licensee shall deposit all client funds before the close of its business on the third business day after the licensee receives the funds. Client funds shall remain on deposit as required by this Section until:

1. Paid over to a client, or
2. Otherwise paid as provided in this Section.

B. A licensee shall pay funds from the trust account either:

1. By prenumbered printed checks, or
2. By electronic payment.

C. A licensee shall deposit in its trust account only the funds it has collected for its client. A licensee, its officers, directors, partners, managers, members, or employees shall not commingle, or permit the commingling of, their own funds with client funds. This prohibition includes any funds that a licensee, or any officer, director, partner, manager, member, or employee claims an interest in if that interest arises outside the licensee's contract with a client.

D. A licensee shall keep unpaid client funds in its trust account. A licensee may maintain a separate trust account for dormant accounts into which the licensee deposits unpaid funds such as those of a client that cannot be located, or any trust account check issued to a client that is returned without being negotiated. As to all those unpaid funds, under A.R.S. § 44-317, a licensee shall file an abandoned property report at the Arizona Department of Revenue as and when required by law.

E. A licensee shall withdraw from its trust account all fees and commissions due the licensee under its contract with a client and deposit them directly into its own operating account.

F. A licensee shall not pay funds from its trust account except as:

1. Provided in this Section,
2. Expressly authorized in its contract with a client, or
3. Authorized in writing by the Superintendent.

Historical Note

Adopted effective December 18, 1979 (Supp. 79-6). R20-4-1505 recodified from R4-4-1505 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4742, effective November 13, 2000 (Supp. 00-4).

R20-4-1506. Articles of Incorporation; Bylaws; Organizing Documents

A. A collection agency organized as a corporation shall file with the Superintendent a copy of each amendment to its articles of incorporation within 30 days after the amendment is adopted. Before filing with the Superintendent, an officer of the collection agency shall:

1. Certify the copy filed in compliance with this Section, in writing, signed by the certifying officer, attesting to the

completeness, accuracy, and authenticity of the certified copy; and

2. Ensure the copy bears a stamp affixed by the Arizona Corporation Commission to evidence filing with the Commission.

B. A collection agency organized as a corporation shall file with the Superintendent a copy of each amendment to its bylaws within 10 days after the amendment is adopted. An officer of the collection agency shall certify the copy filed in compliance with this Section, in writing, attesting to the completeness, accuracy, and authenticity of the certified copy.

C. A collection agency not organized as a corporation shall file with the Superintendent a copy of each amendment to its organizing documents within 10 days after the amendment is adopted. A partner, active manager, or agent of the collection agency shall certify the copy filed in compliance with this Section, in writing, attesting to the completeness, accuracy, and authenticity of the certified copy.

Historical Note
Adopted effective December 18, 1979 (Supp. 79-6). R20-4-1506 recodified from R4-4-1506 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1507. Representations of Collection Agency's Identity
In all communications with debtors, either orally or in writing, all the following rules apply:

1. A collection agency shall represent itself as a collection agency.
2. A collection agency shall not directly or indirectly claim to be a credit reporting agency or credit bureau if it is not.
3. A collection agency shall not directly or indirectly claim to be a law enforcement agency.
4. A collection agency shall not directly or indirectly claim to be a law firm.

Historical Note
Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1507 recodified from R4-4-1507 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1508. Representations of the Law
A collection agency shall not:

1. Misrepresent the state of the law to a debtor,
2. Send a debtor written material that simulates legal process, or
3. Represent or imply that a debtor is, or may be, subject to criminal prosecution or arrest because of a failure to pay the debt.

Historical Note
Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1508 recodified from R4-4-1508 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1509. Representations as to Fees, Costs, and Legal Proceedings; Disinterested Counsel Required

A. A collection agency shall neither threaten to collect, nor attempt to collect, an attorney's fee, collection cost, or other fee that the debtor is not obliged to pay under the debtor's contract with the collection agency's creditor client.

B. A collection agency shall not inform a debtor that legal proceedings have been started unless, in fact, a lawsuit has been filed against the debtor.

C. A collection agency shall not threaten to start legal proceedings against a debtor unless the collection agency actually intends, at the time of the threat, to sue.

D. A collection agency shall not threaten to turn an account over to a lawyer unless the collection agency actually intends to do so at the time of the threat.

E. A collection agency shall not file a lawsuit against a debtor unless the lawsuit is filed by an attorney who has no personal or financial interest in that collection agency.

Historical Note
Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1509 recodified from R4-4-1509 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1510. Representations as to Rights Waived or Remedies Available

A. A collection agency shall not inform a debtor that the debtor waives any legal right or legal defense by a failure to contact the collection agency.

B. A collection agency shall not inform a debtor that the collection agency has the power or right to bypass the legal process.

C. A collection agency shall not misrepresent the remedies available to the collection agency.

Historical Note
Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1510 recodified from R4-4-1510 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1511. Prohibition of Harassment

A. A collection agency shall not use unauthorized or oppressive tactics designed to harass any person to pay a debt.

B. A collection agency shall not use written or oral communications that either ridicule, disgrace, or humiliate any person or tend to ridicule, disgrace, or humiliate any person.

C. A collection agency shall not state, imply, or tend to imply, in written or oral communications that any person is guilty of fraud or any other crime.

D. A collection agency shall not permit its agents, employees, representatives, debt collectors, or officers to use obscene or abusive language in efforts to collect a debt.

E. A collection agency or its agents, employees, representatives or officers are subject to penalties listed in A.R.S. § 32-1056(B) for any violation of this Article, as well as other liabilities imposed under any other provision of law.

Historical Note
Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1511 recodified from R4-4-1511 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1512. Contacts with Debtors and Others

A. A collection agency shall contact a debtor by telephone only during reasonable hours. A collection agency shall make a reasonable attempt to contact a debtor at the debtor's residence. A collection agency may contact a debtor at the debtor's place of employment if a reasonable attempt to contact the debtor at the debtor's residence has failed.

B. A collection agency shall not contact a third party, including a debtor's friend, relative, neighbor, or employer and:
1. Inform the third party of the debt;
2. Ask the third party to pressure the debtor into paying the debt, or;
3. Ask the third party to pay the debt, unless the third party is legally obligated to pay the debt.

C. A collection agency shall not threaten to contact a third party listed in subsection (B) for any purpose listed in subsection (B).

D. Despite the other provisions of this Section, a collection agency may make lawful service on third parties, including employers, of a writ of garnishment or other writ in aid of execution after judgment has been entered against a debtor.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1512 recodified from R4-4-1512 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1513. Cessation of Communication with the Debtor

A. A collection agency shall stop contacting a debtor, directly or indirectly, if the debtor tells the collection agency that the debtor is represented by a lawyer and wants the collection agency to communicate with the debtor through that lawyer. The collection agency may later contact the debtor if the collection agency contacts the lawyer named by the debtor and learns that the lawyer does not represent the debtor.

B. A collection agency shall stop contacting a debtor, directly or indirectly, if the debtor gives the collection agency written notice that the debtor:
1. Refuses to pay the debt, or;
2. Wants the collection agency to stop all further communication with the debtor.

C. Despite the provisions of subsection (B), a collection agency may contact a debtor to inform the debtor that:
1. The collection agency has stopped trying to collect the debt, or
2. The collection agency or the creditor may invoke specific remedies that are customarily used by the collection agency or the creditor.

D. The debtor's written notice under subsection (B) is effective upon receipt by the collection agency if delivered by mail.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). Amended effective December 18, 1979 (Supp. 79-6). R20-4-1513 recodified from R4-4-1513 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1514. Disclosure of Information to Debtor

A. Within five days after the initial communication with the debtor, a collection agency shall obtain, and be able to inform the debtor of:
1. The name of the creditor;
2. The time and place of the creation of the debt;
3. The merchandise, services, or other value provided in exchange for the debt; and
4. The date when the account was turned over to the collection agency by the creditor.

B. A collection agency shall give the debtor access to any of the collection agency's records that contain the information listed in subsection (A).

C. At the debtor's request, the collection agency shall give the debtor, free of charge, a copy of any document from its records that contains the information listed in subsection (A).

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1514 recodified from R4-4-1514 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1515. Aiding and Abetting

A collection agency shall not help or encourage, directly or indirectly, any other person to evade or violate any provision of:
1. This Article, or
2. A.R.S. Title 32, Chapter 9.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1515 recodified from R4-4-1515 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1516. Advertising

A collection agency shall not use any form of communication to state or imply that it is:
1. Approved, bonded by, or affiliated with the state of Arizona;
2. A state agency;
3. The director of any state agency; or
4. Authorized to practice law.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1516 recodified from R4-4-1516 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1517. Repealed

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1517 recodified from R4-4-1517 (Supp. 95-1). Section repealed by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1518. Agreements with Clients

A collection agency's records shall document each client's account in writing. The records for an account shall include either a written agreement between the client creditor and the collection agency, or a written direction from the creditor to the collection agency concerning a specific debt placed for collection. The collection agency

shall keep records that are specific, easily understood, and unambiguous. A provision of a written agreement or written direction that suggests the collection agency has authority to represent the client in court or to practice law in any other way is void and prohibited by this Section. The records for an account shall separately state:

1. The names of the parties to the agreement or written direction,
2. The terms or rate of compensation paid to the collection agency,
3. The length of time the agreement or written direction is intended to be in effect, and
4. Any conditions regarding collection of a particular debt.

Historical Note

Adopted effective December 18, 1979 (Supp. 79-6). R20-4-1518 recodified from R4-4-1518 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1519. Licensee Names and Control

A. The Department shall not issue a license with a name that is:
1. Similar to, or that may be confused with, any federal, state, county, or municipal government function or agency;
2. Descriptive of any business activity that the applicant does not actually conduct;
3. The same as, or similar to, the name of any existing collection agency, or;
4. Otherwise deceptive or misleading.

B. The Department may permit the use of a name otherwise prohibited under subsection (A)(3) based on its analysis of whether the name includes geographic or other information that distinguishes it from the other collection agency.

C. A collection agency shall not use a collection agency license to do business under more than one name. Each collection agency shall apply for and obtain a separate license for each business name it intends to use in Arizona.

Historical Note

Adopted effective December 18, 1979 (Supp. 79-6). R20-4-1519 recodified from R4-4-1519 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1520. Representations of Collection Agency Employees' Identity or Position

A. A collection agency shall not allow its debt collector, agent, representative, employee, or officer to:
1. Misrepresent the person's true position with the collection agency,
2. Claim to be, or imply that the person is, an attorney unless the person is licensed to practice law, or
3. Claim to be, or imply that the person is, a public official, peace officer, or any other type of public employee, or
4. Claim to be, or imply that the person is, any other third party.

B. In any communication with a debtor, a person working for a collection agency shall indicate that the person is a debt collector.

C. A collection agency shall keep a record of all fictitious names used by its debt collectors during their employment. The collection agency shall record the information required by this subsection before permitting the use of a fictitious name. The collection agency shall file a copy of the record of fictitious names with the Department on July 1 and December 31 of each year. After filing the initial report, a collection agency shall identify all changes to the record on July 1 and December 31 of each year. The collection agency's record of fictitious names shall include:
1. The true name of each debt collector that uses a fictitious name,
2. Each fictitious name used by the debt collector, together with the dates when the name is used, and
3. The residential street address and residential mailing address of each debt collector that uses a fictitious name.

Historical Note

Adopted effective December 18, 1979 (Supp. 79-6). R20-4-1520 recodified from R4-4-1520 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1521. Duty of Investigation

A collection agency shall give copies of its evidence of the debt to the debtor or the debtor's attorney on request. After providing the evidence, but before continuing its collection efforts against the debtor, the collection agency shall investigate any claim by the debtor or the debtor's attorney that:
1. The debtor has been misidentified,
2. The debt has been paid,
3. The debt has been discharged in bankruptcy, or
4. Based on any other reasonable claim, the debt is not owed.

Historical Note

Adopted effective December 18, 1979 (Supp. 79-6). R20-4-1521 recodified from R4-4-1521 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1522. Reserved

R20-4-1523. Reserved

R20-4-1524. Reserved

R20-4-1525. Reserved

R20-4-1526. Reserved

R20-4-1527. Reserved

R20-4-1528. Reserved

R20-4-1529. Reserved

R20-4-1530. Repealed

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1530 recodified from R4-4-1530 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4742, effective November 13, 2000 (Supp. 00-4).

ARTICLE 16. ACQUIRING CONTROL OF FINANCIAL INSTITUTIONS

R20-4-1601. Definitions

In this Article, unless the context otherwise requires:

"Acquiring party" means a person who intends to acquire control of a bank, trust company, savings and loan association, or controlling person under A.R.S. Title 6, Chapter 1, Article 4.

"Acquisition of control" has the meaning stated in A.R.S. § 6-141.

"Bank" has the meaning stated in A.R.S. § 6-101.

"Control" has the meaning stated in A.R.S. § 6-141.

"Controlling person" has the meaning stated in A.R.S. § 6-141.

"Person" has the meaning stated in A.R.S. § 6-141.

"Savings and loan association" means a person required to possess a permit issued by the Superintendent under A.R.S. Title 6, Chapter 3.

"Superintendent" has the meaning stated in A.R.S. § 6-101.

"Target company" means a bank, savings and loan association, trust company, or controlling person to be acquired by an acquiring party.

"Trust company" has the meaning stated in A.R.S. § 6-851.

"Voting security" has the meaning stated in A.R.S. § 6-141.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective January 12, 1979 (Supp. 79-1). R20-4-1601 recodified from R4-4-1601 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 5055, effective January 3, 2004 (Supp. 03-4).

R20-4-1602. Application for Approval to Acquire Control of Financial Institution

A. An applicant seeking approval to acquire control of a bank, savings and loan association, or controlling person of a bank or savings and loan association, under A.R.S. Title 6, Chapter 1, Article 4, shall file with the Superintendent copies of all application documents filed with federal regulatory agencies in connection with the planned acquisition of control.

B. As used in this subsection, "executive officer" includes the chairman of the board, president, each vice president, cashier, secretary, treasurer, and every other person who participates in major policymaking functions of the applicant. Under A.R.S. § 6-145(A), an applicant seeking approval to acquire control of a trust company or controlling person of a trust company, under A.R.S. Title 6, Chapter1, Article 4 shall supply all information the Superintendent requires under this subsection. The Superintendent may require an applicant to supplement or amend its application based on issues raised by the initial submission. The initial application shall consist of the following items:

1. A copy of the signed purchase agreement,
2. The applicant's audited financial statement,
3. A personal history statement, on a form supplied by the Department, for each executive officer and each director of the acquiring party,
4. Each executive officer's and each director's audited financial statement,
5. A fingerprint card for each executive officer and each director, and
6. A copy of each executive officer's and each director's driver's license.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective January 12, 1979 (Supp. 79-1). R20-4-1602 recodified from R4-4-1602 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 5055, effective January 3, 2004 (Supp. 03-4).

R20-4-1603. Repealed

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective January 12, 1979 (Supp. 79-1). R20-4-1603 recodified from R4-4-1603 (Supp. 95-1). Section repealed by final rulemaking at 9 A.A.R. 5055, effective January 3, 2004 (Supp. 03-4).

R20-4-1604. Repealed

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective January 12, 1979 (Supp. 79-1). R20-4-1604 recodified from R4-4-1604 (Supp. 95-1). Section repealed by final rulemaking at 9 A.A.R. 5055, effective January 3, 2004 (Supp. 03-4).

ARTICLE 17. ARIZONA INTERSTATE BANK AND SAVINGS AND LOAN ASSOCIATION ACT

R20-4-1701. Definitions

In this Article, unless the context otherwise requires:

"Acquire" has the meaning stated at A.R.S. § 6-321(1).

"Applicant" means an out-of-state financial institution that intends to acquire control of an in-state financial institution.

"Control" has the meaning stated at A.R.S. § 6-321(2).

"In-state financial institution" has the meaning stated at A.R.S. § 6-321(5).

"Out-of-state financial institution" has the meaning stated at A.R.S. § 6-321(6).

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5). R20-4-1701 recodified from R4-4-1701 (Supp. 95-1). Amended by final rulemaking at 11 A.A.R. 2031, effective July 2, 2005 (Supp. 05-2).

R20-4-1702. Notice to the Superintendent of Intent to Acquire Control of an In-state Financial Institution; Surrender of an Acquired Financial Institution's Charter

A. An applicant shall give written notice of an acquisition to the Superintendent in the form of a courtesy copy of its federal application. The acquiring entity shall ensure that the notice is delivered to the Superintendent not less than ten days before the effective date of the acquisition. No other application is required under the provisions of A.R.S. Title 6, Chapter 2, Article 7, the Arizona Interstate Bank and Savings and Loan Association Act. The Superintendent may impose conditions on an acquisition under the authority of A.R.S. §§ 6-324 and 6-328.

B. An acquired in-state financial institution shall surrender, by delivery to the Superintendent, all permits and certificates issued by the Superintendent within ten days after the effective date of the acquisition unless the acquired institution intends to continue operating, after the acquisition, as a stand alone subsidiary under the authority of its existing Arizona banking permit.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5). R20-4-1702 recodified from R4-4-1702 (Supp. 95-1). Amended

by final rulemaking at 11 A.A.R. 2031, effective July 2, 2005 (Supp. 05-2).

R20-4-1703. Repealed

Historical Note
Adopted effective October 1, 1986 (Supp. 86-5). R20-4-1703 recodified from R4-4-1703 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 2031, effective July 2, 2005 (Supp. 05-2).

R20-4-1704. Public Notice

A. An applicant shall transmit to the Superintendent of Banks two copies of each notice and the publisher's affidavit of publication required by the Federal Reserve Board, Federal Home Loan Bank Board, the Federal Deposit Insurance Corporation, or other regulatory authority that has concurrent jurisdiction.

B. An applicant shall provide the Superintendent of Banks copies of any protests known to have been received by the Federal Reserve Board, Federal Home Loan Bank Board, the Federal Deposit Insurance Corporation, or other regulatory authority that has concurrent jurisdiction.

Historical Note
Adopted effective October 1, 1986 (Supp. 86-5). R20-4-1704 recodified from R4-4-1704 (Supp. 95-1). Amended by final rulemaking at 11 A.A.R. 2031, effective July 2, 2005 (Supp. 05-2).

R20-4-1705. Repealed

Historical Note
Adopted effective October 1, 1986 (Supp. 86-5). R20-4-1705 recodified from R4-4-1705 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 2031, effective July 2, 2005 (Supp. 05-2).

R20-4-1706. Repealed

Historical Note
Adopted effective October 1, 1986 (Supp. 86-5). R20-4-1706 recodified from R4-4-1706 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 2031, effective July 2, 2005 (Supp. 05-2).

ARTICLE 18. MORTGAGE BANKERS

R20-4-1801. Exemption for an Entity Regulated by an Agency of this State, Other States, or by the United States

A. The exemption under A.R.S. § 6-942(A)(1) only applies to a person whose offers to make or negotiate a "mortgage banking loan" or a "mortgage loan," as those terms are defined in A.R.S. § 6-941, and all mortgage banking loans and mortgage loans made or negotiated by the person are regulated directly by an agency of this state, any other state, or the United States.

B. The required regulation of the transactions listed in subsection (A) includes:
1. Rules governing a claimant's accounting and recordkeeping practices;
2. The authority to examine a claimant's books and records relating to its mortgage banking activities or mortgage lending activities, or both; and
3. The ability to place a claimant in a receivership or conservatorship with regard to the claimant's mortgage banking activities, mortgage lending activities, or both.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1802. Equivalent and Related Experience

A. An applicant may satisfy the three years' experience requirement of A.R.S. § 6-943 by the types of lending-related experience listed in this subsection. The Department counts each month in the following types of work experience toward the three years required either for a mortgage banker license, or as a responsible individual, both under A.R.S. § 6-943(C). The Department counts a fractional month of experience, at least 15 days long, as a full month.
1. Mortgage banker with an Arizona license, responsible individual, or branch manager for a licensee;
2. Mortgage broker with an Arizona license, responsible individual, or branch manager for a licensee;
3. Loan officer with responsibility primarily for loans secured by lien interests on real property;
4. Lender's branch manager with responsibility primarily for loans secured by lien interests on real property;
5. Mortgage banker with license from another state, or responsible individual for the mortgage banker;
6. Mortgage broker with license from another state, or responsible individual for the mortgage broker;
7. Attorney certified by any state as a real estate specialist.

B. An applicant with insufficient actual experience of the types listed in subsection (A) may satisfy the remainder of the three years' experience requirement of A.R.S. § 6-943 by the types of related experience listed in this subsection. The Department counts each month in the following types of work experience according to the ratio listed below, of actual experience to equivalent experience, credited toward qualifying for a license, or as a responsible individual, both under A.R.S. § 6-943(C). The Department counts a fractional month of experience, at least 15 days long, as a full month. An applicant receives credit in only one area listed and for not more than three years' actual experience. The remaining years of experience required to qualify for a license shall be obtained from types of work experiences listed in subsection (A).
1. Attorney without state bar certified real estate specialty...3:2
2. Paralegal with experience in real estate matters...3:2
3. Loan underwriter...3:2
4. Mortgage banker or mortgage broker from another state without license...3:2
5. Real estate broker with an Arizona license or license from a state with substantially equivalent licensing requirements...3:2
6. Escrow officer...3:2
7. Trust officer with a title company...3:2
8. Executive, supervisor, or policy maker involved in administering or operating a mortgage-related business...3:1.5
9. Title officer with a title company...3:1.5
10. Real estate broker, not qualified under subsection (B)(5)...3:1.5
11. Loan processor with responsibility primarily for loans secured by lien interests on real property...3:1.5
12. Lender's branch manager with responsibility primarily for loans not secured by lien interests on real property...3:1.5
13. Real property salesperson, with an

Arizona license or a license from a state with substantially equivalent licensing requirements...3:1

14. Loan officer, with responsibility primarily for loans not secured by lien interests on real property...3:1

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1803. Restrictions on the Term of a Cash Alternative to a Surety Bond

A licensee or applicant shall not place a certificate of deposit or investment certificate as a cash alternative to a surety bond with the Superintendent that is renewable or expires earlier than 12 months from the date of issuance.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1804. Requirements for a Person Intended to Oversee a Branch Office

A person designated to oversee the operations of a branch office shall be knowledgeable about the branch activities of the licensee, supervise compliance by the branch with applicable law and rules, and have sufficient authority to ensure such compliance. One person may oversee more than one branch.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1805. Notification of Change of Address

If a licensee changes the licensee's principal place of business, or the location of a branch office, the licensee shall notify the Superintendent at least five business days before the address change. With the notice, a licensee shall provide the Superintendent with the license for the office changing its address and the fee required by A.R.S. § 6-126 for changing an office address. A copy of the license shall continue to be displayed at the place of business until a new license is issued.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2). Amended by final rulemaking at 8 A.A.R. 145, effective December 10, 2001 (Supp. 01-4).

R20-4-1806. Recordkeeping Requirements

A. The Superintendent shall approve a licensee's use of a computer or mechanical recordkeeping system if the licensee gives the Superintendent advanced written notice that it intends to do so. The Department shall not require a licensee to keep a written copy of the records if the licensee can generate all information required by this Section in a timely manner for examination or other purposes. A licensee may add, delete, modify, or customize an approved computer or mechanical recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a licensee shall report to the Superintendent any alteration in the approved system's fundamental character, medium, or function if the alteration changes:

1. Any approved computer or mechanical system back to a paper-based system; or
2. An approved mechanical system to a computer system; or
3. An approved computer system to a mechanical system.

B. In addition to any statutory requirement regarding records, a record maintained by a mortgage banker shall include the following:

1. A list of all executed loan applications or executed fee agreements that includes the following information:
   a. Applicant's name;
   b. Application date;
   c. Amount of initial loan request;
   d. Final disposition date;
   e. Disposition (funded, denied); and
   f. Name of loan officer;
2. A record, such as a cash receipts journal, of all money received in connection with mortgage banking loans or mortgage loans including:
   a. Payor's name;
   b. Date received;
   c. Amount; and
   d. Receipt's purpose including identification of a related loan, if any;
3. A sequential listing of checks written for each bank account relating to the mortgage banker business, such as a cash disbursement journal, including:
   a. Payee's name;
   b. Amount;
   c. Date; and
   d. Payment's purpose including identification of a related loan, if any;
4. Bank account activity source documents for the mortgage banker business including receipted deposit tickets, numbered receipts for cash, bank account statements, paid checks, and bank advices;
5. A trust subsidiary ledger for each borrower that deposits trust funds showing:
   a. Borrower's name or co-borrowers' names;
   b. Loan number, if any;
   c. Amount received;
   d. Purpose for the amount received;
   e. Date received;
   f. Date deposited into trust account;
   g. Amount disbursed;
   h. Date disbursed;
   i. Disbursement's payee and purpose; and
   j. Balance;
6. A file for each application for a mortgage banking loan or a mortgage loan containing:
   a. The agreement with the customer concerning the mortgage banker's services, whether as a loan application, fee agreement, or both;
   b. Document showing the application's final disposition, such as a settlement statement, or a denial or withdrawal letter;
   c. Correspondence sent, received, or both by the licensee;
   d. Contract, agreement and escrow instructions to or with any depository;
   e. Documents showing compliance with the Consumer Credit Protection Act's (15 U.S.C. §§ 1601 through 1666j) and the Real Estate Settlement Procedures Act's (12 U.S.C. §§ 2601 through 2617) disclosure requirements, to the extent applicable;
   f. If the loan is closed in the licensee's name, and funded by a lender that is not an institutional investor as defined at A.R.S. § 6-943, a copy of the executed note, executed deed of trust or mortgage, and

each assignment of beneficial interest by the licensee, if any. If any of the documents listed in this subsection have been recorded, the file shall also contain legible copies of the recorded documents, and;

g. Itemized list of all fees taken in advance including appraisal fee, credit report fee, and application fee;

7. Samples of every piece of advertising relating to the mortgage banker's business in Arizona;
8. Copies of governmental or regulatory compliance reviews;
9. If the licensee is not a natural person, a file containing:
   a. Organizational documents for the entity;
   b. Minutes;
   c. A record, such as a stock or ownership transfer ledger, showing ownership of all proportional equity interests in the licensee, ascertainable as of any given record date; and
   d. Annual report, if required by law;
10. If the licensee or anyone directly or indirectly owning more than 20% of the licensee has a felony conviction, a copy of the judgment or other record of conviction;
11. If the licensee or anyone directly or indirectly owning more than 20% of the licensee has, in the previous seven years, been named a defendant in any civil suit, a copy of the complaint, any answer filed by the licensee, and any judgment, dismissal or other final order disposing of the action;
12. If the Superintendent has granted approval to maintain records outside this state, the specific address where the records are kept, and a person's name to contact for them;
13. If a licensee does business in other states, it must be able to separate Arizona loan information from information relating to other states to enable the Superintendent to conduct an examination.
14. A licensee shall produce a trial balance of the general ledger monthly to evidence the mortgage banker's net worth.

C. If 10 or fewer transactions have occurred during the prior calendar quarter, a licensee shall reconcile and update all records specified in subsection (B) at least once each calendar quarter. A licensee shall reconcile and update all records specified in subsection (B) monthly if more than 10 transactions occurred during the prior calendar quarter. In addition to reconciling each trust bank account, a licensee shall verify each trust balance to each trust subsidiary ledger at each reconciliation.

D. A licensee shall retain the documents described in subsections (B)(1) and (6) for the length of time provided in A.R.S. § 6-946. For the purposes of A.R.S. § 6-946, the mortgage banking loan's closing date, on a loan application that did not result in the making of a loan, is either:

1. The date a licensee receives a written cancellation notice from an applicant; or
2. The date a licensee mails written notice to an applicant that an application has been denied, as required by federal law.

E. A licensee shall maintain all other records described in this Section, and not included in subsection (D), for at least two years.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1807. Providing Copies of Records

For each loan closed in an Arizona mortgage broker's name with a concurrent assignment of beneficial interest to a mortgage banker, the mortgage banker licensee shall provide to the mortgage broker in whose name the loan closed a copy of:

1. The closing instructions;
2. Any applicable rescission notice;
3. The HUD-1 settlement statement;
4. The final truth-in-lending disclosure;
5. The note;
6. The executed deed of trust or mortgage; and
7. Each assignment of beneficial interest by the mortgage banker licensee.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1808. Authorization to Complete Blank Spaces

An authorization, under A.R.S. § 6-947, allowing a licensee or escrow agent to complete certain blank spaces in a document after it is signed by a party to the transaction shall:

1. Specifically identify the document and the blank spaces to be completed;
2. Be in writing, dated, and signed by the authorizing parties, and
3. Contain the following notice, conspicuously printed on its face: YOUR SIGNATURE BELOW AUTHORIZES YOUR MORTGAGE BANKER OR ESCROW AGENT TO FILL IN SPACES YOU LEFT BLANK IN SPECIFIED LOAN DOCUMENTS YOU ARE ABOUT TO SIGN OR MAY HAVE ALREADY SIGNED. UNDER STATE LAW YOU CAN GIVE THIS AUTHORITY, BUT YOU ARE NOT REQUIRED TO DO SO. YOU CAN REFUSE TO SIGN ANY DOCUMENTS UNTIL ALL BLANKS ARE COMPLETELY FILLED IN.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1809. Determining Loan Amounts

The amount of a mortgage banking loan or a mortgage loan under A.R.S. § 6-947(E) or 6-947(K), is the principal amount of the loan and does not include any points, interest, finance charges, insurance premiums of any kind, compensation paid to third parties, or compensation retained by a mortgage banker or its agents.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1810. Delay or Cause Delay

A mortgage banker does not delay or cause delay if the delay occurs due to events outside the control of the mortgage banker.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1811. Impound Account

The total of all funds retained by a mortgage banker from all periodic payments made by a borrower to maintain a cushion, as defined in R20-4-102, shall not exceed 1/6th of the estimated total annual payments from the impound account.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1812. Acquisition of Additional Interest in Licensee by Majority Owner
A person that owns 51% or more of a licensee's outstanding voting equity interests, and that acquires the power to vote additional fractional equity interests, shall deliver written notice of the acquisition to the Superintendent. The person shall deliver the notice before completing the acquisition. Within 10 days after completing the acquisition, the person shall deliver documentation evidencing the acquisition to the Superintendent.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1813. Conversion to Mortgage Broker License
Under A.R.S. § 6-949 to apply for a conversion from a mortgage banker license to a mortgage broker license, the applicant shall submit during the renewal period all applicable renewal documents and renewal fees required by A.R.S. §§ 6-126 and 6-903 for mortgage brokers.

Historical Note
New Section adopted by final rulemaking at 18 A.A.R. 2622, effective December 2, 2012 (Supp. 12-4).

ARTICLE 19. COMMERCIAL MORTGAGE BANKERS

R20-4-1901. Exemption for an Institutional Investor
A. The exemption from the licensure requirement for an institutional investor, solely as that term is used in A.R.S. §§ 6-971, 6-972, and this Article, applies only if a person claiming the exemption meets all the following criteria:
1. The claimant originates or directly or indirectly makes, negotiates, or offers to make or negotiate commercial mortgage loans that are all exclusively funded by the claimant's own resources, as defined in A.R.S. § 6-971;
2. The claimant does so in the regular course of business;
3. The claimant makes only commercial mortgage loans, as defined in A.R.S. § 6-971;
4. The claimant makes each loan on the security of commercial property, as defined in A.R.S. § 6-971; and
5. The claimant makes only loans of more than $250,000.

B. If a claimant makes even one commercial mortgage loan that does not satisfy all the above criteria, any claim of exemption is invalid, and that person shall not engage in any lending activity before obtaining a license.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1902. Exemption for an Entity Regulated by an Agency of this State, Other States, or by the United States
A. The exemption under A.R.S. § 6-972(9) only applies to a person whose offers to make or negotiate a "commercial mortgage loan," as that term is defined in A.R.S. § 6-971, and all commercial mortgage loans made or negotiated by the person are regulated directly by an agency of this state, any other state, or the United States.

B. The required regulation of the transactions listed in subsection (A) includes:
1. Rules governing a claimant's accounting and recordkeeping practices;
2. The authority to examine a claimant's books and records relating to its commercial mortgage lending activities;
3. The ability to place a claimant in a receivership or conservatorship with regard to the claimant's commercial mortgage lending activities.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1903. Equivalent and Related Experience
A. An applicant may satisfy the three years' experience requirement of A.R.S. § 6-973 by the types of lending-related experience listed in this subsection. The Department counts each month in the following types of work experience towards the three years required either for a commercial mortgage banker license, or as a responsible individual, both under A.R.S. § 6-973(D). The Department counts a fractional month of experience, at least 15 days long, as a full month.
1. Commercial mortgage banker with an Arizona license, or Responsible Individual or branch manager for a licensee;
2. Mortgage broker with Arizona license, or Responsible Individual or branch manager for a licensee;
3. Mortgage banker with an Arizona license, or Responsible Individual or branch manager for a licensee;
4. Loan officer, with responsibility primarily for loans secured by lien interests on commercial real property;
5. Lender's branch manager, with responsibility primarily for loans secured by lien interests on commercial real property;
6. Commercial mortgage banker with license from another state, or Responsible Individual for the commercial mortgage banker;
7. Mortgage broker with license from another state, or Responsible Individual for the mortgage broker;
8. Mortgage banker with license from another state, or responsible individual for the mortgage banker;
9. Attorney certified by any state as a real estate specialist.

B. The experience of an applicant with insufficient actual experience of the types listed in subsection (A) is reviewed and evaluated on a case by case basis.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1904. Restrictions on the Term of a Cash Alternative to a Surety Bond
A licensee or applicant shall not place a certificate of deposit or investment certificate as a cash alternative to a surety bond with the Superintendent that is renewable or expires earlier than 12 months from the date of issuance.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1905. Requirements for a Person Intended to Oversee a Branch Office
A Person designated to oversee the operations of a branch office shall be knowledgeable about the branch activities of the licensee, supervise compliance by the branch with applicable law and rules, and have sufficient authority to ensure such compliance. One Person may oversee more than one branch.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1906. Notification of Change of Address
If a licensee changes the licensee's principal place of business, or the location of a branch office, the licensee shall notify the Superintendent within five business days after the address change. With the notice, a licensee shall provide the Superintendent with the license for the office changing its address and the fee required by A.R.S. § 6-126 for changing an office address. A copy of the license shall continue to be displayed at the place of business until a new license is issued.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1907. Recordkeeping Requirements

A. The Superintendent shall approve a licensee's use of a computer or mechanical recordkeeping system if the licensee gives the Superintendent advanced written notice that it intends to do so. The Department shall not require a licensee to keep a written copy of the records if the licensee can generate all information required by this Section in a timely manner for examination or other purposes. A licensee may add, delete, modify, or customize an approved computer or mechanical recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a licensee shall report to the Superintendent any material alteration in the approved system's fundamental character, medium, or function if the alteration changes:
1. Any approved computer or mechanical system back to a paper-based system; or
2. An approved mechanical system to a computer system; or
3. An approved computer system to a mechanical system.

B. In addition to any statutory requirement regarding records, a record maintained by a commercial mortgage banker shall include the following:
1. A list of all executed loan applications or executed fee agreements that includes the following information:
   a. Applicant's name;
   b. Application date;
   c. Amount of initial loan request;
   d. Final disposition date;
   e. Disposition (funded, denied); and
   f. Name of loan officer;
2. A record, such as a cash receipts journal, of all money received in connection with commercial mortgage loans including:
   a. Payor's name;
   b. Date received;
   c. Amount; and
   d. Receipt's purpose including identification of a related loan, if any;
3. A sequential listing of checks written for each bank account relating to the commercial mortgage banker business, such as a cash disbursement journal, including:
   a. Payee's name;
   b. Amount;
   c. Date; and
   d. Payment's purpose including identification of a related loan, if any;
4. Bank account activity source documents for the commercial mortgage banker business including receipted deposit tickets, numbered receipts for cash, bank account statements, paid checks, and bank advices.
5. A trust subsidiary ledger for each borrower that deposits trust funds showing:
   a. Borrower's name or co-borrowers' names;
   b. Loan number, if any;
   c. Amount received;
   d. Purpose for the amount received;
   e. Date received;
   f. Date deposited into trust account;
   g. Amount disbursed;
   h. Date disbursed;
   i. Disbursement's payee and purpose, and
   j. Balance.
6. A file for each application for a commercial mortgage loan containing:
   a. The agreement with the customer concerning the commercial mortgage banker's services, whether as a loan application, fee agreement, or both;
   b. The documents showing the application's final disposition, such as a settlement statements, a denial or withdrawal letter, or internal memorandum;
   c. Correspondence sent, received, or both by the licensee;
   d. Contract, agreement, and escrow instructions to or with any depository;
   e. If the loan is closed in the licensee's name, a copy of all closing documents including: closing instructions, copy of the executed note, executed deed of trust or mortgage, and each assignment of beneficial interest by the licensee, if any. If any of the documents listed in this subsection have been recorded, the file shall also contain legible copies of the recorded documents, and
   f. Itemized list of all fees taken in advance including appraisal fee, credit report fee, and application fee.
7. Samples of every piece of advertising relating to the commercial mortgage banker's business in Arizona;
8. Copies of governmental or regulatory reviews;
9. If the licensee is a not a natural person, a file containing:
   a. Organizational documents for the entity;
   b. Minutes;
   c. A record, such as a stock or ownership transfer ledger, showing ownership of all proportional equity interests in the licensee, ascertainable as of any given record date; and
   d. Annual report, if required by law;
10. If the licensee or anyone directly or indirectly owning more than 20% of the licensee has a felony conviction, a copy of the judgment or other record of conviction.
11. If the licensee or anyone directly or indirectly owning more than 20% of the licensee has, in the previous seven years, been named a defendant in any civil suit, a copy of the complaint, any answer filed by the licensee, and any judgment, dismissal or other final order disposing of the action.
12. If the Superintendent has granted approval to maintain records outside this state, the specific address where the records are kept, and a person's name to contact for them.
13. If a licensee does business in other states, it must be able to separate Arizona loan information from information relating to other states to enable the Superintendent to conduct an examination.

14. A licensee shall produce a trial balance of the general ledger monthly to evidence the commercial mortgage banker's net worth.

C. If 10 or fewer transactions have occurred during the prior calendar quarter, a licensee shall reconcile and update all records specified in subsection (B) at least once each calendar quarter. A licensee shall reconcile and update all records specified in subsection (B) monthly if more than 10 transactions occurred during the prior calendar quarter. In addition to reconciling each trust bank account, a licensee shall verify each trust balance to each trust subsidiary ledger at each reconciliation.

D. A licensee shall retain the documents described in subsections (B)(1) and (6) for the length of time provided in A.R.S. § 6-983. For the purposes of A.R.S. § 6-983, the commercial mortgage loan's closing date, on a loan application that did not result in the making of a loan, is either:

1. The date a licensee receives a written cancellation notice from the applicant; or
2. The date a licensee mails written notice to an applicant that an application has been denied; or
3. The date of a licensee's internal memorandum closing a loan file.

E. A licensee shall maintain all other records described in this Section, and not included in subsection (D), for at least two years.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1908. Impound Accounts

The total of all funds, if any, retained by the commercial mortgage banker from all periodic payments made by the borrower to maintain a Cushion, as defined in R20-4-102, is limited only by the written agreement of the parties, if at all.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1909. Authorization to Complete Blank Spaces

An authorization, under A.R.S. § 6-984, allowing a licensee or escrow agent to complete certain blank spaces in a document after it is signed by a party to the transaction shall:

1. Specifically identify the document and the blank spaces to be completed;
2. Be in writing, dated, and signed by the authorizing party, and
3. Contain the following notice, conspicuously printed on its face: YOUR SIGNATURE BELOW AUTHORIZES YOUR COMMERCIAL MORTGAGE BANKER OR ESCROW AGENT TO FILL IN SPACES YOU LEFT BLANK IN SPECIFIED LOAN DOCUMENTS YOU ARE ABOUT TO SIGN OR MAY HAVE ALREADY SIGNED. UNDER STATE LAW YOU CAN GIVE THIS AUTHORITY, BUT YOU ARE NOT REQUIRED TO DO SO. YOU CAN REFUSE TO SIGN ANY DOCUMENTS UNTIL ALL BLANKS ARE COMPLETELY FILLED IN.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1910. Delay or Cause Delay

A commercial mortgage banker does not delay or cause delay if the delay occurs due to events outside the control of the commercial mortgage banker.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1911. Acquisition of Additional Interest in Licensee by Majority Owner

A person that owns 51% or more of a licensee's outstanding voting equity interests, and that acquires the power to vote additional fractional equity interests, shall deliver written notice of the acquisition to the Superintendent. The person shall deliver the notice before completing the acquisition. Within 10 days after completing the acquisition, the person shall deliver documentation evidencing the acquisition to the Superintendent.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 4. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – FINANCIAL INSTITUTIONS

ARTICLE 4. CREDIT UNIONS
ARTICLE 10. SAFE DEPOSIT AND SAFEKEEPING CODE
ARTICLE 11. PUBLIC DEPOSITORIES FOR PUBLIC MONIES
ARTICLE 16. ACQUIRING CONTROL OF FINANCIAL INSTITUTIONS
ARTICLE 17. ARIZONA INTERSTATE BANK AND SAVINGS AND LOAN ASSOCIATION ACT

Authorizing Statute: A.R.S. § 6-123(2)

6-123. Deputy director; powers

In addition to the other powers, express or implied, the deputy director may:

1. Exercise all powers that are necessary for the administration and enforcement of the laws and rules relating to financial institutions and enterprises.

2. In accordance with title 41, chapter 6, adopt rules that are necessary or appropriate to administer, enforce and accomplish the purposes of this title and adopt rules and issue orders that limit transactions between financial institutions or enterprises and the directors, officers or employees of the financial institutions or enterprises.

3. Require appropriate records, documents, information and reports from any financial institution or enterprise.

4. Submit to the department of public safety, or the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor, the name and fingerprints of any applicant, licensee, active manager or responsible individual or the name and fingerprints of any organizer, director or officer of any corporate applicant or licensee for:

(a) A banking permit.

(b) Permission to organize a savings and loan association or credit union.

(c) Any license.

(d) Any certificate.

(e) Authority to engage in interstate banking and branching in this state.

The department of public safety shall report the criminal record, if any, of such applicant, licensee or organizer, director or officer of such corporate applicant or licensee within ninety days after receipt of the deputy director's request.

5. Employ appraisers to appraise any property that is owned or held as security by any financial institution or enterprise. The reasonable expenses and compensation of such appraisers shall be paid by the financial institution or enterprise.

6. Hold membership in, pay dues to and attend the convention of the national and regional organizations of state officials occupying like offices or performing similar functions.

7. Cooperate with other regulatory agencies and professional associations to promote the efficient, safe and sound operation and regulation of interstate banking and branching activities, including the formulation of interstate examination policies and procedures and the drafting of model rules and agreements.

8. Participate in the nationwide mortgage licensing system and registry established by the secure and fair enforcement for mortgage licensing act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 United States Code sections 5101 through 5116) or its successor. The deputy director may allow the system to collect licensing fees on behalf of the deputy director, to collect a processing fee for the services of the system directly from each applicant for a license or licensee and to process and maintain records on behalf of the deputy director, including information collected pursuant to this section and section 6-123.01. This paragraph does not affect the records disclosure requirements and limitations prescribed in section 6-129.01.

Implementing Statutes: Article 4: A.R.S. §§ 6-537(A)(1), and 6-537(C)

6-537. Certain duties of directors; insurance

A. In addition to the duties prescribed in this chapter, the board of directors shall:

1. Purchase adequate fidelity coverage for the credit union covering the president and other officials and employees handling or having custody of monies or property of the credit union.

2. Authorize the employment and compensation of the president, who may hire other persons as are necessary to carry out the business of the credit union.

3. Approve an operating budget for the credit union.

4. Authorize the conveyance of property.

5. Borrow or lend money to carry on the functions of the credit union.

6. Appoint special committees.

B. The board of directors shall perform other duties as the members from time to time may direct and perform or authorize any action not inconsistent with law or not specifically reserved by the bylaws to the members.

C. The board of directors shall purchase and maintain insurance for the credit union on behalf of a person who is or was a director, officer, employee or agent of the credit union, or who is or was serving at the request of the credit union as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against the person and incurred by the person in any such capacity or arising out of the person's status as such, whether or not the credit union would have the power to indemnify the person against the liability.

Implementing Statutes: Article 10: A.R.S. § 6-1003

6-1003. Change of location of repositories

A lessor may, during the term of any lease, move its repositories and the contents to another location on giving notice to the lessees in the manner and time required by such regulations as the deputy director may adopt.

Implementing Statutes: Article 11: A.R.S. §§ 35-312, 35-321(3) and (5)

35-312. Eligible depositories; collateral

A. Any eligible depository that receives an investment or any deposit of treasury monies of more than the amount insured by an instrumentality of the United States shall collateralize those deposits with any of the following:

1. Securities listed in section 35-313, subsection A, paragraphs 1 and 3.

2. State treasurer's warrant notes.

3. The safekeeping receipt of a federal reserve bank or any bank located in a reserve city, or any bank authorized to do business in this state, whose combined capital, surplus and outstanding capital notes and debentures on the date of the safekeeping receipt are $100,000,000 or more, evidencing the deposit therein of any securities or instruments described in this section. A safekeeping receipt does not qualify as security if issued by a bank to secure its own public deposits unless issued directly through its trust department. The safekeeping receipt shall show on its face that it is issued for the account of the state treasurer and shall be delivered to the state treasurer.

4. Letters of credit issued by a federal home loan bank if:

(a) The letter of credit has been delivered pursuant to this section or chapter 10, article 1 of this title to the statewide collateral pool administrator.

(b) The letter of credit meets the required conditions of:

(i) Being irrevocable.

(ii) Being issued, presentable and payable at a federal home loan bank in United States dollars. Presentation may be made by the beneficiary submitting the original letter of credit, including any amendments, and the demand in writing, by overnight delivery.

(iii) If the letter of credit is for purposes of chapter 10, article 1 of this title, containing a statement that identifies the statewide collateral pool administrator as the beneficiary.

(iv) Containing an issue date and a date of expiration.

(c) For the purposes of chapter 10, article 1 of this title, the eligible depository, if notified by the statewide collateral pool administrator, may not use new letters of credit issued by a federal home loan bank if that federal home loan bank fails to pay a draw request as provided for in the letters of credit or fails to properly complete a confirmation of the letters of credit.

B. The securities, warrants or safekeeping receipt for those items shall be accepted at market value equal to one hundred two percent of the deposit liability to the state treasurer, and, if at any

time their market value becomes less than one hundred two percent of the deposit liability to the state treasurer, additional items required to guarantee deposits shall be deposited immediately with the state treasurer by the eligible depository. When items pledged as collateral mature or are called for redemption, the cash received for the item shall be held in place of the items until the eligible depository has obtained a written release or provided substitute securities, instruments or warrants.

C. The deposit of securities, warrants or a safekeeping receipt must be such that the eligible depository will promptly pay to the state treasurer monies in its custody on lawful demand and will, when required by law, pay the monies to the state treasurer.

D. The securities, warrants or safekeeping receipt of an eligible depository shall be deposited with the state treasurer, and the state treasurer is the custodian of those items. The state treasurer may then deposit with the eligible depository monies then in the state treasurer's possession in accordance with this article.

E. Eligible depositories shall report to the state treasurer monthly and on demand the par and market value of any pledged collateral and the total deposits of the state treasurer.

35-321. Definitions

In this article, unless the context otherwise requires:

1. "Agency pool participant" means a subdivision or an entity of a subdivision that has monies maintained by the treasurer and that has the authority to draw negotiable instruments on the treasurer or make other disbursements from monies that the treasurer holds for the subdivision or entity.

2. "Board of deposit" means, in the case of a county, the board of supervisors, and in the case of a city or town, the common council.

3. "Capital structure" means the amount of the capital of the eligible depository shown by the latest call statement of condition as defined by rule of the department of insurance and financial institutions for the purpose of administration of this article.

4. "Collecting entity" means the entity from which the treasurer receives general funding including the county for collections performed by a county treasurer, the city for collections performed by a city treasurer or the district for collections performed by a district treasurer.

5. "Eligible depository" means any:

(a) Commercial or savings bank or savings and loan association that has either a branch in this state or its principal place of business in this state and that is insured by the federal deposit insurance corporation or its successor or any other insuring instrumentality of the United States according to the applicable federal law.

(b) Credit union that is insured by the national credit union administration or its successor.

6. "Involuntary pool participant" means a subdivision that only receives the principal ratio of the monies collected, for which the principal monies are mandated to be distributed on a specific date and for which the interest earned on the monies between the time of collection and other statutory requirements reverts to the general fund of the collecting entity.

7. "Permissible rate of interest" means a rate of interest that an eligible financial institution is permitted to pay by state or federal law or valid state rules or federal regulations.

8. "Public deposit" means public monies deposited in an eligible depository pursuant to this article.

9. "Public monies" includes subdivision monies.

10. "State monies" means all monies in the treasury of this state or coming lawfully into the possession or custody of the state treasurer.

11. "Subdivision" means any county, noncharter city or town. Cities governed by charter have the option of operating under this article.

12. "Subdivision monies" means all monies in the treasury of a subdivision or coming lawfully into the possession or custody of the treasurer.

13. "Treasurer" includes the treasurer or officer exercising the functions of treasurer of any subdivision but excludes the state treasurer.

14. "Trust funds" means those monies entrusted to a public body or official for preservation and investment, as prescribed by the instrument establishing such funds.

Implementing Statutes: Article 16: A.R.S. §§ 6-141, and 6-145

6-141. Definitions

In this article, unless the context otherwise requires:

1. "Acquisition of control" means any transaction whereby a person obtains, directly or indirectly, control of a bank, trust company, savings and loan association or controlling person.

2. "Control" means direct or indirect ownership of or power to vote twenty-five percent or more of the outstanding voting securities of a bank, trust company, savings and loan association or controlling person or to control in any manner the election of a majority of the directors of a bank, trust company, savings and loan association or controlling person. For the purposes of determining the percentage of voting securities owned, controlled or held by a person, there shall be aggregated with the voting securities attributed to such person the voting securities of any other person directly or indirectly controlling, controlled by or under common control with such other person or by any officer, partner, employee or agent of such person, or by any spouse, parent or child of such person.

3. "Controlling person" means any person directly or indirectly in control of a bank, trust company or savings and loan association.

4. "Person" means an individual, corporation, partnership, association, trust or agency or any similar entity.

5. "Voting security" means any security presently entitling the owner or holder of such security to vote for the election of directors of a bank, trust company, savings and loan association or controlling person, excluding, in the case of a savings and loan association, votes attributable to savings accounts. A specified percentage of outstanding voting securities means such amount of the outstanding voting securities as entitles the holder or holders of such securities to cast that specified percentage of the aggregate votes that the holders of all the outstanding voting securities are entitled to cast.

6-145. Application for approval

A. An application for approval of the deputy director shall be in writing in such form as the deputy director may prescribe and shall be accompanied by such information, data and records as the deputy director may require. For such purpose the deputy director shall adopt rules prescribing the form and the information, data or records that may be required.

B. On receipt of any initial application for approval or any amendment or supplement to the application, the deputy director shall cause copies of the application, amendment or supplement to be given to the bank, trust company or savings and loan association concerned within three business days.

Implementing Statutes: Article 17: A.R.S. § 6-327(G)

6-327. Applicable laws and rules; cooperative agreements; contracting exemption

A. Any bank, savings and loan association, out-of-state financial institution or holding company doing business as such in this state is subject to the applicable laws of this state and all the rules adopted pursuant to such laws, including examination and supervision by the deputy director.

B. In the case of an acquisition to create a branch in this state, the acquisition is prohibited unless the home state of the out-of-state financial institution allows reciprocal acquisitions for the same purposes.

C. An out-of-state financial institution that acquires an in-state financial institution or an out-of-state financial institution that is the result of a merger with an in-state financial institution may do either of the following subject to applicable state and federal laws:

1. Continue to operate the in-state financial institution.

2. Convert any existing principal banking office or any or all branches in this state into a branch of the out-of-state financial institution.

D. An in-state branch of an out-of-state financial institution shall comply with the laws of the institution's home state, or shall comply with federal law in the case of a federally chartered institution. The laws of the institution's home state apply, except as follows:

1. The laws of this state apply if necessary to preserve the safety and sound operation of a branch in this state or to otherwise protect the citizens of this state.

2. Any laws of this state regarding community reinvestment, consumer protection, fair lending and intrastate branching apply to a branch in this state of an out-of-state financial institution to the same extent that those laws apply to an in-state financial institution.

3. An out-of-state financial institution that is authorized to operate a branch in this state may engage in activity only to the extent the activity is allowed for an in-state financial institution.

E. Subsection D of this section does not limit the jurisdiction or authority of the deputy director to examine, supervise and regulate an out-of-state financial institution that is operating or seeking to operate a branch in this state or to take any action or issue any order with respect to that branch.

F. An out-of-state bank that operates a branch in this state shall do both of the following:

1. Obtain a grant of authority to transact business in this state and comply with all other applicable filing requirements prescribed by title 10 to the same extent as any other entity transacting business in this state.

2. Provide written notice to the deputy director of the out-of-state bank's grant of authority to transact business in this state.

G. The deputy director may adopt rules, including the imposition of reasonable application and examination fees, to implement and administer this article.

H. The deputy director may do any of the following:

1. Examine, supervise and regulate a branch operated in this state by an out-of-state bank and take any action or issue any order with respect to that branch.

2. Examine, supervise and regulate a branch operated in another state by a bank and take any action or issue any order with respect to that branch.

3. Coordinate these activities with any other state or federal agency that shares jurisdiction over that financial institution.

4. Coordinate the examination, supervision and regulation of any in-state financial institution with the examination, supervision and regulation of a branch or affiliated financial institution that is operating in another state by doing any of the following:

(a) Contracting with an agency that shares jurisdiction over the financial institution to retain its examiners at a reasonable rate of compensation.

(b) Offering the services of the department's examiners at a reasonable rate of compensation to an agency that shares jurisdiction over the financial institution.

(c) Collecting fees on behalf of or receiving payment of fees through an agency that has jurisdiction over the financial institution.

5. Enter into cooperative agreements with federal and state regulatory authorities for the examination and supervision of any acquired or de novo entry bank, savings and loan association or holding company and may accept reports of examination and other records from those authorities instead of conducting an examination.

I. The department is exempt from title 41, chapter 23 in contracting for examiners pursuant to subsection H, paragraph 4, subdivision (a) of this section.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
Title 9, Chapter 22

New Section: R9-22-1428

Amend: R9-22-711

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: August 1, 2023

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

FROM: Council Staff

DATE: **July 13, 2023**

SUBJECT: **Arizona Health Care Cost Containment System (AHCCCS)**
Title 9, Chapter 22, Article

Amend: R9-22-711
New: R9-22-1428

Summary:

This regular rulemaking from AHCCCS seeks to amend rules in Title 9, Chapter 22, Articles 7 and 14 relating to Standards for Payments and AHCCCS Medical Coverage for Households. Specifically, AHCCCS seeks to amend two rules in response to recent statutory changes; Laws 2022, Chapter 314. Currently, certain AHCCCS members receiving postpartum care are currently eligible for 60-days postpartum coverage through AHCCCS. Laws 2022, Chapter 314 grants individuals who meet the requirements specified in rule to opt-in a 12-month postpartum coverage option. R9-22-1428 specifies the different eligibility requirements for the two different postpartum coverage categories. Lastly, R9-22-711 is being amended to clarify that individuals who are more than 60 days postpartum are subject to copays.

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

The Department 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?

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

4. Summary of the agency's economic impact analysis:

The Agency states that certain AHCCCS members receiving postpartum care are currently eligible for 60-days postpartum coverage through AHCCCS. As a result of Arizona's decision to opt-in to a 12-month postpartum coverage option through Laws 2022, Chapter 314, AHCCCS submitted a State Plan Amendment for the Center for Medicare and Medicaid Services (CMS) approval. If the State Plan Amendment is approved, individuals who meet the requirements specified in the rule will be eligible for the 12 months of postpartum coverage while some individuals will still qualify for only the 60 days of postpartum coverage. The Agency indicates that proposed AHCCCS rule R9-22-1428 specifies the different eligibility requirements for the two different postpartum coverage categories and clarifies copays.

The Agency anticipates that the change will have a general fund impact but also states that the legislature envisioned this when they passed House Bill 2863. The Agency does not envision any additional fiscal impact in order to implement this eligibility category as part of the Administration. Stakeholders include the Agency and certain AHCCCS members eligible to receive postpartum 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 Agency 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 flexibility identified by CMS.

6. What are the economic impacts on stakeholders?

The Agency indicates that the rule is designed to provide longer eligibility for postpartum individuals and that if the rule is not changed then the rules will not be aligned with AHCCCS's contract with CMS and the State Plan. In addition, the costs to the general fund were considered when the legislature approved this extended eligibility for persons in House Bill 2863. The Agency indicates that newly eligible members will be directly benefited by this rulemaking. The Agency does not anticipate that the rule will have an effect on State revenues or materially impact other agencies. The Agency states that the

rulemaking does not directly affect political subdivisions and will not impact small businesses.

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

AHCCCS indicates it corrected a typographical error between the Notice of Proposed Rulemaking and the Notice of Final Rulemaking. Specifically, AHCCCS corrected a zero missing in R9-22-1428(B) and the postpartum period was described as 6 days instead of 60.

Council staff does not believe these changes make the final rules substantially different from the proposed rules pursuant to A.R.S. § 41-1025.

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

The Department indicates it received no public 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?

The rules do not require the issuance of 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?

Not applicable. AHCCCS indicates no federal law is applicable to the subject of these rules.

11. Conclusion

As mentioned above, this regular rulemaking from AHCCCS seeks to amend two rules in response to recent statutory changes; Laws 2022, Chapter 314, which will grant eligible individuals to opt-in to a 12-month postpartum coverage through AHCCCS.

AHCCCS is requesting an immediate effective date pursuant to A.R.S. § 41-1032 (A)(4) "to provide a benefit to the public and a penalty is not associated with a violation of the rule." Council staff believes AHCCCS meets the requirements for an immediate effective date. Council staff recommends approval of this rulemaking.

May 23, 2023

VIA EMAIL: grrc@azdoa.gov
Nicole Sornsin, Chair
Governor's Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

RE: R9-22-711/R9-22-1428 Rulemaking

Dear Ms. Sornsin:

1.	The close of record date:	02/06/2023
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,

/s/
Nicole Fries
Deputy General Counsel

Attachments

NOTICE OF FINAL RULEMAKING

TITLE 9 HEALTH SERVICES

CHAPTER 22 ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS &

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR HOUSEHOLDS

PREAMBLE

1.	**Article, Part, or Section Affected (as applicable)**	**Rulemaking Action**
	R9-22-711	Amend
	R9-22-1428	New

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

Implementing statute: Laws 2022, Chapter 314

3. The effective date of the rule:

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

AHCCCS selects the effective date of this rule to be immediate in order to, (4) "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* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 29 A.A.R. 22, January 6, 2023

Notice of Proposed Rulemaking: 29 A.A.R. 5, January 6, 2023

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

Name: Sladjana Kuzmanovic

Address: AHCCCS Office of the General Counsel

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:

Certain AHCCCS members receiving postpartum care are currently eligible for 60-days postpartum coverage through AHCCCS. As a result of Arizona's decision to opt-in to a 12-months postpartum coverage option through Laws 2022, Chapter 314, AHCCCS submitted a State Plan Amendment for CMS's approval. If the State Plan Amendment is approved, individuals who meet the requirements specified in rule, will be eligible for the 12months of postpartum coverage while some individuals will still qualify only for the 60days of postpartum coverage. Proposed AHCCCS rule R9-22-1428 specifies the different eligibility requirements for the two different postpartum coverage categories.

In addition, modifications to A.A.C. R9-22-711 as well as language added to R9-22-1428 clarify that individuals who are more than 60days postpartum are subject to copays. The previous language regarding copays specified that postpartum individuals (in general) were not subject to copays, because the only postpartum eligibility available was for the 60 days. In the 12-month postpartum coverage option, individuals who are more than 60-days postpartum are subject to copays.

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 this will have a general fund impact, however the legislature envisioned this when

they passed House Bill 2863. However, the Administration does not envision any additional fiscal impact in order to implement this eligibility category as part of the Administration.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

There was a zero missing in R9-22-1428(B) which means that the postpartum period was described as 6 days instead of 60 days. Due to the references throughout the rulemaking regarding a 60-day postpartum period this technical change will not prejudice eligible individuals since it clarifies the postpartum eligibility period is 2 months instead of 6 days.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

Not applicable.

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:

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:

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 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-711. Copayments

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR HOUSEHOLDS

Section

R9-22-1428. ~~Reserved~~Postpartum Extended Eligibility

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-711. Copayments

A. For purposes of this Article:

1. A copayment is a monetary amount that a member pays directly to a provider at the time a covered service is rendered.
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. 1396d(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~~including the postpartum period ~~following the pregnancy~~which is the last day of the month in which the 60th day following the date the pregnancy ends;

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(6)(a)(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(6)(g).

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.

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR HOUSEHOLDS

R9-22-1428. ~~Reserved~~Postpartum Extended Eligibility

A. Eligibility for 12-months postpartum coverage. Individuals who applied and were determined eligible while pregnant, including prior quarter months under R9-22-303(A), remain eligible through the last day of the month in which a 12-month postpartum period, beginning on the last day of the pregnancy, ends.

B. Copayments during the Postpartum Extended Eligibility period. Individuals eligible under this section are subject to copayments after the end of the 60-day postpartum period described in R9-22-1427.

ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM -ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS (R9-22-711)

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR HOUSEHOLDS (R9-22-1428)

1. Identification of rulemaking.

The Arizona Health Care Cost Containment System Administration is the single State agency responsible for administration of the Medicaid program in Arizona. The program is jointly funded by the State, counties, and the federal government. Federal law imposes a substantial number of conditions on the receipt of federal financial assistance reflected in federal statutes (42 U.S.C. § 1396 et seq.) and regulation (generally, 42 C.F.R. Parts 430 through 455). Certain AHCCCS members receiving postpartum care are currently eligible for 60-days postpartum coverage through AHCCCS. As a result of Arizona's decision to opt-in to a 12-months postpartum coverage option through Laws 2022, Chapter 314, AHCCCS submitted a State Plan Amendment for CMS's approval. If the State Plan Amendment is approved, individuals who meet the requirements specified in rule, will be eligible for the 12 months of postpartum coverage while some individuals will still qualify only for the 60 days of postpartum coverage. Proposed AHCCCS rule R9-22-1428 specifies the different eligibility requirements for the two different postpartum coverage categories.

In addition, modifications to A.A.C. R9-22-711 as well as language added to R9-22-1428 clarify that individuals who are more than 60 days postpartum are subject to copays. The previous language regarding copays specified that postpartum individuals (in general) were not subject to copays, because the only postpartum eligibility available was for the 60 days. In the 12 month postpartum coverage option, individuals who are more than 60-days postpartum are subject to copays.

a. The conduct and its frequency of occurrence that the rule is designed to change:

The rule is designed to provide a longer eligibility period for postpartum individuals.

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:

If the rule is not changed then the rules will not be aligned with AHCCCS's contract with the Center for Medicare and Medicaid Services (CMS), the State Plan.

c. The estimated change in frequency of the targeted conduct expected from the rule change:

There is no estimated change in frequency of the targeted conduct.

2. Identification of the persons who will be directly affected by, bear the costs of, or directly benefit from the rule making.

The costs to the general fund were considered when the legislature approved this extended eligibility period in House Bill 2863, however newly eligible members will be directly benefitted by this 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 federal government, through the Medicaid program, will fund a substantial percentage of the services members are likely to receive when in this new eligibility category. The Administration does not anticipate that the rule will have an effect on State revenues or materially impact other agencies.

ii. Benefit:

The Administration anticipates that the rulemaking will ensure better health outcomes for postpartum individuals.

iii. Need for additional Full-time Employees:

The Agency 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 Agency anticipates that public and private employment will not be impacted by the changes.

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 rulemaking will not impact small businesses.

b. Administrative and other costs required for compliance with the proposed rulemaking.

The Agency anticipates no impact on the administrative expenses of small businesses.

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.

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.

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.

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.

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 affect private persons and consumers unless they will be part of this new eligibility category.

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 Agency 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 flexibility identified by CMS.

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.

No additional data was obtained and used as the basis of this rule.

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 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.

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ADMINISTRATIVE RULES DIVISION

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

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
January 1, 2023 through March 31, 2023

Questions about these rules? Contact:

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The release of this Chapter in Supp. 21-3 replaces Supp. 22-4, 1-144 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. § 41-5505.

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.

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Administrative Rules Division
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TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

Authority: A.R.S. § 36-2901.08

Supp. 21-3

Editor's Note: Historical notes for Sections made, repealed or amended in Supp. 14-1 were updated to reflect the effective date as immediate per the original notice filed by the agency. A number of other publication errors have been corrected in Supplement 20-4 that should have been made in Supp. 14-1. These include: adding new Sections R9-22-301 and R9-22-302; correcting a punctuation error in R9-22-1401; repealing Sections R9-22-1407 and R9-22-1443; and the amending of R9-22-1501 (Supp. 20-4).

Editor's Note: The Office of the Secretary of State prints all Code Chapters on white paper (Supp 01-3).

Editor's Note: This Chapter contains rules which were adopted or amended under an exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6), under Laws 1992, Ch. 301, § 61 and Ch. 302, § 13, and Laws 1993, Ch. 6, § 34. Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review these rules; AHCCCS was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper.

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Former Article 1, consisting of Section R9-22-101, repealed effective December 8, 1997 (Supp. 97-4).

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ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

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

Definition	Section or Citation
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"Administration"	A.R.S. § 36-2901
"Adult behavioral health therapeutic home"	9 A.A.C. 10, Article 1
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"Affiliated corporate organization"	R9-22-101
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501
"Agency"	R9-22-1201
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"AHCCCS"	R9-22-101
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B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"ADHS" means the Arizona Department of Health Services.

"Adverse action" means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

"Affiliated corporate organization" means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation.

"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.

"AHCCCS registered provider" means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A), and

Meets license or certification requirements to provide covered services.

"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).

"Applicant" means a person who submits or whose authorized representative submits a written, signed, and dated application for AHCCCS benefits.

"Application" means an official request for AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a Fee-For-Service member.

"Authorized representative" means a person who is authorized to apply for medical assistance or act on behalf of another person.

"Behavioral health paraprofessional" means an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

If the behavioral health services were provided in a setting other than a licensed health care institution,

If the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33,

If the behavioral health services were provided in a setting other than a licensed health care institution; and

Are provided under supervision by a behavioral health professional R9-10-101.

"Behavioral Health Professional" has the same meaning as defined A.A.C. R9-10-101 excluding subsection (g).

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific covered service or equipment provided to a member. A payment is made in accordance with an upper or capped limit established by the Director. This capped limit can either be a specific dollar amount or a percentage of billed charges.

"Case record" means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.

"Children's Rehabilitative Services" or "CRS" means the program that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means a period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

"Contract year" means the period beginning on October 1 of a year and continuing until September 30 of the following year.

"Covered services" means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.

"Day" means a calendar day unless otherwise specified.

"DBHS" means the Division of Behavioral Health Services within the Arizona Department of Health Services.

"DES" means the Department of Economic Security.

"Diagnostic services" means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

"Director" means the Director of the Administration or the Director's designee.

"Discussion" means an oral or written exchange of information or any form of negotiation.

"DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

"Equity" means the county assessor full cash value or market value of a resource minus valid liens, encumbrances, or both.

"Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

"FBR" means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

"Fee-For-Service" or "FFS" means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a member not enrolled with a contractor.

"FES member" means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.

"FESP" means the federal emergency services program under R9-22-217 which covers services to treat an emergency medical or behavioral health condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

"FQHC" means federally qualified health center.

"GSA" means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with the contractor.

"Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

"IHS" means Indian Health Service.

"IMD" or "Institution for Mental Diseases" means an Institution for Mental Diseases as described in 42 CFR 435.1010 that is licensed by ADHS.

"Legal representative" means a custodial parent of a child under 18, a guardian, or a conservator.

"License" or "licensure" means a nontransferable authorization that is granted based on established standards in law by a state or a county regulatory agency or board and allows a health care provider to lawfully render a health care service.

"Mailing date" when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered as the date on the document, if there is no legible postmark or postage meter mark.

"Medical record" means a document that relates to medical or behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that is kept at the site of the provider.

"Medical supplies" means consumable items that are designed specifically to meet a medical purpose.

"Medically necessary" means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or to prolong life.

"Medicare claim" means a claim for Medicare-covered services for a member with Medicare coverage.

"Non-FES member" means an eligible person who is entitled to full AHCCCS services.

"Offeror" means an individual or entity that submits a proposal to the Administration in response to an RFP.

"Physician" means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

"Practitioner" means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a registered nurse practitioner certified under A.R.S. Title 32, Chapter 15.

"Prescription" means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.

"Primary care provider" or "PCP" means an individual who meets the requirements of A.R.S. § 36-2901 (14), and who is responsible for the management of a member's health care.

"Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable contract provisions. Prior authorization is not a guarantee of payment.

"Prior period coverage" means the period prior to the member's enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, which-

ever is later, and continues until the day the member is enrolled with a contractor.

"Proposal" means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

"Radiology" means professional and technical services rendered to provide medical imaging, radiation oncology, and radioisotope services.

"Referral" means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

"Rehabilitation services" means physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level.

"Responsible offeror" means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

"Responsive offeror" means an individual or entity that submits a proposal that conforms in all material respects to an RFP.

"Review" means a review of all factors affecting a member's eligibility.

"Review month" means the month in which the individual's or family's circumstances and case record are reviewed.

"RFP" means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

"Service location" means a location at which a member obtains a covered service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

"Service site" means a location designated by a contractor as the location at which a member is to receive covered services.

"S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

"Specialist" means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

"Spouse" means a person who has entered into a contract of marriage recognized as valid by this state.

"SSN" means Social Security number.

"Standard of care" means a medical procedure or process that is accepted as treatment for a specific illness, injury, or medical condition through custom, peer review, or consensus by the professional medical community.

"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member,

A marketing organization, or

Any other organization or person that agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

"Taxi" is as defined in A.R.S. § 28-101(53).

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 R9-22-101 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-101 repealed, former Sections R9-22-102 and R9-22-301 renumbered as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency by adding new paragraphs (24), (46), (84) and (91) and renumbering accordingly effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency by adding new paragraphs (2) and (15) and renumbering accordingly effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment added paragraphs (2) and (15) and renumbered accordingly effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended paragraphs (10) and (15) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended by deleting paragraphs (39) and (62) and renumbering accordingly effective July 1, 1988 (Supp. 88-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). 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). Amended effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted effective December 8, 1997 (Supp. 97-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking

at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3830, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 461, effective April 1, 2012 (Supp. 12-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-102. 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 R9-22-102 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1092 (Supp. 82-4). Former Section R9-22-102 renumbered together with former Section R9-22-301 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section adopted effective December 8, 1997 (Supp. 97-4). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Section repealed by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3).

R9-22-103. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-104. Reserved

R9-22-105. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-106. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

R9-22-107. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-108. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-109. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. effective 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-110. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

R9-22-111. Reserved

R9-22-112. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Repealed by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1).

R9-22-113. Reserved

R9-22-114. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

R9-22-115. Repealed

Historical Note
Final Section adopted at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

R9-22-116. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-117. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-118. Reserved

R9-22-119. Reserved

R9-22-120. Repealed

Historical Note
New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

ARTICLE 2. SCOPE OF SERVICES

R9-22-201. Scope of Services-related Definitions
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Anticipatory guidance" means a person responsible for a child receives information and guidance of what the person should expect of the child's development and how to help the child stay healthy.

"Behavioral health recipient" means a Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS/DBHS.

"Benefit year" means a one-year time period of October 1st through September 30th.

"Emergency behavioral health condition for a non-FES member" means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

Placing the health of the person, including mental health, in serious jeopardy;

Serious impairment to bodily functions;

Serious dysfunction of any bodily organ or part; or

Serious physical harm to another person.

"Emergency behavioral health services for a non-FES member" means those behavioral health services provided for the treatment of an emergency behavioral health condition.

"Emergency medical condition for a non-FES member" means treatment for a medical condition, including labor and delivery, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

Placing the member's health in serious jeopardy,

Serious impairment to bodily functions, or

Serious dysfunction of any bodily organ or part.

"Emergency medical services for a non-FES member" means services provided for the treatment of an emergency medical condition.

"Hearing aid" means an instrument or device designed for, or represented by the supplier as aiding or compensating for impaired or defective human hearing, and includes any parts, attachments, or accessories of the instrument or device.

"Home health services" means services and supplies that are provided by a home health agency that coordinates in-home intermittent services for curative, habilitative care, including home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.

"Occupational therapy" means medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual's ability to perform tasks required for independent functioning.

"Pharmaceutical service" means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.

"Physical therapy" means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.

"Post-stabilization services" means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.

"Primary care provider services" means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.

"Psychosocial rehabilitation services" means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:

Living skills training,

Cognitive rehabilitation,

Health promotion,

Supported employment, and

Other services that increase social and communication skills to maximize a member's ability to participate in the community and function independently.

"RBHA" or "Regional Behavioral Health Authority" means the same as in A.R.S. § 36-3401.

"Residual functional deficit" means a member's inability to return to a previous level of functioning, usually after experiencing a severe psychotic break or state of decompensation.

"Respiratory therapy" means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.

"Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

"Speech therapy" means medically prescribed diagnostic and treatment services provided by or under the supervision of a certified speech therapist.

"Sterilization" means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:

Prevent the progression of disease, disability, or adverse health conditions; or

Prolong life and promote physical health.

"Substance abuse" means the chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are 21 years of age or older

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 R9-22-201 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3217, effective October 1, 2005 (Supp. 05-3). Section repealed; new Section made by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-202. General Requirements

A. For the purposes of this Article, the following definitions apply:
1. "Authorization" means written, verbal, or electronic authorization by:
   a. The Administration for services rendered to a fee-for-service member, or
   b. The contractor for services rendered to a prepaid capitated member.
2. Use of the phrase "attending physician" applies only to the fee-for-service population.

B. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:
1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
2. Covered services for the federal emergency services program (FESP) are under R9-22-217.
3. The Administration or a contractor may waive the covered services referral requirements of this Article.
4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
6. A member may receive physical and behavioral health services as specified in Articles 2 and 12.
7. The Administration or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
8. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
9. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
   a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
   b. Services or items furnished gratuitously, and
   c. Personal care items except as specified under R9-22-212.
10. Medical or behavioral health services are not covered services if provided to:
   a. An inmate of a public institution; or
   b. A person who is in residence at an institution for the treatment of tuberculosis.

C. The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. The Administration or a contractor shall not provide prior authorization for services unless the provider submits documentation of the medical necessity of the treatment along with the prior authorization request.

D. Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.

E. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

F. A service is not a covered service if provided outside the GSA unless one of the following applies:
1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;
2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family;
3. The contractor authorizes placement in a nursing facility located out of the GSA; or
4. Services are provided during prior period coverage or during the prior quarter coverage.

G. If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

H. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.

I. The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care and cost effectiveness.

J. The restrictions, limitations, and exclusions in this Article do not apply to a contractor electing 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.
3. If a member requests a service that is not covered or is not authorized by a contractor, or the Administration, an AHCCCS-registered service provider may provide the service according to R9-22-702.

K. Subject to CMS approval, the restrictions, limitations, and exclusions specified in the following subsections do not apply to American Indians receiving services through IHS or a tribal health program operating under P.L. 93-638 when those services are eligible for 100 percent federal financial participation:
1. R9-22-205(A)(8),
2. R9-22-206,
3. R9-22-207,
4. R9-22-212(C),
5. R9-22-212(D),
6. R9-22-212(E)(8),
7. R9-22-215(C)(5), (C)(6), and
8. R9-22-215(C)(4).

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 R9-22-202 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Amended effective July 1, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1994, Ch. 322, § 21; filed with the Office of the Secretary of State June 22, 1995 (Supp. 95-3). Amended effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3). New Section made by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4). Amended by final rulemaking at 21 A.A.R. 1225, effective July 7, 2015 (Supp. 15-3).

R9-22-203. Experimental Services

A. Experimental services are not covered. A service is not experimental if:
1. It is generally and widely accepted as a standard of care in the practice of medicine in the United States and is a safe and effective treatment for the condition for which it is intended or used.
2. The service does not meet the standard in subsection (A)(1), but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of the evidence in peer-reviewed articles in medical journals published in the United States.
3. The service does not meet the standard in subsection (A)(2) because the condition for which the service is intended or used is rare, but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of opinions from specialists who provide the service or related services.

B. The following factors shall be considered when evaluating the weight of peer-reviewed articles or the opinions of specialists:
1. The mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services.
2. The types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services.
3. The frequency with which the service has been performed in the past.
4. Whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits.

5. The reputation and experience of the authors and/or specialists and their record in related areas.
6. The extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future.
7. Whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study.

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 R9-22-203 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed effective September 22, 1997 (Supp. 97-3). New Section made by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Section amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014 (Supp. 14-3).

R9-22-204. Inpatient General Hospital Services

A. The following limitations apply to inpatient general hospital services that are provided by FFS providers.
1. Providers shall obtain prior authorization from the Administration for the following inpatient hospital services:
   a. Nonemergency and elective admission, including psychiatric hospitalization;
   b. Elective surgery; and
   c. Services or items provided to cosmetically reconstruct or improve personal appearance after an illness or injury.
2. The Administration or a contractor may deny a claim if a provider fails to obtain prior authorization.
3. Providers are not required to obtain prior authorization from the Administration for the following inpatient hospital services:
   a. Voluntary sterilization,
   b. Dialysis shunt placement,
   c. Arteriovenous graft placement for dialysis,
   d. Angioplasties or thrombectomies of dialysis shunts,
   e. Angioplasties or thrombectomies of arteriovenous graft for dialysis,
   f. Hospitalization for vaginal delivery that does not exceed 48 hours,
   g. Hospitalization for cesarean section delivery that does not exceed 96 hours, and
   h. Other services identified by the Administration through the Provider Participation Agreement.
4. The Administration may perform concurrent review for hospitalizations of non-FES members to determine whether there is medical necessity for the hospitalization. A provider shall notify the Administration no later than 72 hours after an emergency admission.

B. Coverage of in-state and out-of-state inpatient hospital services is limited to 25 days per benefit year for members age 21 and older for claims with discharge dates on or before September 30, 2014. The limit applies for all inpatient hospital services with dates of service during the benefit year regardless of whether the member is enrolled in Fee for Service, is enrolled with one or more contractors, or both, during the benefit year.
1. For purposes of calculating the limit:
   a. Inpatient days are counted towards the limit if paid by the Administration or a contractor;
   b. Inpatient days will be counted toward the limit in the order of the adjudication date of a paid claim;
   c. Paid inpatient days are allocated to the benefit year in which the date of service occurs;
   d. Each 24 hours of paid observation services is counted as one inpatient day if the patient is not admitted to the same hospital directly following the observation services,
   e. Observation services, which are directly followed by an inpatient admission to the same hospital are not counted towards the inpatient limit; and
   f. After 25 days of inpatient hospital services have been paid as provided for in this rule Section:
      i. Outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered.
      ii. Continuous periods of observation services of less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered.
      iii. For continuous periods of observation services of 24 hours or more that are not directly followed by an inpatient admission to the same hospital, 23 hours of observations services are covered.
2. The following inpatient days are not included in the inpatient hospital limitation described in this Section:
   a. Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract;
   b. Days related to Behavioral Health:
      i. Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or
      ii. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or
      iii. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.
   c. Days related to treatment for burns and burn late effects at an American College of Surgeons verified burn center;
   d. Same Day Admit Discharge services are excluded from the 25 day limit; and
   e. Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities.

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 R9-22-204 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective Octo-

ber 1, 1985 (Supp. 85-5). Amended subsection (A) effective December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1745, effective October 1, 2012 (Supp. 12-2). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014 (Supp. 14-3). The incorrect label C was changed to B (Supp. 22-3).

R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services

A. A primary care provider, attending physician, or practitioner 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 and equipment;
5. Referral to a specialist or other health care professional if medically necessary;
6. Patient education;
7. Home visits if medically necessary; and
8. Preventive health services, such as, well visits, immunizations, colonoscopies, mammograms and PAP smears.

B. The following limitations and exclusions apply to attending 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, or to a member upon referral from the attending physician or practitioner are limited to the service or condition for which the referral is made, or for which authorization is given by the Administration or a contractor.
2. A member's physical examination is not covered if the sole purpose is to obtain documentation for 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 for the 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. Orthognathic surgery is covered only for a member who is less than 21 years of age;
4. The following services are excluded from AHCCCS coverage:
   a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgeries;
   b. Pregnancy termination counseling services;
   c. Pregnancy terminations, unless required by state or federal law.
   d. Services or items furnished solely for cosmetic purposes; and
   e. Hysterectomies unless determined medically necessary.

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 R9-22-205 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A), paragraph (15) and added paragraph (20) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(2) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

Editor's Note: The following Section was renumbered and a new Section adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not published as a proposed rule in the Arizona Administrative Register; the rule was not reviewed or approved by the Governor's Regulatory Review Council; and the agency was not required to hold public hearings on the rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-206. Organ and Tissue Transplant Services

A. Organ and tissue transplant services are covered for a member if prior authorized and coordinated with the member's contractor, or the Administration. Only the following transplants are covered for individuals 21 years of age or older:
1. Heart, including transplants for the treatment of non-ischemic cardiomyopathy;
2. Liver, including transplants for patients with hepatitis C;
3. Kidney (cadaveric and live donor);
4. Simultaneous Pancreas/Kidney (SPK);
5. Autologous and Allogeneic related and unrelated Hematopoietic Cell transplants;
6. Cornea;
7. Bone;
8. Lung; and
9. Pancreas after a kidney transplant (PAK).

B. The following transplants are not covered for members 21 years of age or older:

1. Pancreas only transplants if it is not performed simultaneously with or following a kidney transplant. Partial pancreas transplants and autologous and allogeneic pancreas islet cell transplants are not covered even if performed simultaneously with or following a kidney transplant,
2. Intestine transplants, and
3. Any other type of transplant not specifically listed in subsection (A).

C. When there is a transplant of multiple organs, reimbursement will only be made for those covered.

D. Organ and tissue transplant services are not covered for nonqualified aliens or noncitizens members of FESP under A.R.S. § 36-2903.03(D).

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 R9-22-206 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-206 renumbered to R9-22-218, new Section R9-22-206 adopted effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by exempt rulemaking at 16 A.A.R. 1386, effective July 15, 2010 (Supp. 10-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by exempt rulemaking at 17 A.A.R. 1122, April 1, 2011 (Supp. 11-2).

R9-22-207. Dental Services

A. The Administration or a contractor shall cover dental services for a member less than 21 years of age under R9-22-213.

B. For individuals age 21 years of age or older, the Administration or a contractor shall cover medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician.
1. Except as specified in subsection (C), such services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. Covered dental services include examination of the oral cavity, radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate level of anesthesia and the prescription of pain medication and antibiotics.
2. Such services do not include services that physicians are not generally competent to perform such as dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.

C. For the purposes of this subsection, simple restorations means silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns. In addition, dental services for an individual 21 years of age or older include:
1. The elimination of oral infections and the treatment of oral disease, which includes dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations as a medically necessary pre-requisite to covered transplantation; and
2. Prophylactic extraction of teeth in preparation for covered radiation treatment of cancer of the jaw, neck or head.

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 R9-22-207 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-207 repealed, new Section R9-22-207 adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3).

R9-22-208. Laboratory, Radiology, and Medical Imaging Services

Laboratory, radiology, and medical imaging services are covered services if:
1. Prescribed by the member's attending physician, practitioner, primary care provider or a dentist, or prescribed by a physician or practitioner upon referral from the primary care provider or dentist.
2. Provided by licensed health care providers in a:
   a. Hospital,
   b. Clinic,
   c. Physician's office, or
   d. Other health care facility.

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 R9-22-208 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-208 repealed, new Section R9-22-208 adopted effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

R9-22-209. Pharmaceutical Services

A. An inpatient or outpatient provider, including a hospital, clinic, other appropriately licensed health care facility, and pharmacy may provide covered pharmaceutical services.

B. The Administration or a contractor shall require a provider to make pharmaceutical services:
1. Available during customary business hours, and
2. Located within reasonable travel distance of a member's residence.

C. Pharmaceutical services are covered if:

1. Prescribed for a member by the member's primary care provider, attending physician, practitioner, or dentist;
2. Prescribed by a specialist upon referral from the primary care provider or attending physician; or
3. The contractor or its designee authorizes the service.

D. The following limitations apply to pharmaceutical services:
1. A medication personally dispensed by a physician, dentist, or a practitioner within the individual's scope of practice is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed.
2. A new prescription or refill in excess of a 30 day supply is not covered unless:
   a. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed a 90 day supply; or
   b. The Contractor authorizes the prescription for an extended time period not to exceed a 90-day supply.
3. An over-the-counter medication, in place of a covered prescription medication, is covered only if the over-the-counter medication is appropriate, equally effective, safe, and less costly than the covered prescription medication.

E. A contractor shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well being.

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 R9-22-209 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 24, 1986 (Supp. 86-5). Amended subsections (A) and (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(3), effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

R9-22-210. Emergency Medical Services for Non-FES Members

A. General provisions.
1. Applicability. This Section applies to emergency medical services for non-FES members. Provisions regarding emergency behavioral health services for non-FES members are in R9-22-210.01. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definitions.
   a. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS or a subcontractor of ADHS/DBHS.
   b. For the purposes of this Section and R9-22-210.01, "fiscal agent" means a person who bills and accepts payment for a hospital or emergency room provider.
3. Verification. A provider of emergency medical services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor.
4. Prior authorization.
   a. Emergency medical services. A provider is not required to obtain prior authorization for emergency medical services.
   b. Non-emergency medical services. If a non-FES member's medical condition does not require emergency medical services, the provider shall obtain prior authorization as required by the terms of the provider agreement under R9-22-714(A) or the provider's subcontract with the contractor, whichever is applicable.
5. Prohibition against denial of payment. Neither the Administration nor a contractor shall:
   a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms,
   b. Deny or limit payment because the provider failed to obtain prior authorization for emergency services,
   c. Deny or limit payment because the provider does not have a subcontract.
6. Grounds for denial. The Administration and a contractor may deny payment for emergency medical services for reasons including but not limited to:
   a. The claim was not a clean claim;
   b. The claim was not submitted timely; and
   c. The provider failed to provide timely notification under subsection (B)(4) to the contractor or the Administration, as appropriate, and the contractor does not have actual notice from any other source that the member has presented for services.

B. Additional requirements for emergency medical services for non-FES members enrolled with a contractor.
1. Responsible entity. A contractor is responsible for the provision of all emergency medical services to non-FES members enrolled with the contractor.
2. Prohibition against denial of payment. A contractor shall not limit or deny payment for emergency medical services when an employee of the contractor instructs the member to obtain emergency medical services.
3. Contractor notification. A contractor shall not deny payment to a hospital, emergency room provider, or fiscal agent for an emergency medical service rendered to a non-FES member based on the failure of the hospital, emergency room provider, or fiscal agent to notify the member's contractor within 10 days from the day that the member presented for the emergency medical service.
4. Contractor notification. A hospital, emergency room provider, or fiscal agent shall notify the contractor no later than the 11th day after presentation of the non-FES member for emergency inpatient medical services. A contractor may deny payment for a hospital's, emergency room provider's, or fiscal agent's failure to provide timely notice, under this subsection.

C. Post-stabilization services for non-FES members enrolled with a contractor.
1. After the emergency medical condition of a member enrolled with a contractor is stabilized, a provider shall

request prior authorization from the contractor for post-stabilization services.

2. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that have been prior authorized by the contractor.
3. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor for prior authorization of further post-stabilization services;
4. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain, improve, or resolve the member's stabilized condition if:
   a. The contractor does not respond to a request for prior authorization within one hour;
   b. The contractor authorized to give the prior authorization cannot be contacted; or
   c. The contractor representative and the treating physician cannot reach an agreement concerning the member's care and the contractor physician is not available for consultation. In this situation, the contractor shall give the treating physician the opportunity to consult with a contractor physician. The treating physician may continue with care of the member until the contractor physician is reached or:
      i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care,
      ii. A contractor physician assumes responsibility for the member's care through transfer,
      iii. The contractor's representative and the treating physician reach agreement concerning the member's care, or
      iv. The member is discharged.
5. Transfer or discharge. The attending physician or practitioner actually treating the member for the emergency medical condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor.

D. Additional requirements for FFS members.

1. Responsible entity. The Administration is responsible for the provision of all emergency medical services to non-FES FFS members.
2. Grounds for denial. The Administration may deny payment for emergency medical services if a provider fails to provide timely notice to the Administration.
3. Notification. A provider shall notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

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 R9-22-210 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-210 repealed, new Section R9-22-210 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (1) effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

R9-22-210.01. Emergency Behavioral Health Services for Non-FES Members

A. General provisions.

1. Applicability. This Section applies to emergency behavioral health services for non-FES members. Provisions regarding emergency medical services for non-FES members are in R9-22-210. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definition. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS, a subcontractor of ADHS/DBHS, or Children's Rehabilitative Services.
3. Responsible entity for inpatient emergency behavioral health services.
   a. Members enrolled with a contractor. ADHS/DBHS. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with the contractor.
   b. FFS members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services for non-FES FFS members with psychiatric or substance abuse diagnoses unless services are provided in an IHS or tribally operated 638 facility.
4. Responsible entity for non-inpatient emergency behavioral health services for non-FES members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all non-inpatient emergency behavioral health services for non-FES members.
5. Verification. A provider of emergency behavioral health services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is a member enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor, and determine whether the member is a behavioral health recipient as defined in R9-22-201.
6. Prior authorization.
   a. Emergency behavioral health services. A provider is not required to obtain prior authorization for emergency behavioral health services.
   b. Non-emergency behavioral health services. When a non-FES member's behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the prior authorization requirements of a contractor

and ADHS/DBHS or a subcontractor of ADHS/DBHS.

7. Prohibition against limitation or denial of payment. A contractor, TRBHA, the Administration, ADHS/DBHS, or a subcontractor of ADHS/DBHS shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services to a non-FES member for the following reasons:
   a. On the basis of lists of diagnoses or symptoms;
   b. Prior authorization was not obtained;
   c. The provider does not have a contract;
   d. An employee of the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS instructs the member to obtain emergency behavioral health services; or
   e. The failure of a hospital, emergency room provider, or fiscal agent to notify the member's contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS within 10 days from the day the member presented for the emergency service.
8. Grounds for denial. A contractor, the Administration, ADHS/DBHS, or a subcontractor of ADHS/DBHS may deny payment for emergency behavioral health. services for reasons including but not limited to the following:
   a. The claim was not a clean claim;
   b. The claim was not submitted timely; or
   c. The provider failed to provide timely notification under subsection (A)(9) to the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS or the Administration.
9. Notification.
   a. A hospital, emergency room provider, or fiscal agent shall notify a contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, whichever is appropriate, no later than the 11th day from presentation of the non-FES member for emergency inpatient behavioral health services.
   b. A hospital, emergency room provider, or fiscal agent shall notify the Administration no later than 72 hours after a FFS member receiving emergency behavioral health services presents to a hospital for inpatient services.
10. Transfer or discharge. The attending physician or the provider actually treating the non-FES member for the emergency behavioral health condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.

B. Post-stabilization requirements for non-FES members.

1. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have been prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.
2. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor, ADHS/DBHS, or a subcontractor for prior authorization of further post-stabilization services;
3. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain, improve, or resolve the member's stabilized condition if:
   a. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, does not respond to a request for prior authorization within one hour;
   b. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS authorized to give the prior authorization cannot be contacted; or
   c. The representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician cannot reach an agreement concerning the member's care and the contractor's, ADHS/DBHS' or the subcontractor's physician, is not available for consultation. The treating physician may continue with care of the member until ADHS/DBHS', the contractor's, or the subcontractor's physician is reached, or:
      i. A contracted physician with privileges at the treating hospital assumes responsibility for the member's care;
      ii. ADHS/DBHS', a contractor's, or a subcontractor's physician assumes responsibility for the member's care through transfer;
      iii. A representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician reach agreement concerning the member's care; or
      iv. The member is discharged.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-211. Transportation Services

A. Emergency ambulance services.

1. A member shall receive medically necessary emergency transportation in a ground or air ambulance:
   a. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
   b. If no other appropriate means of transportation is available.
2. The Administration or a member's contractor shall reimburse a ground or air ambulance transport that originates in response to a 911 call or other emergency response system:
   a. If the member's medical condition justifies the medical necessity of the type of ambulance transportation received,
   b. The transport is to the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
   c. No prior authorization is required for reimbursement of these transports.
3. The member's medical condition at the time of transport determines whether the transport is medically necessary.

4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure of the provider to provide notification is cause for denial.
5. Notification to the Administration of emergency transportation provided to a FFS member is not required, but the provider shall submit documentation with the claim that justifies the service.

B. The Administration or a contractor covers air ambulance services only if at least one criterion in subsection (B)(1) is met and at least one criterion in subsection (B)(2), or the criterion in subsection (B)(3) is met. The criteria are:
1. The air ambulance transport is initiated at the request of:
   a. An emergency response unit,
   b. A law enforcement official,
   c. A clinic or hospital medical staff member, or
   d. A physician or practitioner, and
2. The point of pickup:
   a. Is inaccessible by ground ambulance, or
   b. Is a great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition and ground ambulance service will not suffice, or
3. The medical condition of the member requires immediate intervention from emergency ambulance personnel or providers with the appropriate facilities to treat the member's condition.

C. Coverage of medically necessary nonemergency transportation is limited to the cost of transporting the member to an appropriate provider capable of meeting the member's medical needs.
1. As specified in contract, a contractor shall arrange or provide medically necessary nonemergency transportation services for a member who is unable to arrange transportation to a service site or location.
2. For a fee-for-service member, the Administration shall authorize medically necessary nonemergency transportation for a member who is unable to arrange transportation to a service site or location.

D. For the purposes of this subsection, an individual means a person who is not in the business of providing transportation services such as a family or household member, friend, or neighbor. The Administration or a contractor shall cover expenses for transportation in traveling to and returning from an approved and prior authorized health care service site provided by an individual if:
1. The transportation services are authorized by the Administration or the member's contractor or designee,
2. The individual is an AHCCCS registered provider, and
3. No other means of appropriate transportation is available.

E. The Administration or a contractor shall cover expenses for meals, lodging, and transportation for a member traveling to and returning from an approved health care service site outside of the member's service area or county of residence.

F. The Administration or a contractor shall cover the expense of meals, lodging, and transportation for:
1. A family member accompanying a member if:
   a. The member is traveling to or returning from an approved health care service site outside of the member's service area or county of residence; and
   b. The meals, lodging, and transportation services are authorized by the Administration or the member's contractor or designee.
2. An escort who is not a family member as follows:
   a. If the member is traveling to or returning from an approved and prior authorized health care service site, including an inpatient facility, outside of the member's service area or county of residence;
   b. If the escort services are authorized by the Administration or the member's contractor or designee; and
   c. Wage paid to an escort as reimbursement shall not exceed the federal minimum wage.

G. A provider shall obtain prior authorization from the Administration for transportation services provided for a member for the following:
1. Medically necessary nonemergency transportation services not originated through a 911 call or other emergency response system when the distance traveled exceeds 100 miles (whether one way or round trip); and
2. All meals, lodging, and services of an escort accompanying the member under this Section.

H. A charitable organization routinely providing transportation service at no cost to an ambulatory or chairbound person shall not charge or seek reimbursement from the Administration or a contractor for the provision of the service to a member but may enter into a subcontract with a contractor for medically necessary transportation services provided to a member.

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 R9-22-211 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3).

R9-22-212. Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies

A. Durable medical equipment, orthotic and prosthetic devices, and medical supplies, including incontinence briefs as specified in subsection (E), are covered services to the extent permitted in this Section if provided in compliance with requirements of this Chapter; and
1. Prescribed by the primary care provider, attending physician, or practitioner; or
2. Prescribed by a specialist upon referral from the primary care provider, attending physician, or practitioner; and
3. Authorized as required by the Administration, contractor, or contractor's designee.

B. Covered medical supplies are consumable items that are designed specifically to meet a medical purpose, are disposable, and are essential for the member's health.

C. Covered DME is any item, appliance, or piece of equipment that is not a prosthetic or orthotic; and
1. Is designed for a medical purpose, and is generally not useful to a person in the absence of an illness or injury, and
2. Can withstand repeated use, and
3. Is generally reusable by others.

D. Prosthetics are devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed or malfunctioning portion of the body. Only those prosthetics

that are medically necessary for rehabilitation are covered, except as otherwise provided in R9-22-215.

E. The following limitations on coverage apply:

1. The DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased.
2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair or adjustment is less than the cost of renting or purchasing another unit.
3. A change in, or addition to, an original order for DME is covered if approved by the prescriber in subsection (A), or prior authorized by the Administration or contractor, and the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for DME may be made after a claim for services is submitted to the member's contractor, or the Administration, without prior written notification of the change or addition to the Administration or the contractor.
4. Reimbursement for rental fees shall terminate:
   a. No later than the end of the month in which the prescriber in subsection (A) certifies that the member no longer needs the DME;
   b. If the member is no longer eligible for AHCCCS services; or
   c. If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified in R9-22-509.
5. Except for incontinence briefs for persons over 3 years old and under 21 years old as provided in subsection (E)(6), personal care items including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition. Personal care items are not covered services if used solely for preventive purposes.
6. Incontinence briefs, including pull-ups are covered to prevent skin breakdown and enable participation in social, community, therapeutic and educational activities under the following circumstances:
   a. The member is over 3 years old and under 21 years old;
   b. The member is incontinent due to a documented disability that causes incontinence of bowel or bladder, or both;
   c. The PCP or attending physician has issued a prescription ordering the incontinence briefs;
   d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder;
   e. The member obtains incontinence briefs from providers in the contractor's network;
   f. Prior authorization has been obtained as required by the Administration, contractor, or contractor's designee. Contractors may require a new prior authorization to be issued no more frequently than every 12 months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. Prior authorization will be permitted to ascertain that:
      i. The member is over age 3 and under age 21;
      ii. The member has a disability that causes incontinence of bladder or bowel, or both;
      iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the contractor; and
      iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.
7. First aid supplies are not covered unless they are provided in accordance with a prescription.
8. The following services are not covered for individuals 21 years of age or older:
   a. Hearing aids;
   b. Prescriptive lenses unless they are the sole visual prosthetic device used by the member after a cataract extraction;
   c. Bone Anchor Hearing Aid (BAHA);
   d. Cochlear implant;
   e. Percussive vest;
   f. Insulin pump;
   g. Microprocesser-controlled lower limbs or microprocessor-controlled joints for lower limbs; and
   h. Orthotics, which are defined as devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body.

F. Liability and ownership.

1. Purchased DME that is provided to a member and no longer needed by the member may be disposed of in accordance with each contractor's policy.
2. The Administration shall retain title to purchased DME provided to a member who becomes ineligible or no longer requires use of the DME.
3. If customized DME is purchased by the Administration or contractor for a member, the equipment shall remain with the person during times of transition to a different contractor, or upon loss of eligibility. For purposes of this subsection, customized DME refers to equipment that is altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.
4. A member shall return DME obtained fraudulently to the Administration or the contractor.

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 R9-22-212 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-212 repealed, new Section R9-22-212 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (2), and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3).

R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)

A. The following E.P.S.D.T. services are covered for a member less than 21 years of age:
1. Screening services including:
   a. Comprehensive health and developmental history;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history;
   d. Laboratory tests; and
   e. 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;
   c. Prescriptive lenses; and
   d. Frames.
3. Hearing services including:
   a. Diagnosis and treatment for defects in hearing;
   b. Testing to determine hearing impairment; and
   c. Hearing aids;
4. Dental services including:
   a. Emergency dental services as specified in R9-22-207;
   b. Preventive services including screening, diagnosis, and treatment of dental disease; and
   c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
5. Orthognathic surgery;
6. Medically necessary, nutritional assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;
7. Behavioral health services under 9 A.A.C. 22, Article 12;
8. Hospice services do not include home-delivered meals or services provided and covered through Medicare. The following hospice services are covered:
   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. Services available to a member receiving hospice care are limited to those allowable under 42 CFR 418.202, October 1, 2006, incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments;
9. Incontinence briefs as specified under R9-22-212; and
10. Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5).

B. Providers of E.P.S.D.T. services shall meet the following standards:
1. Ensure that services are provided by or under the direction of the member's primary care provider, attending physician, practitioner, or dentist.
2. Perform tests and examinations under 42 CFR 441 Subpart B, October 1, 2006, which is incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments.
3. Refer a member as necessary for dental diagnosis and treatment and necessary specialty care.
4. Refer a member as necessary for behavioral health evaluation and treatment services.

C. Contractors shall meet other E.P.S.D.T. requirements as specified in contract.

D. A primary care provider, attending physician, or practitioner shall refer a member with special health care needs under R9-7-301 to CRS.

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 R9-22-213 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-213 repealed, new Section R9-22-213 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007 (Supp. 07-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

R9-22-214. 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 R9-22-214 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-214 repealed, new Section R9-22-214 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (4) and added subsection (C), paragraph (2) effective October 1, 1986 (Supp. 86-5). Correction to subsection (C), paragraph (2) (Supp. 87-4). Section repealed effective September 22, 1997 (Supp. 97-3).

R9-22-215. 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:
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, medications, 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;
   b. Sterilization; and
   c. Natural family planning education or referral;
4. Midwifery services provided by a certified nurse practitioner in midwifery;
5. Midwifery services for low-risk pregnancies and home deliveries provided by a licensed midwife;
6. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services under A.R.S. § 36-2907(D);

9. Private or special duty nursing services;
10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
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; and
12. Chemotherapy.

B. Prior authorization from the Administration for a member is required for services listed in subsections (A)(3)(b), and (A)(4) through (11); except for:
1. Voluntary sterilization;
2. Dialysis shunt placement;
3. Arteriovenous graft placement for dialysis;
4. Angioplasties or thrombectomies of dialysis shunts;
5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis;
6. Eye surgery for the treatment of diabetic retinopathy;
7. Eye surgery for the treatment of glaucoma;
8. Eye surgery for the treatment of macular degeneration;
9. Home health visits following an acute hospitalization (limited up to five visits);
10. 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;
11. Physical therapy subject to the limitation in subsection (C);
12. Facility services related to wound debridement,
13. Apnea management and training for premature babies up to the age of 1; and
14. Other services identified by the Administration through the Provider Participation Agreement.

C. The following are not covered services:
1. Occupational and speech therapies provided on an outpatient basis for a member age 21 or older;
2. Abortion counseling;
3. Services or items furnished solely for cosmetic purposes;
4. Services provided by a podiatrist; or
5. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of restoring a skill or level of function and maintaining that skill or level of function once restored.
6. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of acquiring a new skill or a new level of function and maintaining that skill or level of function once acquired.

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 R9-22-215 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

R9-22-216. NF, Alternative HCBS Setting, or HCBS

A. Services provided in a NF, including room and board, an alternative HCBS setting as defined in R9-28-101, or a HCBS as defined in A.R.S. § 36-2939 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.

B. Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:
1. Nursing services, including:
   a. Administering medication;
   b. Tube feedings;
   c. Personal care services, including but not limited to assistance with bathing and grooming;
   d. Routine testing of vital signs; and
   e. Maintenance of a catheter;
2. Basic patient care equipment and sickroom supplies, including:
   a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
   b. Bathing and grooming supplies;
   c. Identification device;
   d. Skin lotion;
   e. Medication cup;
   f. Alcohol wipes, cotton balls, and cotton rolls;
   g. Rubber gloves (non-sterile);
   h. Laxatives;
   i. Bed and accessories;
   j. Thermometer;
   k. Ice bags;
   l. Rubber sheeting;
   m. Passive restraints;
   n. Glycerin swabs;
   o. Facial tissue;
   p. Enemas;
   q. Heating pad; and
   r. Incontinence briefs.
3. Dietary services including preparation and administration of special diets, and adaptive tools for eating;
4. Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal or state licensure standard or county certification requirement;
5. Physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
6. Physical therapy prescribed only as a maintenance regimen; and
7. Assistive devices and non-customized durable medical equipment.

C. A provider shall obtain prior authorization from the Administration for a NF admission for a FFS member.

Historical Note

Adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Subsection (C) amended to correct a typographical error (Supp. 00-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007 (Supp. 07-3). Amended by final rulemaking at 13 A.A.R. 4122, effective November 6, 2007 (Supp. 07-4).

R9-22-217. Services Included in the Federal Emergency Services Program

A. Definition. Notwithstanding the definition in R9-22-201, for the purposes of this Section, an emergency medical or behavioral health condition for a FES member means a medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. Placing the member's health in serious jeopardy,
2. Serious impairment to bodily functions,
3. Serious dysfunction of any bodily organ or part, or
4. Serious physical harm to another person.

B. Services. "Emergency services for a FES member" mean those medical or behavioral health services provided for the treatment of an emergency condition. Emergency services include outpatient dialysis services for a FES member with End Stage Renal Disease (ESRD) where a treating physician has certified for the month in which services are received that in the physician's opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in:
1. Placing the member's health in serious jeopardy, or
2. Serious impairment of bodily function, or
3. Serious dysfunction of a bodily organ or part.

C. Covered services. Services are considered emergency services if all of the criteria specified in subsection (A) are satisfied at the time the services are rendered. The Administration shall determine whether an emergency condition exists on a case-by-case basis.

D. Prior authorization. A provider is not required to obtain prior authorization for emergency services for FES members. Prior authorization for outpatient dialysis services is met when the treating physician has completed and signed a monthly certification as described in subsection (B).

E. Services rendered through the Federal Emergency Services Program are subject to all exclusions and limitation on services in this Article including but not limited to the limitations on inpatient hospital services in R9-22-204.

Historical Note

Adopted 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). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1868, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-218. Repealed

Historical Note

Section R9-22-218 renumbered from R9-22-206 effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3).

ARTICLE 3. GENERAL ELIGIBILITY REQUIREMENTS

R9-22-301. General Eligibility Definitions

Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article, Article 14 and Article 15 have the following meanings unless the context explicitly requires another meaning:

"Applicant," notwithstanding R9-22-101, means a person listed on an application for whom AHCCCS coverage is being sought.

"BHS" means the division of Behavioral Health Services within the Arizona Department of Health Services.

"CRS" means the program administered by the Administration or its designee that provides covered medical services and covered support services in accordance with A.R.S. 36-261.

"DCSS" means the Division of Child Support Services, which is the division within the Department that administers the Title IV-D program and includes a contract agent operating a child support enforcement program on behalf of the Department.

"FAA" means the Family Assistance Administration, the administration within the Department's Division of Benefits and Medical Eligibility with responsibility for providing cash and food stamp assistance to a member and for determining eligibility for AHCCCS medical coverage.

"Income" means combined earned and unearned income.

"Medical support" means to provide health care coverage in the form of health insurance or court-ordered payment for medical care.

"Member" means an applicant who has been determined to qualify for AHCCCS coverage by the Administration or its designee.

"Pre-enrollment process" means the process that provides an applicant the opportunity to choose an AHCCCS health plan before the determination of eligibility is completed.

"Resources" means real and personal property, including liquid assets.

"Sponsor" means an individual who signs the USCIS I-864 Affidavit of Support agreeing to support a non-citizen as a condition of the non-citizen's admission for permanent residence in the United States.

"Sponsor deemed income" means the unearned income deemed available to the applicant named on the USCIS I-864 Affidavit of Support.

"SVES" means the State Verification and Exchange System, a system through which the Department exchanges income and benefit information with the Internal Revenue Service, Social Security Administration, and State Wage and Unemployment Insurance Benefit data files.

"USCIS" means the United States Citizen and Immigration Services.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-301 renumbered together with former Section R9-22-102 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section R9-22-301 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (8), subsection (E), paragraph (3), and subsection (J), paragraph (5) effective October 1, 1986 (Supp. 86-5). Amended subsections (C) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective October 1, 1987; amended subsection (D) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section reserved by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). New Section made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; the adoption of this Section was slated to be codified in Supp. 14-1 but due to a clerical error, was not published. The new Section was published in Supp. 20-4 and no additional amendments have been made to this Section since January 7, 2014 (Supp. 20-4).

R9-22-302. AHCCCS Eligibility Application

Application Process

1. Right to apply. A person may apply for AHCCCS medical coverage by submitting an Administration-approved application to the Administration or its designee, an FAA office, or one of the following outstation locations:
   a. A BHS site;
   b. A Federally Qualified Health Center or disproportionate share hospital under 42 U.S.C. 1396r-4; or
   c. Any other site, including a hospital, approved by the Administration or its designee.
2. Application. To initiate the application process, the Administration or its designee will accept an application from the applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in section 36B(d)(1) of the Internal Revenue Service (IRS) Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant by submitting a written or online application under 42 CFR 435.907.
   a. A phone or written application must contain at least the following to be submitted to the Administration or its designee:
      i. Applicant's legible name,
      ii. Address or location where the applicant can be reached,
      iii. Signature of the person submitting the application,
      iv. Date the application was signed.
      v. The Administration or its designee shall require that a third party witness the signing and attest by signing the application if the individual signing the application signs with a mark.
   b. An online application must be completed in full in order to be submitted to the Administration or its designee.
3. Incomplete application. If the application is incomplete, the Administration or its designee shall do at least one of the following:
   a. Contact an applicant or an applicant's representative by telephone or electronic medium to obtain the missing information required for an eligibility determination;
   b. Mail a request for additional information to an applicant or an applicant's representative, allowing 10 days from the date of the request to provide the required additional information; or
   c. Meet with the applicant, representative, or household member.
4. Date of application. The date of application is the date application is received by the Administration or its designee either on-line or at a location listed in subsection (1).
5. Complete application form. The Administration or its designee shall consider an application complete when all questions are answered. The same person as listed under subsection (2) is the person that must sign the completed application. The application shall be witnessed and signed by a third party if the individual signing the application signs with a mark.
6. Assistance with application. The Administration or its designee shall allow a person of the applicant's choice to accompany, assist, and represent the applicant in the application process.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-302 repealed, new Section R9-22-302 adopted effective November 20, 1984 (Supp. 84-6). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section reserved by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). New Section made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; the adoption of this Section was slated to be codified in Supp. 14-1 but due to a clerical error, was not published. The new Section was published in Supp. 20-4 and no additional amendments have been made to this Section since January 7, 2014 (Supp. 20-4).

R9-22-303. Prior Quarter Eligibility

A. Subject to CMS approval, prior quarter coverage eligibility shall be limited to applicants who meet the requirements in subsection (B) and who also:
1. Are eligible during any of the three months prior to application; and
2. Received one or more covered services described in 9 A.A.C. 22, Article 2 and Article 12, and 9 A.A.C. 28, Article 2 during the month; and
3. Would have qualified for Medicaid at the time services were received if the person had applied regardless of whether the person is alive when the application is made.

B. Prior quarter coverage eligibility is limited to applicants who are:
1. Under the age of 19, or
2. Pregnant, or

3. In the 60 day post-partum period beginning with the last day of the pregnancy.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-303 repealed, new Section R9-22-303 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section made by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 1849, with an immediate effective date of July 1, 2019 (Supp. 19-3).

R9-22-304. Verification of Eligibility Information

A. Except as provided in subsection (E), if information provided by or on behalf of an applicant or member on an application, renewal form or otherwise does not conflict with information obtained by the agency through an electronic data match, the Administration or its designee shall determine or renew eligibility based on such information.

B. The Administration or its designee shall not require an applicant, member, or representative to provide additional verification unless the verification cannot be obtained electronically or the verification obtained electronically conflicts with information provided by or on behalf of the applicant or member.

C. If information provided by or on behalf of an applicant or member does conflict with information obtained through an electronic data match, the applicant or member shall provide the Administration or its designee with information or documentation necessary to verify eligibility, including evidence originating from an agency, organization, or an individual with actual knowledge of the information.

D. Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both meet or both exceed the applicable income limit.

E. The Administration or its designee shall not accept the applicant's or member's statement by itself as verification of:

1. SSN;
2. Qualified alien status, except as described under 42 USC 1320b-7(d)(4)(A); or
3. Citizenship, except as described under 42 USC 1396a(ee)(1).

F. The Administration or its designee shall give an applicant or member at least 10 days from the date of a written or electronic request for information to provide required verification. The Administration or its designee may deny the application or discontinue eligibility if an applicant or a member does not provide the required information timely.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-304 repealed, new Section R9-22-304 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-304 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-305. Eligibility Requirements

As a condition of eligibility, the Administration or its designee must require applicants, and members to do the following:

1. Take all necessary steps to obtain any annuities, pensions, retirement, disability benefits to which they are entitled, unless they can show good cause for not doing so.
2. Furnish a SSN under 42 CFR 435.910 and 435.920, or in the absence of an SSN, provide proof of a submitted application of SSN. The Administration or its designee will assist in obtaining or verifying the applicant's SSN under 42 CFR 435.910 if an applicant cannot recall the applicant's SSN or has not been issued a SSN. An applicant is not required to furnish an SSN if the applicant is not able to legally obtain a SSN. The Administration or its designee shall determine eligibility notwithstanding the applicant's lack of a SSN, if the applicant is cooperating with the Administration or its designee to obtain a SSN and obtain a SSN prior to the next scheduled review of eligibility.
3. Provide proof of residency of Arizona. An applicant or a member is not eligible unless the applicant or member is a resident of Arizona under 42 CFR 435.403 effective 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.
4. A written declaration, signed under penalty of perjury, must be provided for each person for whom benefits are being sought stating whether the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is a qualified alien. The declaration must be provided by the individual for whom eligibility is being sought or an adult member of the individual's family or household.
5. Each applicant who claims qualified alien status must provide either:
   a. Alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or
   b. Other documents that the Administration or its designee accepts as evidence of immigration status, such as:
      i. A Form I-94 Departure Record issued by the USCIS,
      ii. A Foreign Passport,
      iii. A USCIS Parole Notice,
      iv. A Victim of Trafficking Certification or Eligibility Letter issued by the US DHHS Office of Refugee Resettlement,
      v. Other documentation consistent with 42 CFR 435.406 or 435.407.
   c. Sufficient information for the Administration or its designee to obtain electronic verification of immigration status from the USCIS.
6. If a person for whom eligibility is being sought, states that they are an alien, that person is not required to comply with subsections (4) and (5); however, if they do not comply with those sections, and if they meet all other eli-

gibility criteria, benefits will be limited to those necessary to treat an emergency medical condition.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-305 repealed, new Section R9-22-305 adopted effective November 20, 1984 (Supp. 84-6). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-305 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-306. Administration, Administration's designee or Member Responsibilities

A. The Administration or its designee is responsible for the following:

1. The Administration or its designee shall determine eligibility within 90 days for an applicant applying on the basis of disability and 45 days for all other applicants, unless:
   a. The agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or
   b. When there is an administrative or other emergency beyond the agency's control.
2. If an applicant dies while an application is pending, the Administration or its designee shall complete an eligibility determination for the deceased applicant.
3. The Administration or its designee shall complete an eligibility determination on an application filed on behalf of a deceased applicant.
4. During the application process the Administration or its designee shall provide information to the applicant or member explaining the requirements to:
   a. Cooperate with DCSS in establishing paternity and enforcing medical support, except in circumstances when good cause under 42 CFR 433.147 exists for not cooperating;
   b. Establish good cause for not cooperating with DCSS in establishing paternity and enforcing medical support, when applicable;
   c. Report a change listed under subsection (B)(3)(c) no later than 10 days from the date the applicant or member knows of the change;
   d. Send to the Administration or its designee any medical support payments resulting from a court order;
   e. Cooperate with the Administration or its designee's assignment of rights and securing payments received from any liable party for a member's medical care.
5. Offer to help the applicant or member to complete the application form and to obtain the required verification;
6. Provide the applicant or member with information explaining:
   a. The eligibility and verification requirements for AHCCCS medical coverage;
   b. The requirement that the applicant or member obtain and provide a SSN to the Administration or its designee;
   c. How the Administration or its designee uses the SSN;
7. Explain to the applicant or member the practice of exchange of eligibility and income information through the electronic service established by the Secretary;
8. Explain to the applicant and member the right to appeal an adverse action under R9-22-315;
9. Use any information provided by the member to complete data matches with potentially liable parties;
10. Explain the eligibility review process;
11. Explain the AHCCCS pre-enrollment process;
12. Use the Systematic Alien Verification for Entitlements (SAVE) process to verify qualified alien status;
13. Provide information regarding the penalties for perjury and fraud on the application;
14. Review any verification items provided by the applicant or member and inform the member of any additional verification items and time-frames within which the applicant or member shall provide information to the Administration or its designee;
15. Explain to the applicant or member the applicant's and member's responsibilities under subsection (B);
16. Transfer the applicant's information to other insurance affordability programs as described under 42 CFR 435.1200(e) when the applicant does not qualify for Medicaid;
17. Attain a written record of a collateral contact: such as a verbal statement from a representative of an agency or organization, or an individual with actual knowledge of the information;
18. Complete a review of eligibility:
   a. Any time there is a change in a member's circumstance that may affect eligibility,
   b. For a member approved for the MED program under R9-22-1435 through R9-22-1440 before the end of the six-month eligibility period,
   c. Of each member's continued eligibility for AHCCCS medical coverage once every 12 months;
19. The Administration or its designee shall discontinue eligibility and notify the member of the discontinuance under R9-22-307 if the member:
   a. Fails to comply with the review of eligibility,
   b. Fails to comply under 42 CFR 433.148 with the requirements and conditions of eligibility under this Article regarding assignment of rights and cooperation of establishing paternity and obtaining medical support, or
   c. Does not meet the eligibility requirements; and
20. Redetermine eligibility for a person terminated from the SSI cash program.
   a. Continuation of AHCCCS medical coverage. The Administration shall continue AHCCCS medical coverage for a person terminated from the SSI cash program until a redetermination of eligibility is completed.
   b. Coverage group screening. Before terminating a person from the SSI cash program, the Administration shall determine if the person is eligible for coverage as a person described in A.R.S. §§ 36-2901(6)(a)(i) through (vi) or 36-2934.
   c. Eligibility decision.
      i. If a person is eligible under this Article or 9 A.A.C. 28, Article 4, the Administration shall send a notice informing the applicant that AHCCCS medical coverage is approved.

ii. If a person is ineligible, the Administration shall send a notice to deny AHCCCS medical coverage.

B. Applicant and Member Responsibilities.

1. An applicant or a member shall authorize the Administration or its designee to obtain verification for initial eligibility or continuation of eligibility.
2. As a condition of eligibility, an applicant or a member shall:
   a. Provide the Administration or its designee with complete and truthful information. The Administration or its designee may deny an application or discontinue eligibility if:
      i. The applicant or member fails to provide information necessary for initial or continuing eligibility;
      ii. The applicant or member fails to provide the Administration or its designee with written authorization or electronic authorization to permit the Administration or its designee to obtain necessary initial or continuing eligibility verification;
      iii. The applicant or member fails to provide verification under R9-22-304 after the Administration or its designee made an effort to obtain the necessary verification but has not obtained the necessary information; or
      iv. The applicant or member does not assist the Administration or its designee in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility;
   b. Cooperate with the Division of Child Support Services (DCSS) in establishing paternity and enforcing medical support obligations when requested unless good cause exists for not cooperating under 42 CFR 433.147 as of October 1, 2012, which is incorporated by reference, on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments. The Administration or its designee shall not deny AHCCCS eligibility to an applicant who would otherwise be eligible, is a minor child, and whose parent or legal representative does not cooperate with the medical support requirements or first- and third-party liability requirements under Article 10 of this Chapter; and
   c. Provide the information needed to pursue third party coverage for medical care, such as:
      i. Name of policyholder,
      ii. Policyholder's relationship to the applicant or member,
      iii. Name and address of the insurance company, and
      iv. Policy number.
3. A member or an applicant shall:
   a. Send to the Administration or its designee any medical support payments received while the member is eligible that result from a medical support order;
   b. Cooperate with the Administration or its designee regarding any issues arising as a result of Eligibility Quality Control described under A.R.S. § 36-2903.01; and
   c. Inform the Administration or its designee of the following changes within 10 days from the date the applicant or member knows of a change:
      i. In address;
      ii. In the household's composition;
      iii. In income;
      iv. In resources, when required under the Medical Expense Deduction (MED) program;
      v. In Arizona state residency;
      vi. In citizenship or immigrant status;
      vii. In first- or third-party liability that may contribute to the payment of all or a portion of the person's medical costs;
      viii. That may affect the member's or applicant's eligibility, including a change in a woman's pregnancy status;
      ix. Death;
      x. Change in marital status; or
      xi. Change in school attendance.
4. As a condition of eligibility, an applicant or a member shall cooperate with the assignment of rights as required by R9-22-311. If the applicant or member receives medical care and services for which a first or third party is or may be liable, the applicant or member shall cooperate with the Administration or its designee in assisting, identifying and providing information to assist the Administration or its designee in pursuing any first or third party who is or may be liable to pay for medical care and services.
5. A pregnant woman under A.R.S. § 36-2901(6)(a)(ii) is not required to provide the Administration or its designee with information regarding paternity or medical support from a father of a child born out of wedlock.

C. Administration or its designee responsibilities at Eligibility Renewal.

1. The Administration or its designee shall renew eligibility without requiring information from the individual if able to do so based on reliable information available to the agency, including through an electronic data match. If able to renew eligibility based on such information, the Administration or its designee shall send the member notice of:
   a. The eligibility determination; and
   b. The member's requirement to notify the Administration or its designee if any of the information contained in the renewal notice is inaccurate.
2. If unable to renew eligibility, the Administration or its designee shall:
   a. Send a pre-populated renewal form listing the information needed to renew eligibility,
   b. Give the member 30 days from the date of the renewal form to submit the signed renewal form and the information needed,
   c. Send the member notice of the renewal decision under R9-22-312 or R9-22-1413(B) as applicable.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-306 repealed, new Section R9-22-306 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraphs (1) and (6) effective October 1, 1986 (Supp. 86-5). Amended subsection (B),

paragraph (1) and added a new subsection (N) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective October 1, 1987; amended subsection (N) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). 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). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-306 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-307. Approval or Denial of Eligibility

A. Approval. If the applicant meets all the eligibility requirements and conditions of eligibility of this Article, the Administration or its designee shall approve the application and provide the applicant with an approval notice. The approval notice shall contain:

1. The name of each approved applicant,
2. The effective date of eligibility for each approved applicant,
3. The reason and the legal citations if a member is approved for only emergency medical services, and
4. The applicant's right to appeal the decision.

B. Denial. If an applicant fails to meet the eligibility requirements or conditions of eligibility of this Article, the Administration or its designee shall deny the application and provide the applicant with a denial notice. The denial notice shall contain:

1. The name of each ineligible applicant,
2. The specific reason why the applicant is ineligible,
3. The income and resource calculations for the applicant compared to the income or resource standards for eligibility when the reason for the denial is due to the applicant's income or resources exceeding the applicable standard,
4. The legal citations supporting the reason for the ineligibility,
5. The location where the applicant can review the legal citations,
6. The date of the application being denied; and
7. The applicant's right to appeal the decision and request a hearing.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (C), added subsection (G) and (H) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-307 repealed, new Section R9-22-307 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) as an emergency effective December 4, 1985 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 85-6). Permanent amendment to subsection (A) effective February 5, 1986 (Supp. 86-1). Amended subsections (E) and (F) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). 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 under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-307 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-308. Reinstating Eligibility

The Administration or its designee shall reopen an application or reinstate eligibility of a member when any of the following conditions are met:

1. The denial or discontinuance of eligibility was due to an administrative error,
2. The discontinuance of eligibility was due to noncompliance with a condition of eligibility and the applicant or member complies prior to the effective date of the discontinuance,
3. The member informs the Administration or its designee of a change of circumstances prior to the effective date of the discontinuance, that would allow for continued eligibility, or
4. Following a discontinuance, the member qualifies for continuation of medical coverage pending an appeal.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended by adding subsection (C) effective March 2, 1984 (Supp. 84-2). Former Section R9-22-308 repealed, new Section R9-22-308 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). 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). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-308 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-309. Confidentiality and Safeguarding of Information

The Administration or its designee shall maintain the confidentiality of an applicant or member's records and limit the release of safeguarded information under R9-22-512 and 6 A.A.C. 12, Article 1. In the event of a conflict between R9-22-512 and 6 A.A.C. 12, Article 1, R9-22-512 prevails.

Historical Note

Adopted effective August 30, 1984 (Supp. 82-4). Amended (D)(1)(d) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-309 repealed, new Section R9-22-309 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5).

Amended subsection (F) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A), (B) and (C) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-309 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-310. Ineligible Person

A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution, or
2. Over age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except as allowed in 42 USC 1396d(h) or as allowed under the Administration's Section 1115 waiver.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended (B)(7) and added subsections (C) and (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-310 repealed, new Section R9-22-310 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (7) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-310 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-311. Assignment of Rights Under Operation of Law

By operation of law and under A.R.S. § 36-2903, a person determined eligible assigns rights to the system medical benefits to which the person is entitled.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-311 repealed, new Section R9-22-311 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-311 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-312. Member Notices

A. Contents of notice. The Administration or its designee shall issue a notice by mail, personal delivery, or electronic means when an action is taken regarding a person's eligibility or premiums. The notice shall contain the following information:

1. The date of the notice issued;
2. A statement of the action being taken;
3. The effective date of the action;
4. The specific reason for the intended action;
5. If eligibility is being discontinued due to income in excess of the income standards, the actual figures used in the eligibility determination and the amount by which the person exceeds income standards;
6. If a premium is imposed or increased, the actual figures used in determining the premium amount;
7. The specific law or regulation that supports the action, or a change in federal or state law that requires an action;
8. An explanation of the member's rights to an appeal and continued benefits.

B. Advance notice of changes in eligibility or premiums. "Advance notice" means a notice that is issued to a person at least 10 days before the effective date of the change. Except as specified in subsection (C), advance notice shall be issued whenever the following adverse action is taken:

1. To discontinue or suspend or reduce eligibility or covered services; or
2. To impose a premium or increase a person's premium.

C. The Administration or its designee shall issue a Notice of Adverse Action to a member no later than the effective date of action if:

1. The Administration or its designee receives a request to withdraw;
2. A person provides information that requires termination of eligibility or an increase or imposition of the premium and the person signs a clear written statement waiving advance notice;
3. A person cannot be located and mail sent to that person has been returned as undeliverable;
4. A person has been admitted to a public institution where the person is ineligible under R9-22-310;
5. A person has been approved for Medicaid or CHIP in another state; or
6. The Administration or its designee has information that confirms the death of the person.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (B), added subsection (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-312 repealed, new Section R9-22-312 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-312 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-313. Withdrawal of Application

A. An applicant may withdraw an application at any time before the Administration or its designee completes an eligibility determination by making an oral or written request for withdrawal to the Administration or its designee and stating the reason for withdrawal.

B. If an applicant orally requests withdrawal of the application, the Administration or its designee shall document the:
1. Date of the request,
2. Name of the applicant for whom the withdrawal applies, and
3. Reason for the withdrawal.

C. An applicant may withdraw an application in writing by:
1. Completing an Administration-approved voluntary withdrawal form; or
2. Submitting a written, signed, and dated request to withdraw the application.

D. The effective date of the withdrawal is the date of the application.

E. If an applicant requests to withdraw an application, the Administration or its designee shall:
1. Deny the application, and
2. Notify the applicant of the denial following the notice requirements under R9-22-307.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended subsections (C) and (D) as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended subsections (D) and (E) as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-313 repealed, new Section R9-22-313 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E) and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). 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). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-313 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-314. Withdrawal from AHCCCS Medical Coverage

A. A member may withdraw from AHCCCS medical coverage at any time by giving oral or written notice of withdrawal to the Administration or its designee. The member or the member's legal or authorized representative shall provide the Administration or its designee with:
1. The reason for the withdrawal,
2. The date the notice is effective, and
3. The name of the member for whom AHCCCS medical coverage is being withdrawn.

B. If a notice of withdrawal does not identify specific members the Administration or its designee shall discontinue eligibility for any members that the person submitting the withdrawal has legal authority to act on behalf of.

C. The Administration or its designee shall notify the member of the discontinuance as required by R9-22-312.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsection (A) and added subsection (F) as an emergency effective February 28, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended subsection (A) and added subsection (F) as a permanent rule effective May 16, 1983; text of the amended rule identical to the emergency (Supp. 83-3). Former Section R9-22-314 repealed, new Section R9-22-314 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-314 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-315. Notice of Adverse Action

A. Adverse actions. An applicant or member may appeal, as described under Chapter 34, by requesting a hearing from the Administration or its designee concerning any of the following adverse actions:
1. Complete or partial denial of eligibility under R9-22-307 and R9-22-313(E);
2. Suspension, termination, or reduction of AHCCCS medical coverage under R9-22-307, R9-22-312 and R9-22-314;
3. Delay in the eligibility determination beyond the timeframes under this Article;
4. The imposition of or increase in a premium or copayment; or
5. The effective date of eligibility.

B. Notice of Adverse Action. The Administration or its designee shall personally deliver or send, by mail, or electronic means a Notice of Adverse Action to the person affected by the action. For the purpose of this Section, the date of the Notice of Adverse Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.

C. Automatic change and hearing rights.
1. An applicant or a member is not entitled to a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
2. An applicant or a member is entitled to a hearing if a federal or state law requires an automatic change and the applicant or member timely files an appeal that alleges a misapplication of the facts to the law.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-315 repealed, new Section R9-22-315 adopted effective November 20, 1984 (Supp. 84-6). Repealed effective October 1, 1985 (Supp. 85-5). New Section R9-22-315 adopted effective February 5, 1986 (Supp. 86-1). Amended effective February 26, 1988 (Supp. 88-1). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking

at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-315 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-316. Exemptions from Sponsor Deemed Income

A. An applicant shall provide proof to the Administration or its designee when claiming an exemption from sponsor deemed income.

B. The Administration or its designee shall grant an exemption from deeming a sponsor's income for a Lawful Permanent Resident applicant if the applicant:
1. Adjusted immigration status to Lawful Permanent Resident from status as a refugee or asylee;
2. Is the spouse or dependent child of the sponsor and lives with the sponsor;
3. Is indigent as specified in subsection (C);
4. Is a victim of domestic violence or extreme cruelty as specified in subsection (D); or
5. Has acquired 40 qualified quarters of work credit based on earnings as specified in subsection (E).

C. Exemption from sponsor deeming based on indigence.
1. The Administration or its designee shall consider the applicant indigent and grant an exemption from sponsor deemed income for an applicant, for a period of 12 months beginning with the first month of eligibility if all the following are met:
   a. An applicant is indigent if all of the following are met:
      i. The applicant does not reside with the applicant's sponsor;
      ii. The applicant does not receive free room and board; and
      iii. The applicant's total gross income including monies received from the sponsor and the value of any vendor payments received for food, utilities, or shelter does not exceed 100% of the FPL for the size of the income group.
2. The Administration or its designee shall send a notice under 8 U.S.C. 1631(e)(2) to the Attorney General's Office when approving an applicant who is exempt from sponsor deemed income due to indigence.

D. The Administration or its designee shall grant an exemption from sponsor deemed income for an applicant who is a victim of domestic violence or extreme cruelty under 8 CFR 204.2 for a period of 12 months beginning with the first month of eligibility. The Administration or its designee shall redetermine the exemption status at each renewal.
1. The Administration or its designee considers an applicant to be a victim of domestic violence or extreme cruelty when all of the following are met:
   a. The applicant is the victim, the parent of a child victim, or the child of a parent victim;
   b. The perpetrator of the domestic violence or extreme cruelty was the spouse or parent of the victim or other family member related by blood, marriage or adoption to the victim;
   c. The perpetrator was residing in the same household as the victim when the abuse occurred;
   d. The abuse occurred in the United States;
   e. The applicant did not participate in the domestic violence or cruelty; and
   f. The victim does not currently live with the perpetrator.
2. The applicant shall provide proof that the applicant or the applicant's child is a victim of domestic violence or extreme cruelty by presenting one of the following:
   a. USCIS form I-360 Petition for Ameriasian, Widow, or Special Immigrant;
   b. USCIS form I-797 USCIS approval of the I-360 petition;
   c. Reports or affidavits concerning the domestic violence or cruelty documented by police, judges, or other court officials, medical personnel, school officials, clergy, social workers, counseling or mental health personnel, or other social service agency personnel;
   d. Legal documentation, such as an order of protection against the perpetrator or an order convicting the perpetrator of committing an act of domestic violence or extreme cruelty that chronicles the existence of domestic violence or extreme cruelty;
   e. Evidence that indicates that the applicant sought safe haven in a battered women's shelter or similar refuge because of the domestic violence or extreme cruelty against the applicant or the applicant's child; or
   f. Photographs of the applicant or applicant's child showing visible injury.

E. The Administration or its designee shall grant an exemption from sponsor deemed income for an applicant who has reached 40 qualifying quarters of work credit.
1. The Administration or its designee shall not count quarters credited after January 1, 1997 that were earned while the applicant was receiving any federal means-tested benefits.
2. The Administration or its designee shall not count the 40 qualifying quarters of work credit unless the credited quarters are:
   a. Quarters that the applicant worked;
   b. Quarters worked by the applicant's spouse or deceased spouse during their marriage; or
   c. Quarters worked by the applicant's parents when the applicant was under age 18.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as an emergency effective February 9, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of permanent rule identical to the emergency (Supp. 83-3). Amended effective October 1, 1983 (Supp. 83-5). Correction subsection (A), paragraph (1) amended effective October 1, 1983, (Supp. 83-6). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-316 repealed, new Section R9-22-316 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective October 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-316

made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-317. Sponsor Deemed Income

A. The Administration or its designee shall use income of a USCIS sponsor to determine eligibility for a non-citizen applicant, whether or not the income is available, to the non-citizen applicant unless exempt under R9-22-316.

B. Counting the income from a sponsor.
1. This Section applies to non-citizen applicants who:
   a. Are Lawful Permanent Residents under 8 CFR 101.3;
   b. Applied for Lawful Permanent Resident Status on or after December 19, 1997;
   c. Are sponsored by an individual who signed a USCIS I-864 Affidavit of Support; and
   d. Are eligible for full AHCCCS medical coverage.
2. Sponsor deemed income shall be considered the income of the non-citizen applicant only.
3. The Administration or its designee shall not use the provisions of this Section when:
   a. The applicant becomes a naturalized U.S. citizen;
   b. The applicant qualifies for an exemption listed in R9-22-316; or
   c. The sponsor dies.

C. Determining income from a sponsor.
1. For an applicant who is exempt from sponsor deeming under R9-22-316, only cash contributions actually received from the sponsor are countable income to the applicant.
2. For an applicant to whom the sponsor's income is deemed, the Administration or its designee shall exclude any cash contributions received from the sponsor.

D. Calculation of income from a sponsor.
1. The Administration or its designee shall include the total gross income of the sponsor and the sponsor's spouse, when living with the sponsor;
2. The Administration or its designee shall subtract an amount equal to 100% of the FPL for the sponsor's household size from the total gross income under (D)(1); and
3. The amount calculated under subsection (D)(2) is deemed as income to the applicant for purposes of determining eligibility.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-317 repealed, new Section R9-22-317 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-317 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-318. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-318 repealed, new Section R9-22-318 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) and added subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective October 1, 1987; amended subsection (A) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective December 13, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-319. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-319 repealed, new Section R9-22-319 adopted effective November 20, 1984 (Supp. 84-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-320. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-320 repealed, new Section R9-22-320 adopted effective November 20, 1984 (Supp. 84-6). Amended effective April 13, 1990 (Supp. 90-2). Repealed effective December 13, 1993 (Supp. 93-4).

R9-22-321. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-321 repealed, new Section R9-22-321 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (E) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-322. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 27, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-3). Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-323. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective November 20, 1984 Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (B) and (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B), (D) and (E) effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-324. Repealed

Historical Note

Adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-4). Former Section R9-22-324 adopted as an emergency renumbered as Section R9-22-327. New Section R9-22-324 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-324 repealed, former Section R9-22-323 renumbered as Section R9-22-324 and adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Former Section R9-22-324 repealed, new Section R9-22-324 adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-324 repealed, new Section R9-22-324 adopted effective November 20, 1984 (Supp. 84-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-325. Repealed

Historical Note

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-325 repealed, new Section R9-22-325 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Sup. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-326. Repealed

Historical Note

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-326 repealed, new Section R9-22-326 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-327. Repealed

Historical Note

Former Section R9-22-324 adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days renumbered as Section R9-22-327 and adopted as a permanent rule effective October 1, 1983 (Supp. 83-5). Former Section R9-22-327 repealed, new Section R9-22-327 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A), (D), (E), (G), (H), and (I) effective October 1, 1986 (Supp. 86-5). Amended subsection (D) and added a new subsection (J) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A) and (E) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-328. Repealed

Historical Note

Adopted as an emergency effective October 6, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-5). Emergency Expired. New Section R9-22-328 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (D) effective October 1, 1987 (Supp. 87-4). Amended subsection (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2).

Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-329. Repealed

Historical Note

Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-329 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-330. Repealed

Historical Note

Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-330 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-331. Repealed

Historical Note

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-332. Repealed

Historical Note

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1,1985 (Supp. 85-5). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-333. Repealed

Historical Note

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-334. Repealed

Historical Note

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-335. Repealed

Historical Note

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-336. Repealed

Historical Note

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective September 16, 1987 (Supp. 87-3). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-337. Repealed

Historical Note

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Correction to subsection (B), paragraph (1) (Supp. 87-3). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-338. Repealed

Historical Note

Adopted effective November 20, 1984 (Supp. 84-6). Heading changed effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-339. Repealed

Historical Note

Adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-340. Reserved

Historical Note
Adopted effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-341. Repealed

Historical Note
Adopted effective March 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-342. Repealed

Historical Note
Adopted effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-343. Repealed

Historical Note
Adopted 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). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-344. Repealed

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

ARTICLE 4. PENALTY FOR OBTAINING ELIGIBILITY BY FRAUD

R9-22-401. Definitions
Definitions. The following definitions apply specifically to terms used within this Article:

"Amounts incurred by the system" include capitation payments, costs incurred by any contractor in excess of capitation, reinsurance, and other administrative, legal or investigative costs associated with a person who obtained eligibility contrary to A.R.S. §§ 36-2905.04 and/or A.R.S. § 36-2991.

"Application for eligibility" means any request for benefits administered by AHCCCS under the authority of A.R.S. Title 36, Chapter 29, including applications for presumptive eligibility submitted to hospitals as described under Article 16 of this Chapter.

"Penalty" means an amount not to exceed the amounts incurred by the system during any time period that the person would have been ineligible for benefits but for the false or fraudulent information provided on the application for eligibility. A penalty does not include, and does not need to be reduced by, the amount of any overpayments that AHCCCS may be entitled to recoup from a person who violated A.R.S. § 36-2905.04 and/or A.R.S. § 36-2991.

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 R9-22-401 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 31, 1997 (Supp. 97-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-402. Determining the Amount of the Penalty

A. AHCCCS shall determine the amount of a penalty according to A.R.S. § 36-2905.04(B) or A.R.S. § 36-2991(B), whichever is applicable, and this Article.

B. In addition to any penalty imposed pursuant to ARS §§ 36-2905.04 or 36-2991, and this Article, the Administration may also recoup from the person the amounts incurred by the system as a part of the notice and appeal process described in this Article.

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 R9-22-402 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-403. Mitigating and Aggravating Circumstances

A. AHCCCS shall consider any of the following to be mitigating circumstances when determining the amount of a penalty for obtaining eligibility by fraud.

1. Degree of culpability. The degree of culpability of a person is a mitigating circumstance if the person did not intend to provide or cause to be provided false information on the application for eligibility but was negligent as to the truthfulness of the information provided.
2. Prior Offenses. At the time of the submittal of the application the person:
   a. Did not have any prior criminal convictions; and
   b. Had not been held civilly liable for defrauding a public assistance program.
3. Financial condition. The financial condition of a person who violates A.R.S. §§ 36-2905.04 or 36-2991 is a mitigating circumstance if the imposition of a penalty without reduction will render the person incapable of obtaining necessities of life such as food, clothing, and shelter. AHCCCS may consider the resources available to the person when determining the amount of the penalty.
4. Other matters as justice may require. AHCCCS shall take into account other circumstances of a mitigating nature, if in the interest of justice; the circumstances require a reduction of the penalty.

B. AHCCCS shall consider any of the following to be aggravating circumstances when determining the amount of a penalty for obtaining eligibility by fraud.

1. Degree of culpability. The degree of culpability of a person who provides or causes to be provided false information on the application for eligibility is an aggravating circumstance if the person knows or had reason to know that the information provided on the application for eligibility was false, or the person failed to correct the false information prior to AHCCCS incurring a financial loss as a result of the application for eligibility.
2. Prior offenses. At any time before the submittal of the application for eligibility, the person was held criminally or civilly liable for committing any fraud, waste, or abuse against any public assistance program.
3. Financial Loss. The person's violation of A.R.S. §§ 36-2905.04 or 36-2991 caused a loss to the system equal to or exceeding $5,000.00.
4. Other matters as justice may require. AHCCCS shall take into account other circumstances of an aggravating nature, if in the interest of justice; the circumstances require an increase of the penalty.

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 R9-22-403 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-404. Notice of Intent

A. If AHCCCS imposes a penalty pursuant to this Article, AHCCCS shall hand deliver or send by certified mail, return receipt requested, or Federal Express to the person, a written Notice of Intent to impose a penalty.

B. The Notice of Intent shall include:
1. The legal and factual basis for AHCCCS' determination that there has been a violation of A.R.S §§ 36-2905.04 and/or 36-2991;
2. The penalty;
3. The amounts incurred by the system as a result of the violation of A.R.S. §§ 36-2905.04 and/or 36-2991, if AHCCCS intends to recoup those amounts through this process; and
4. The procedure for requesting a State Fair Hearing.

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 R9-22-404 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-405. Failure to Respond to the Notice of Intent

If a person fails to respond to the Notice of Intent within the timeframe described in A.A.C. § R9-22-406(A), AHCCCS shall uphold the penalty and recoupment amounts described in the Notice of Intent.

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 R9-22-405 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 amended rule similar to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-406. Request for State Fair Hearing

A. To dispute the agency action described in the Notice of Intent, the person shall file a written Request for State Fair Hearing with AHCCCS within sixty (60) days from the date of receipt of the Notice of Intent.

B. If AHCCCS receives a timely request for a State Fair Hearing from the person, AHCCCS shall mail a Notice of Hearing pursuant to the Uniform Administrative Hearing Procedures described in A.R.S. Title 41, Chapter 6, Article 10.

C. AHCCCS shall accept a written request for withdrawal of a hearing request if the written request for withdrawal is received from the person before AHCCCS mails a Notice of Hearing under the Uniform Administrative Hearing Procedures described in A.R.S. Title 41, Chapter 6, Article 10.

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 R9-22-406 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-406 repealed, new Section R9-22-406 adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of the Section identical to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-407. Burden of Proof

A. In any State Fair Hearing conducted under this Article, AHCCCS shall prove a violation of A.R.S. §§ 36-2905.04 and/or 36-2991, and any aggravating circumstances by a preponderance of the evidence.

B. AHCCCS does not have to prove any specific intent to defraud.

C. A person shall bear the burden of producing and proving by a preponderance of the evidence any affirmative defense or any circumstance that would justify reducing the amount of the penalty.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-408. Rescission of the Notice of Intent
AHCCCS may rescind the Notice of Intent at any time prior to the State Fair Hearing without prejudice.

Historical Note
New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-22-501. General Provisions and Standards - Related Definitions
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Quality management" means a process used by professional health personnel through a formal program involving multiple organizational components and committees to:

Assess the degree to which services provided conform to desired medical standards and practices; and

Quality improvement or maintenance of care and services.

"Quality Improvement" means a process designed to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time, in the areas of clinical care and non-clinical care and is expected to have a favorable effect on health outcomes and member satisfaction. Quality Improvement includes focusing organizational efforts on improving performance and utilizing data to develop intervention strategies to improve performance and outcomes.

"Utilization management/review" means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided. Utilization management applies to a contractor's process to evaluate and approve or deny the medical necessity, appropriateness, efficacy and efficiency of health care services, procedures, or settings. Utilization review includes processes for prior authorization, concurrent review, retrospective review, and case management.

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 R9-22-501 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-501 repealed, former Section R9-22-502 renumbered and adopted without change as Section R9-22-501 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-501 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-502. Pre-existing Conditions
A. A contractor shall not impose a pre-existing condition exclusion with respect to covered services.
B. A contractor or subcontractor shall not adopt or use any procedure to identify a person who has an existing or anticipated medical or psychiatric condition in order to discourage or exclude the person from enrolling in the contractor's health plan or encourage the person to enroll in another health plan.

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 R9-22-502 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-502 renumbered without change as Section R9-22-501, former Section R9-22-503 renumbered and amended as Section R9-22-502 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-502 repealed, new Section R9-22-502 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4). Amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

R9-22-503. Provider Requirements Regarding Records
The provider shall maintain records that meet uniform accounting standards and generally accepted practices for maintenance of medical records, including detailed specification of all patient services delivered, the rationale for delivery, and the service date. A provider shall maintain and upon request, make available to a contractor and to the Administration, financial and medical records relating to payment for not less than five years from the date of final payment, or for records relating to costs and expenses to which the Administration has taken exception, five years after the date of final disposition or resolution of the exception. Providers shall provide one copy of a medical record at no cost if requested by the member.

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 R9-22-503 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-503 renumbered and amended as Section R9-22-502, new Section R9-22-503 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective May 30, 1986 (Supp. 86-3). Amended subsection (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (F) and (G) effective December 22, 1987 (Supp. 87-4). Amended subsection (I) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). New Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-504. Marketing; Prohibition Against Inducements; Misrepresentations; Discrimination; Sanctions
A. A contractor or the contractor's marketing representative shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure AHCCCS enrollment with the contractor. Any marketing solicitation offering a benefit, good, or service in excess of the covered services in Article 2 is deemed an inducement.
B. A marketing representative shall not misrepresent itself, the contracting health plan represented, or the AHCCCS program,

through false advertising, false statements, or in any other manner to induce a member of another contractor to enroll in the represented health plan. Violations of this subsection include, but are not limited to, false or misleading claims, inferences, or representations such as:

1. A member will lose benefits under the AHCCCS program or lose any other health or welfare benefits to which a member is legally entitled, if the member does not enroll in the represented contracting health plan;
2. Marketing representatives are employees of the state or representatives of the Administration, a county, or any health plan other than the health plan by which they are employed, or by which they are reimbursed; and
3. The represented health plan is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the health plan and the Administration.

C. A marketing representative shall not engage in any marketing or pre-enrollment practice that discriminates against a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.

D. The Administration shall hold a contractor responsible for a violation of this Section resulting from the performance of any marketing representative, subcontractor, agent, program, or process under the contractor's employ or direction and shall impose contract sanctions on the contractor as specified in contract.

E. A contractor shall produce and distribute informational materials that are approved by the Administration to each enrolled member or designated representative after the contractor receives notification of enrollment from the Administration. The contractor shall ensure that the informational materials include, at a minimum:

1. A description of all covered services as specified in contract;
2. An explanation of service limitations and exclusions;
3. An explanation of the procedure for obtaining services;
4. An explanation of the procedure for obtaining emergency services;
5. An explanation of the procedure for filing a grievance and appeal; and
6. An explanation of when plan changes may occur as specified in contract.

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 R9-22-504 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-504 repealed, former Section R9-22-505 renumbered and adopted without change as Section R9-22-504 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-504 repealed, former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-505. Standards, Licensure, and Certification for Providers of Hospital and Medical Services

A provider shall not provide hospital or medical services to a member unless the provider is licensed by the Arizona Department of Health Services and meets the requirements in 42 CFR 441 and 482, as of October 1, 2007, and 42 CFR 456 Subpart C, as of October 1, 2007, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation contains no future editions or amendments. An Indian Health Service (IHS) hospital and a Veterans Administration hospital shall not provide services to a member unless accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

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 R9-22-505 adopted as an emergency expired, former Section R9-22-506 adopted as an emergency now adopted, amended and renumbered as Section R9-22-505 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-505 renumbered without change as Section R9-22-504, new Section R9-22-505 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-505 renumbered and amended as Section R9-22-509, former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5). Editorial correction, spelling of "paraphernalia" in subsection (A) (Supp. 87-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). New Section made by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-506. 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 R9-22-506 adopted as an emergency adopted, amended and renumbered as Section R9-22-505, former Section R9-22-507 adopted as an emergency now adopted, amended and renumbered as Section R9-22-506 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (D) effective December 22, 1987 (Supp. 87-4). Repealed effective April 13, 1990 (Supp. 90-2). New Section adopted effective December 13, 1993 (Supp. 93-4). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-507. 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 R9-22-507 adopted as an emergency adopted, amended and renumbered as Section R9-22-506, former Section R9-22-508 adopted as an emergency now adopted, amended and renumbered as Section R9-22-507 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-507 repealed, new Section R9-22-507 adopted effective October 1, 1985 (Supp. 85-5).

Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-508. 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 R9-22-508 adopted as an emergency adopted, amended and renumbered as Section R9-22-507, former Section R9-22-509 adopted as an emergency now adopted, amended and renumbered as Section R9-22-508 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-509. Transition and Coordination of Member Care

A. A contractor shall assist in the transition of members to and from other AHCCCS contractors.

1. Both the receiving and relinquishing contractor shall:
   a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. If requested by the Administration, a contractor shall submit the policies and procedures regarding transition of members to the Administration for review and approval;
   b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
   c. Develop policies and procedures to be followed when transitioning members who have significant medical conditions; are receiving ongoing services; or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract;
3. The relinquishing contractor shall forward medical records and other relevant materials to the receiving contractor. The relinquishing contractor shall bear the cost of reproducing and forwarding medical records and other relevant materials;
4. Within the timelines specified in contract, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
   a. Information regarding the contractor's providers,
   b. Emergency numbers, and
   c. Instructions about how to obtain services.

B. A contractor shall not use a county or noncontracting provider health resource alternative to diminish the contractor's contractual responsibility or accountability for providing the full scope of covered services. The Administration may impose sanctions as described in contract if a contractor makes referrals to other agencies or programs to reduce expenses incurred by the contractor on behalf of its members.

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 R9-22-509 adopted as an emergency adopted, amended and renumbered as Section R9-22-508, former Section R9-22-510 adopted as an emergency now adopted and renumbered as Section R9-22-509 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-509 repealed, former Section R9-22-505 renumbered and amended as Section R9-22-509 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-510. 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 R9-22-510 adopted as an emergency adopted and renumbered as Section R9-22-509, former Section R9-22-511 adopted as an emergency now adopted, amended and renumbered as Section R9-22-510 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-510 repealed, new Section R9-22-510 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-511. 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 R9-22-511 adopted as an emergency adopted, amended and renumbered as Section R9-22-510, former Section R9-22-512 adopted as an emergency now adopted, amended and renumbered as Section R9-22-511 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-511 repealed, new Section R9-22-511 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-512. Release of Safeguarded Information

A. The Administration, contractors, providers, and noncontracting providers shall limit the release of safeguarded information to persons or agencies for the following purposes in accordance with 45 CFR 160 and 45 CFR 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments:

1. Official purposes directly related to the administration of the AHCCCS program including:
   a. Establishing eligibility and post-eligibility treatment of income, as applicable;
   b. Determining the amount of medical assistance;
   c. Providing services for members;
   d. Performing evaluations and analysis of AHCCCS operations;
   e. Filing liens on property as applicable;
   f. Filing claims on estates, as applicable; and

g. Filing, negotiating, and settling medical liens and claims.

2. Law enforcement. The Administration may release safeguarded information without the applicant's or member's written or verbal consent, for the purpose of conducting or assisting an investigation, prosecution, or criminal or civil proceeding related to the administration of the AHCCCS program.

3. The Administration may release safeguarded member information to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant or member.

B. Except as provided in subsection (A), the Administration, contractors, providers, and noncontracting providers shall disclose safeguarded information only to:

1. An applicant;
2. A member;
3. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
   a. An Administration employee, authorized representative, or responsible caseworker is present during the examination of the safeguarded information; or
   b. After written notification to the provider, and at a reasonable time and place.
4. Persons authorized by the applicant or member; or
5. A court order or subpoena compliant with 45 CFR 164.512(e), October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments.

C. The Administration, contractors, providers, and noncontracting providers shall safeguard identifiable information, protected health information as specified in 45 CFR 160, and information obtained in the course of application for or redetermination of eligibility concerning an applicant or member, that includes, but is not limited to the following:

1. Name and address;
2. Social Security number;
3. Social and economic conditions or circumstances;
4. Agency evaluation of personal information;
5. Medical data and information concerning medical services received, including diagnosis and history of disease or disability;
6. State Data Exchange (SDX) tapes, and other types of information received from outside sources for the purpose of verifying income eligibility and amount of medical assistance payments; and
7. Any information received in connection with the identification of legally liable third-party resources.

D. The restriction upon disclosure of information in this Section does not apply to:

1. De-identified information as described by 45 CFR 164.514, October 1, 2004, incorporated by reference in subsection (A); or
2. A disclosure, in response to a request for information, that complies with 45 CFR 160 and 45 CFR 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference in subsection (A).

E. A provider shall furnish records requested by the Administration or a contractor to the Administration or the contractor at no charge.

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 R9-22-512 adopted as an emergency adopted, amended and renumbered as Section R9-22-511, former Section R9-22-513 adopted as an emergency now adopted and renumbered as Section R9-22-512 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-512 repealed, new Section R9-22-512 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-513. 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 R9-22-513 adopted as an emergency adopted and renumbered as Section R9-22-512, former Section R9-22-514 adopted as an emergency now adopted, amended and renumbered as Section R9-22-513 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-513 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-513 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-514. 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 R9-22-514 adopted as an emergency adopted, amended and renumbered as Section R9-22-513, former Section R9-22-515 adopted as an emergency now adopted, amended and renumbered as Section R9-22-514 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-514 repealed, former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-515. 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 R9-22-515 adopted as an emergency adopted, amended and renumbered as Section R9-22-514, former Section R9-22-517 adopted as an emergency now adopted, amended and renumbered as Section R9-22-515 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-515 repealed, former Section R9-22-522 renumbered and amended as Section R9-22-515 effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-516. Renumbered

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 R9-22-516 adopted as an emergency expired, former Section R9-22-518 adopted as an emergency now adopted, amended and renumbered as Section R9-22-516 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-516 renumbered as Section R9-22-513 effective October 1, 1985 (Supp. 85-5).

R9-22-517. Renumbered

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 R9-22-517 adopted as an emergency adopted, amended and renumbered as Section R9-22-515, former Section R9-22-519 adopted as an emergency now adopted and renumbered and amended as Section R9-22-517 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5).

R9-22-518. Information to Enrolled Members

A. Each contractor shall produce and distribute printed informational materials to each member or family unit no later than 10 days of receipt of notification of enrollment from the Administration. The contractor shall ensure that the informational materials meet the requirements specified in the contractor's current contract.

B. A contractor shall provide a member with the name, address, and telephone number of the member's primary care provider no later than 10 days from the date of enrollment. The contractor shall include information on how the member may change primary care providers.

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 R9-22-518 adopted as an emergency adopted, amended and renumbered as Section R9-22-516, former Section R9-22-520 adopted as an emergency now adopted, amended and renumbered as Section R9-22-518 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-518 repealed, new Section R9-22-518 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-519. 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 R9-22-519 adopted as an emergency adopted, amended and renumbered as Section R9-22-517, former Section R9-22-521 adopted as an emergency now adopted, amended and renumbered as Section R9-22-519 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-519 repealed, new Section R9-22-519 adopted effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-520. Expired

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 R9-22-520 adopted as an emergency adopted, amended and renumbered as Section R9-22-518, former Section R9-22-522 adopted as an emergency now adopted, amended and renumbered as Section R9-22-520 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-520 repealed, new Section R9-22-520 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

R9-22-521. Program Compliance Audits

A. The Administration shall conduct an onsite program compliance audit of a contractor at least once every three years during the term of the Administration's contract with the contractor. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit.

B. An audit team may perform any or all of the following procedures:

1. Conduct private interviews and group conferences with members, physicians, other health professionals, and members of the contractor's administrative staff including, but not limited to, the contractor's principal management persons;
2. Examine records, books, reports, and papers of the contractor and any management company, and all providers or subcontractors providing health care and other services. The examination may include, but need not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the health plan, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

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 R9-22-521 adopted as an emergency adopted, amended and renumbered as Section R9-22-519, former Section R9-22-523 adopted as an emergency now adopted, amended and renumbered as Section R9-22-521 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-521 repealed, new Section R9-22-521 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

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 has not certified this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements

A. A contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.

B. In addition to any requirements specified in contract, a contractor shall:

1. Submit to the Administration a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
   a. Monitoring and evaluating the types of services provided,
   b. Identifying the numbers and costs of services provided,
   c. Assessing and improving the quality and appropriateness of care and services,
   d. Evaluating the outcome of care provided to members, and
   e. Determining the actions necessary to improve service delivery;
2. Submit the QM/UM plan to the Administration on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan to the Administration before implementation;
3. Receive approval from the Administration before implementing the initial or revised QM/UM plan;
4. Ensure that a QM/UM committee operates under the control of the contractor's medical director and includes representation from medical and executive management personnel. The committee shall:
   a. Oversee the development, revision, and implementation of the QM/UM plan; and
   b. Ensure that there are qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities; and
5. Ensure that the QM/UM activities include at least:
   a. Prior authorization for non-emergency or scheduled hospital admissions;
   b. Concurrent review of inpatient hospitalization;
   c. Retrospective review of hospital claims;
   d. Program and provider audits designed to detect over- or under-utilization, service delivery effectiveness, and outcome;
   e. Medical records audits;
   f. Surveys to determine satisfaction of members;
   g. Assessment of the adequacy and qualifications of the contractor's provider network;
   h. Review and analysis of QM/UM data;
   i. Measurement of performance using objective quality indicators;
   j. Ensuring individual and systemic quality of care;
   k. Integrating quality throughout the organization;
   l. Process improvement;
   m. Credentialing a provider network;
   n. Resolving quality of care grievances; and
   o. Quality improvement activities focused on improving the quality of care and the efficient, cost-effective delivery and utilization of services.

C. A member's primary care provider shall maintain medical records that:

1. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data;
2. Facilitate follow-up treatment; and
3. Permit professional medical review and medical audit processes.

D. Within 30 days following termination of the contract between a subcontractor and a contractor, the subcontractor or the subcontractor's designee shall forward to the primary care provider medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services.

E. The Administration shall monitor each contractor and the contractor's providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor's QM/UM plan.

1. A contractor and the contractor's providers shall cooperate with the Administration in the performance of the Administration's QM/UM monitoring activities; and
2. A contractor and the contractor's providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

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 R9-22-522 adopted as an emergency adopted, amended and renumbered as Section R9-22-520, former Section R9-22-524 adopted as an emergency now adopted and renumbered as Section R9-22-522 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-522 renumbered and amended as Section R9-22-515, new Section R9-22-522 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-523. Expired

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 R9-22-523 adopted as an emergency adopted, amended and renumbered as Section R9-22-521, former Section R9-22-525 adopted as an emergency now adopted, amended and renumbered as Section R9-22-523 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

R9-22-524. 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 R9-22-524 adopted as an emergency

adopted and renumbered as Section R9-22-522, former Section R9-22-526 adopted as an emergency now adopted, amended and renumbered as Section R9-22-524 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-524 repealed, new Section R9-22-524 adopted effective October 1, 1985 (Supp. 85-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

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

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of the permanent rule identical to the emergency (Supp. 83-3). Former Section R9-22-526 repealed, new Section R9-22-526 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-1).

R9-22-527. Renumbered

Historical Note

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5).

R9-22-528. Renumbered

Historical Note

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5).

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. 1396u-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

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 R9-22-601 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended 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).

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;
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 confi-

dential. 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 to discussion and revision of a proposal. The Administration shall not disclose information derived from a proposal submitted by a competing offeror.
4. The Administration shall allow for the adjustment of covered services by expansion, deletion, segregation, or combination in order to secure the most financially advantageous proposals for the state.
5. The Administration may conduct an investigation of a person or organization who has ownership or management interests in corporate offerors or affiliated corporate organizations of an offeror.
6. The Administration may issue a written request for best and final offers. The Administration shall state in the request the date, time, and place for the submission of best and final offers.
7. 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. The Administration shall state in the written request for best and final offers that if the offeror does not submit a notice of withdrawal or a best and final offer, the Administration shall take the most recent offer as the offeror's best and final offer.

C. Proposal rejection.

1. The Administration may reject an offeror's proposal if the offeror fails to supply the information requested by the Administration.
2. The offeror shall not disclose information pertaining to its proposal to any other offeror prior to contract award. The offeror may disclose proposal information to a person other than another offeror if the recipient agrees to keep the information confidential until contract award. Disclosure in violation of this subsection may be grounds for rejecting a proposal.
3. The Administration shall provide written notification to an offeror whose proposal is rejected. The rejection notice shall be part of the contract file and a public record.
4. If the Administration determines that it is in the best interest of the state, the Administration may reject any and all proposals, in whole or in part, under the RFP. The reasons for rejection shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a proposal is rejected in whole or in part.

D. Proposal cancellation. If the Administration determines that it is in the best interest of the state, the Administration may cancel a RFP. The reasons for cancellation shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a RFP is cancelled.

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 R9-22-602 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-603. Contract Award

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

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 R9-22-603 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

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 protester 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 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.
4. If the procurement officer fails to issue a decision within the time-limits in subsection (G)(1) or (G)(3), the protester 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.

Historical Note
Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended 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).

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
Adopted effective January 31, 1986 (Supp. 86-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). 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).

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. Standards 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 death, if applicable, but excluding 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.

"CHC" means a Community Health Center, which includes both Federally Qualified Health Centers and Rural Health Clinics.

"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 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 120 pediatric beds that is dedicated to providing 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 or fellowship 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 provider experiences as a result of having an approved graduate medical education program and that is not accounted for by the direct program costs.

"Intern and Resident Information System" means a software program used by teaching providers and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

"Medical education costs" means direct 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.

"Primary care GME program" means a graduate medical education program that prepares a physician for the practice of internal medicine, family medicine, pediatrics, obstetrics, geriatrics, or psychiatry.

"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 UB04 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
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 R9-22-701 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-701 repealed, new Section R9-22-701 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Section repealed; new Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 1782, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by exempt rulemaking at 13 A.A.R. 4032, effective November 1, 2007 (Supp. 07-4). Amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014; amended by exempt rulemaking at 20 A.A.R. 2755, effective January 1, 2015 (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 28 A.A.R. 837 (April 29, 2022), with an immediate effective date of April 5, 2022 (Supp. 22-2).

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 AHCCCS;
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

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 R9-22-702 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 identical to the emergency (Supp. 83-3). Former Section R9-22-702 repealed, new Section R9-22-702 adopted effective October 1, 1983 (Supp. 83-5). Amended by adding subsection (B) effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3217, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3).

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 HIS 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.

D. Prior authorization.
1. An AHCCCS-registered provider shall:
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.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.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

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 R-22-703 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-703 repealed, new Section R9-22-703 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (1) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective September 16, 1987 (Supp. 87-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 19 A.A.R. 3309, November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 27 A.A.R. 237, effective April 4, 2021 (Supp. 21-1).

R9-22-704. 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 R9-22-704 adopted as an emergency now adopted and amended as a permanent rule effective August 30 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended subsection A., Paragraph 2. effective October 1, 1985 (Supp. 85-5). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

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 amended rule identical to emergency (Supp. 83-3). Former Section R9-22-705 repealed, new Section R9-22-705 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (C) effective October 1, 1987; amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-706. 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 R9-22-706 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-706 repealed, new Section R9-22-706 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (D), (E), (F), and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (F) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (F) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 10 A.A.R. 4656, effective January 1, 2005 (Supp. 04-4).

R9-22-707. 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 R9-22-707 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Repealed as a permanent action effective May 16, 1983 (Supp. 83-3). New Section R9-22-707 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effec-

tive October 1, 1985 (Supp. 85-5). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

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 (HHS) 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 A.A.C. 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

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 R9-22-708 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-708 repealed, new Section R9-22-708 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-708 renumbered and amended as Section R9-22-709, new Section R9-22-708 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended by final rulemaking at 10 A.A.R. 4656, effective January 1, 2005 (Supp. 04-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

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.

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 R9-22-709 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-709 repealed, new Section R9-22-709 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-709 renumbered and amended as Section R9-22-713, former Section R9-22-708 renumbered and amended as Section R9-22-709 effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

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.
2. Procedure codes. The Administration shall maintain a current copy of the National Standard Code Sets mandated under 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004), 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.
   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 specified 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(l)(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 collocated 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 PBM 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). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective July 1, 1988 (Supp. 88-3). Amended subsection (B) effective April 27, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 11 A.A.R. 3830, effective November 12, 2005 (Supp. 05-3). Amended by exempt rulemaking at 18 A.A.R. 212, effective February 1, 2012 (Supp. 12-1). Amended by exempt rulemaking at 18 A.A.R. 1971, effective August 1, 2012 (Supp. 12-3). Amended by exempt rulemaking at 18 A.A.R. 2630, effective October 1, 2012 (Supp. 12-4). Amended by final rulemaking at 19 A.A.R. 1681, effective August 9, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3525, effective October 18, 2013 (Supp. 13-4)

R9-22-711. Copayments

A. For purposes of this Article:
1. A copayment is a monetary amount that a member pays directly to a provider at the time a covered service is rendered.
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. 1396d(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(6)(a)(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(6)(g).

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

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Sections R9-22-711 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-711 repealed, new Section R9-22-711 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). 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 September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4557, effective October 1, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 2194, effective May 3, 2004 (Supp. 04-2). Amended by exempt rulemaking at 10 A.A.R. 4266, effective October 1, 2004 (Supp. 04-3). Amended by final rulemaking at 16 A.A.R. 1449, effective October 1, 2010 (Supp. 10-3). Section amended by exempt rulemaking at 18 A.A.R. 461, effective April 1, 2012 (Supp. 12-1). Section amended by final rulemaking at 19 A.A.R. 2954, effective November 11, 2013 (Supp. 13-3). Amended by exempt rulemaking at 20 A.A.R. 128, effective December 30, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 2755, effective January 1, 2015 (Supp. 14-3).

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 pended for additional documentation required under A.R.S. § 36-2903.01(G)(4), the period during which the claim is pended 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)]
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

Adopted as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to emergency (Supp. 83-3). Former Section R9-22-712 repealed, new Section R9-22-712 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). New Section R9-22-712 adopted under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective January 14, 1997 (Supp. 97-1). Amended by exempt rulemaking at 10 A.A.R. 3831, effective August 25, 2004 (Supp. 04-3). Amended by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 17 A.A.R. 1337, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

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 AHCCCS inpatient hospital day of care into one of several tiers appro-

priate 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 meets 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 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 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 April 1, 2011 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 freestanding 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

New Section made by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by exempt rulemaking at 17 A.A.R. 1337, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

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 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)(2).
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)(ii) 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 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)(iii).
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 residents 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)(i).
      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. Reallocation 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 distributions 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 avail-

able 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)(i).

Historical Note

New Section made by final rulemaking at 13 A.A.R. 1782, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 13 A.A.R. 4032, effective November 1, 2007 (Supp. 07-4). Amended by final rulemaking at 21 A.A.R. 3469, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 24 A.A.R. 185, effective January 9, 2018 (Supp. 18-1). Amended by final rulemaking at 24 A.A.R. 3321, effective January 5, 2019 (Supp. 18-4).

R9-22-712.06. Supplemental Graduate Medical Education Fund Allocation

A. Gradual Medical Education (GME) reimbursement as of July 1, 2020.

1. In addition to distributions according to Section R9-22-712.05, and subject to the availability of funds and approval by CMS, the Administration shall annually distribute monies appropriated for the GME programs approved by the Administration to hospitals for direct and indirect costs for graduate medical education programs which were established or expanded on or after July 1, 2020. The Administration shall estimate the distributions using information possessed by the Administration as of December 15 of each calendar year. The actual distributions will be made using information possessed by the Administration as of September first of the year in which the new residency or fellowship begins.
2. Eligible Hospitals. A hospital is eligible for distributions under this Section 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;
   d. It has established a new GME program or expanded the number of residents or fellows in an existing GME program on or after July 1, 2020.
3. Eligible positions. For purposes of determining distributions under this Section the following resident and fellowship positions qualify to the extent that the training takes place in Arizona at an eligible health care facility:
   a. Filled resident or fellow positions in approved programs which began on or after July 1, 2020;
   b. Eligible positions do not include residents or fellows that receive payments for services under the Access to Professional Services Initiative (APSI) program established in the Contractors' prepaid capitation contracts with the Administration.
4. Annual Reporting
   a. By December 15 of each year, a GME program shall provide all of the following information for GME programs and positions which are expected to be eligible for funding under this Section as of the upcoming academic year (i.e., July 1 to June 30 of each year):
      i. The program name and number assigned by the accrediting organization if available;
      ii. The original date of accreditation if available;
      iii. The names of the sponsoring institution and all participating institutions expected as of the date of reporting;
      iv. The number of anticipated resident and fellowship positions eligible for funding as of the upcoming academic year;
      v. The number of months or partial months during the upcoming academic year that each resident or fellow is expected to work in each hospital or in a non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
      vi. The academic year of anticipated resident and fellowship positions;
      vii. The length of the program; and
      viii. The names and other information requested by AHCCCS to ensure the total GME distributions for each eligible position are not greater than the costs for each eligible position in the Intern and Resident Information System (IRIS) file.
   b. By December 15 of each year, a GME program located in a county with a population of less than 500,000 persons shall provide the estimated one-time and ongoing costs for each program which it expects to be eligible for funding.
   c. By September 1 of each year, a GME program shall provide the actual name of residents and fellows hired in the current academic year and other information requested by AHCCCS to ensure that total

GME distributions for the eligible position are not greater than the costs for each eligible position in the IRIS file.

B. Preliminary allocation of funds for urban hospitals. Annually by January 15, the Administration shall estimate the annual GME distributions under this Section using the funds appropriated for hospitals in counties with a population of 500,000 persons or more based on the number of new residents and fellows in graduate medical education programs in the following manner:

1. Each eligible resident and fellow is placed into tiers with the following priority:
   a. Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this Section for the previous academic year and who is continuing in the same GME program.
   b. Residents and fellows that are not a returning resident or fellow but are in a GME program for Family Medicine, Internal Medicine, General Pediatrics, Obstetrics and Gynecology, Psychiatry including Subspecialties, General Surgery, and any other program determined as high needs by the AHCCCS Administration.
   c. Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this Section in a prior year.
   d. All other residents and fellows.
2. The amount of the distribution for each GME program for direct costs is calculated as the product of:
   a. The number of eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospitals;
   b. The Arizona Medicaid utilization as determined by R9-22-712.05(B)(4)(c)(i) in the previous calendar year; and,
   c. The average direct cost per resident determined under R9-22-712.05(B)(4)(d) in the previous calendar year.
3. If monies are still remaining after direct funding has been allocated, indirect funding shall be allocated based on the priority of each tier and sub-tier. The amount of the distribution for each GME program for indirect costs is calculated as the product of:
   a. The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
   b. The indirect cost per resident per month calculated in R9-22-712.05(D)(4)(b)(vi) in the previous calendar year; and
   c. Twelve months.
   d. Funds shall be allocated based on the priority of each tier and sub-tier. Distributions for eligible positions in a tier or sub-tier with a lower priority will not receive a distribution until distributions are allocated for the costs of all positions in a higher tier or sub-tier. If funding is insufficient to fully fund a tier or sub-tier, the remainder of funds will be prorated for eligible positions in that tier or sub-tier.
4. Payments are made to participating hospitals based on the FTEs who worked at their hospitals per year.

C. Preliminary allocation of funds for rural hospitals. Annually by January 15, the Administration shall estimate the annual GME distributions under this Section using the funds appropriated for rural hospitals based on the number of eligible resident and fellow positions in graduate medical education programs located in a county with a population of less than 500,000 persons in the following manner:

1. Each resident and fellow will then be placed into a tier with the following priority:
   a. Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this Section for the previous academic year and who is continuing in the same GME program.
   b. Residents and fellows that are not a returning resident or fellow but are in a GME program for Family Medicine, Internal Medicine, General Pediatrics, Obstetrics and Gynecology, Psychiatry including Subspecialties, General Surgery, and any other program determined as high needs by the AHCCCS Administration.
   c. Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this Section in a prior year.
   d. All other residents and fellows.
2. Residents and fellows in each tier are further divided into four sub-tiers with the following priority based on the location of the sponsoring or participating hospital:
   a. Hospitals in a county designated by the Health Resource and Services Administration of the U.S. Department of Health & Human Services as a HPSA with a greater than 85 percent primary care shortage.
   b. Hospitals in a county designated as a HPSA with a greater than 50 percent to 85 percent primary care shortage.
   c. Hospitals in a county designated as a HPSA with a 25-50 percent primary care shortage.
   d. Hospitals in a county designated as a HPSA with a less than 25 percent primary care shortage.
3. Funds shall first be allocated for direct and indirect costs based in order of priority of each tier. If not enough funding is available to fully fund a tier or sub-tier, the remainder of funds will be prorated in a tier or sub-tier.
4. The amount of the distribution for each GME program for direct costs is calculated as the product of:
   a. The number of eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospitals;
   b. The Arizona Medicaid utilization determined under R9-22-712.05(B)(4)(c)(i); and,
   c. The actual direct cost per resident per year.
5. The amount of the distribution for each GME program for indirect costs is calculated as the product of:
   a. The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital;

b. The indirect cost per resident per month calculated in R9-22-712.05(D)(4)(b)(vi) in the previous calendar year; and
c. Twelve months.

6. Payments are made to participating hospitals based on the FTEs who worked at their hospitals per year.

D. Final allocation of funds. Annually no sooner than September 1 following the start of the academic year, the Administration will recalculate the allocation for urban and rural hospitals using the same methodology used to estimate distributions, but using the actual residents and fellows as reported in R9-22-712.06(A)(4)(c).

F. Exclusions. To ensure that residents and fellows are not double counted residents/fellows which receive funding through R9-22-712.06 shall not receive funding through R9-22-712.05.

Historical Note

New Section made by final rulemaking at 27 A.A.R. 2496 (October 29, 2021), with an immediate effective date of October 6, 2021 (Supp. 21-4). Amended by final rulemaking at 29 A.A.R. 923 (April 21, 2023), with an immediate effective date of March 31, 2023 (Supp. 23-1).

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 hospital that will result in the hospital's claims paid amount plus 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).

Exhibit 1. Pool Example

Pool A receives $2,000,000. Pool B receives $7,000,000. Pool C receives $3,000,000.

If all of the funds in Pool B are paid to eligible hospitals and there is $1,000,000 remaining, the remaining funds would be allocated to Pool A and Pool C based on the ratio of each pool's original allocation (original allocations of $2,000,000 and $3,000,000) to the total of their original allocation ($2,000,000 + $3,000,000 = $5,000,000).

Pool A would receive 2/5 of the remaining funds ($400,000) and Pool C would receive 3/5 of the remaining funds ($600,000).

Historical Note
Exhibit 1 made by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2).

R9-22-712.08. Federally Qualified Health Center and Rural Health Clinic Graduate Medical Education Program

A. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for primary care GME programs approved by the Administration to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) for direct and indirect program costs eligible for funding under A.R.S. § 36-2907.06(I).
1. 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).
2. For purposes of this subsection, the term "FQHC" includes Federally Qualified Health Center Look-Alikes.

B. Eligible health care facilities. A health care facility is eligible for a distribution under subsection (G) if all of the following apply:
1. It is an FQHC or RHC in Arizona that is the sponsoring institution of, or a full member of a consortium that is the sponsoring institution of, or a participating institution in, one or more approved primary care GME programs in Arizona;
2. It incurs direct or indirect costs for the training of residents in Arizona in approved primary care GME programs;
3. The GME program is not eligible for funding under R9-22-712.05; and
4. The GME program is not fully funded by the federal government.

C. Eligible residents and resident positions. For purposes of determining program allocation amounts under subsections (E) and (F) the following residents and 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. All filled resident positions in approved primary care GME programs; or
2. For approved primary care GME programs established for less than one year as of the date of annual reporting under subsection (D) and that 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.

D. Annual reporting. By April 1st of each year, an FQHC or RHC seeking a distribution under this subsection shall:
1. Provide to the Administration the following information about each approved primary care GME program:
   a. The program name and number assigned by the accrediting organization;
   b. The original date of accreditation of the program;
   c. The names of the sponsoring institution and all participating institutions current as of the date of reporting;
   d. The number of approved resident positions and the number of filled resident positions current as of the date of reporting;
   e. The academic year rotation schedule on file with the program current as of the date of reporting; and
   f. For programs described under subsection (C)(2), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
2. Provide to the Administration the most recent Medicare Cost Report for the FQHC or RHC seeking the distribution, and
3. For an FQHC or RHC that is a full member of a consortium that is the sponsoring institution of an approved primary care GME program, provide to the Administration a signed letter attesting to the responsibility of the full member FQHC or RHC for direct or indirect costs of training residents in the program.

E. Allocation of funds for direct graduate medical education costs. Annually the Administration shall allocate available funds for direct graduate medical education costs to each eligible FQHC or RHC in the following manner:
1. A Medicaid utilization percent for each FQHC or RHC seeking a distribution shall be calculated using the Medicare Cost Report submitted under subsection (D)(2), dividing the Title XIX visit count by the whole number of visits reported and rounding the result up to the nearest multiple of 5 percent.
2. A total number of residents eligible for funding in each program shall be calculated using the information submitted under subsection (D)(1), dividing the number of resident rotations in the year that take place in Arizona and not at a health care facility made ineligible under subsection (B) by the total number of resident rotations in the program for that year, multiplying the result by the total number of filled resident positions in the program and rounding to two digits after the decimal.
3. The allocation for direct graduate medical education costs for each eligible FQHC or RHC shall be calculated by multiplying the number of residents determined under subsection (E)(2) by the statewide average per-resident amount determined under this subsection and multiplying the result by the Medicaid utilization percent calculated for the FQHC or RHC under subsection (E)(1). The statewide average per-resident amount for the academic year ending June 30, 2022 is $170,090. Annually thereafter, a statewide average per-resident amount shall be calculated by applying the Federally Qualified Health Center PPS Market Basket Update less Productivity Adjustment published by CMS for the calendar year in which the GME academic year begins.

F. Allocation of funds for indirect program costs. Annually the Administration shall allocate available funds for indirect program costs to each eligible FQHC or RHC in the following manner:
1. By multiplying the number of residents determined under subsection (E)(2) by the statewide average per-resident amount determined under this subsection and multiplying the result by the Medicaid utilization percent calculated for the FQHC or RHC under subsection (E)(1). The statewide average per-resident amount for the academic year ending June 30, 2022 is $167,330;
2. Annually thereafter, a statewide average per-resident amount shall be calculated by applying the Federally Qualified Health Center PPS Market Basket Update less

Productivity Adjustment published by CMS for the calendar year in which the GME academic year begins.

G. Distribution of funds. On an annual basis subject to available funds, the Administration shall distribute to each eligible FQHC and RHC the sum of all amounts calculated for the FQHC or RHC under subsections (E)(3) and (F).

H. The Administration may enter into intergovernmental agreements with local, county, and tribal governments and any university under the jurisdiction of the Arizona Board of Regents wherein such entities may transfer funds or certify public expenditures to the Administration. Such funds or certification, subject to approval by CMS, will contribute to the state funding to qualify for federal matching funds. Those funds will be used for the purposes of reimbursing FQHCs and RHCs that are eligible under this rule and designated by the local, county, or tribal governments for receipt of the contributed funds. The Administration shall allocate available funds in accordance with subsections (E) and (F).

Historical Note
New Section made by final rulemaking at 28 A.A.R. 837 (April 29, 2022), with an immediate effective date of April 5, 2022 (Supp. 22-2).

R9-22-712.09. Hierarchy for Tier Assignment through September 30, 2014

TIER	IDENTIFICATION CRITERIA	ALLOWED SPLITS
MATERNITY	A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx.	None
NICU	Revenue Code of 174 and the provider has a Level II or Level III NICU.	Nursery
ICU	Revenue Codes of 200-204, 207-212, or 219.	Surgery Psychiatric Routine
SURGERY	Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list.	ICU
PSYCHIATRIC	Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND primary Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx - 316.xx, classify as a psychiatric claim.	ICU
NURSERY	Revenue Code of 17x, not equal to 174.	NICU
ROUTINE	Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.	ICU

Historical Note
New Section made by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

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).

R9-22-712.11. Reserved

R9-22-712.12. Reserved

R9-22-712.13. Reserved

R9-22-712.14. 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 item CCR 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.

C. 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

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). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4).

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.

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

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). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4).

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, 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 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 (1)(a), (b), (c) or (d):
   a. By April 1, 2022, the hospital must have submitted a Letter of Intent (LOI) to 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 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 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 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.

xi. DAP HIE Data Quality Standards CYE 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%)

(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. (0.5%)

(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%)

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 Participa-

tion 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.

c. 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 (2)(a),(b), (c) or (d):

a. By April 1, 2022 the hospital must have submitted a LOI to 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 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 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 complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

viii. No later than 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.

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 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.

xi. DAP HIE Data Quality Standards CYE 2023 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 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. (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. (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. (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.

c. 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, and
   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 (3)(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 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 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.
   (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.

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 0.5% DAP increase for each category of the five measure categories, for a total potential increase of 2.0% 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%)
   (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. (0.5%)
   (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%)

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.

c. 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.

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 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.

e. 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.

f. 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.

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, and
   vi. Number of Telemetry beds available for use.

5. 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 (5)(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 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. 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 2022, 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.

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). Amended by final rulemaking at 28 A.A.R. 3283 (October 14, 2022), with an immediate effective date of September 23, 2022 (Supp. 22-3).

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.

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 exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

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

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 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 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.
3. "Medicare" means Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.
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
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. 2896, effective January 1, 2018 (Supp. 17-4).

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 801 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, 2022 through September 30, 2023, 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 (1)(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 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 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 October 2022 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.

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 0.5% DAP increase for each category of the five measure categories, for a total potential increase of 2.0% 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%)
(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. (0.5%)
(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%)

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.

c. 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, and
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 (2)(a), (b), (c), or (d):

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 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 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 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 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.
   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 DAP increase for 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. (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. (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. (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.

c. 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, and
vi. Number of Telemetry beds available for use.

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). Amended by final rulemaking at 28 A.A.R. 3283 (October 14, 2022), with an immediate effective date of September 23, 2022 (Supp. 22-3).

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 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 85 Fed. Reg. 59060 through 59061 (September 18, 2020). The hospital's wage index is determined based on the wage index tables reference in 85 Fed. Reg. 59059 (September 18, 2020). 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

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4). Amended by final rulemaking at 27 A.A.R. 2512 (October 29, 2021), with an immediate effective date of October 6, 2021 (Supp. 21-4).

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 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.

C. Notwithstanding Section R9-22-712.62, a rural hospital 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. A health care institution that is licensed as an acute care hospital, that has one hundred or fewer beds, and that is located in a county with a population of less than five hundred thousand persons; or
2. A health care institution that is licensed as a critical access hospital.

D. The rural hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.

E. Notwithstanding Section R9-22-712.62 and R9-22-712.63(B), a hospital standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) or R9-22-712.63(B) to calculate the DRG base rate for a health care institution that is licensed as an acute care hospital, that has one hundred or fewer beds, that is located in a county with a population of less than five hundred thousand persons and has greater than twenty percent of Medicaid inpatient reimbursement with a primary diagnosis of behavioral health in the prior federal fiscal year as of April 30th.

F. The hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.

G. Notwithstanding Section R9-22-712.62 and R9-22-712.63(B), a hospital standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) or R9-22-712.63(B) to calculate the DRG base rate for a health care institution with two separate ADHS acute care hospital licenses, with one facility that has one hundred or fewer beds, that is located in a county with a population of less than five hundred thousand persons and has one single AHCCCS registration for both licenses.

H. The hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.

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 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4). Amended by final rulemaking at 29 A.A.R. 19 (January 6, 2023), with an immediate effective date of December 16, 2022 (Supp. 22-4).

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.

C. 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

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final

rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.65. DRG Provider Policy Adjustor

A. After calculating the DRG base payment as required in 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 percent 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

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

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

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. 2896, effective January 1, 2018 (Supp. 17-4).

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 adjustors, 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 adjustors, 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

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

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, 2014 (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

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 801 E. Jefferson Street, Phoenix, Arizona.

E. 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:
   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 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 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 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.
      xi. DAP HIE Data Quality Standards CYE 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 2.0% 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%)
         (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. (0.5%)
(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%)

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 or forms for participation using the form or forms 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.

c. 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 the criteria specified;
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 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 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 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.

xi. DAP HIE Data Quality Standards CYE 2023 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 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. (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. (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. (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.

c. 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, and
vi. Number of Telemetry beds available for use.

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 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4). 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 31, 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). Amended by final rulemaking at 28 A.A.R. 3283 (October 14, 2022), with an immediate effective date of September 23, 2022 (Supp. 22-3).

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 same manner as other interim claims as described in R9-22-712.76.

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 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

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.
   e. 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
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 25 A.A.R. 3111, effective October 1, 2019 (Supp. 19-4).

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).

R9-22-712.77. DRG Reimbursement: Admissions and Dis-

charges 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 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

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

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 R9-22-712.63 and R9-22-712.64, the provider policy adjustor in R9-22-712.65, service policy adjustors in R9-22-712.66, and the fixed loss amounts and marginal cost percentages used to calculate the outlier threshold in 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

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

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 R9-22-712.20 through R9-22-712.30. All other covered codes shall be reimbursed in accordance with R9-22-712.20 through R9-22-712.30 without a percentage reduction.

1. 60 percent for a level 1 emergency department visit as indicated by CPT 99281.
2. 80 percent for a level 2 emergency department visit as indicated by CPT 99282.
3. 90 percent for a level 3 emergency department visit as indicated by CPT 99283.
4. 100 percent 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 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
Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Former Section R9-22-713 repealed, new Section R9-22-713 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714, former Section R9-22-709 renumbered and amended as Section R9-22-713 effective October 1, 1985 (Supp. 85-5). Amended 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).

R9-22-714. 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.

Historical Note

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule is similar to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714 effective October 1, 1985 (Supp. 85-5). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 9 A.A.R. 3800, effective October 4, 2003 (Supp. 03-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

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

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). New Section R9-22-715 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

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

Historical Note

Adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

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. § 36-2905.01 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 percent 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. Outpatient services in an urban hospital that result in an admission shall be paid as inpatient services in accordance with this Section.

E. Urban Hospital Contract.

1. Provisions of an urban hospital contracts. The urban hospital contract shall contain but is not limited to the following provisions:
   a. Required provisions as described in the Request for Proposals (RFP);
   b. Dispute settlement procedures. If the AHCCCS Grievance System prescribed in A.R.S. § 36-2903.01(B) and rule is not used, then arbitration shall be used;
   c. Arbitration procedure. If arbitration is used, the urban hospital contract shall identify:
      i. The parties' agreement on arbitrating claims arising from the contract,
      ii. Whether arbitration is nonbinding or binding,
      iii. Timeliness of arbitration,
      iv. What contract provisions may be appealed,
      v. What rules will govern arbitrations,
      vi. The number of arbitrators that shall be used,
      vii. How arbitrators shall be selected, and
      viii. How arbitrators shall be compensated.
   d. Timeliness of claims submission and payment;
   e. Prior authorization;
   f. Concurrent review;
   g. Electronic submission of claims;
   h. Claims review criteria;
   i. Payment of discounts or penalties such as quick-pay and slow-pay provisions;
   j. Payment of outliers;
   k. Claim documentation specifications under A.R.S. § 36-2904.
   l. Treatment and payment of emergency room services; and
   m. Provisions for rate changes and adjustments.
2. AHCCCS review and approval of urban hospital contracts:
   a. AHCCCS may review, approve, or disapprove the hospital contract rates, terms, conditions, and amendments to the contract;
   b. The AHCCCS evaluation of each urban hospital contract shall include but not be limited to the following areas:
      i. Availability and accessibility of services to members,
      ii. Related party interests,
      iii. Inclusion of required terms pursuant to this Section, and
      iv. Reasonableness of the rates.

F. Quick-Pay/Slow-Pay. A payment made by a contractor to a noncontracted hospital shall be subject to quick-pay discounts and slow-pay penalties under A.R.S. § 36-2904.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective January 29, 1997; pursuant to Laws 1996, Ch. 288, § 24 (Supp. 97-1). Amended by exempt rulemaking at 10 A.A.R. 500, effective February 1, 2004 (Supp. 04-1). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final 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;
   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:

1. "2019 Medicare Cost Report" means The Medicare Cost Report for the hospital fiscal year ending in calendar year 2019 as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated October 9, 2020.
2. "2019 Uniform Accounting Report" means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of December 10, 2020 for the hospital's fiscal year ending in calendar year 2019.
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, 2022.
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, 2022, 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. $829.50 per discharge and 1.5314% 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. $829.50 per discharge and 0.6381% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
3. $207.50 per discharge and 0.6381% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
4. $207.50 per discharge and 0.6381% 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. $663.50 per discharge and 1.6590% 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 2019 Uniform Accounting Report.
6. $746.50 per discharge and 1.9142% 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. $166.00 per discharge and 0.5105% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.
8. $829.50 per discharge and 2.5523% 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, 2022.

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 $207.50 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 24,000 discharges on the hospital's 2019 Medicare Cost Report, discharges in excess of 24,000 are assessed a rate of $83.00 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 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, 2022:
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".
3. Hospitals designated as type: hospital, subtype: psychiatric that reported fewer than 2,500 discharges on the 2019 Medicare Cost Report.
4. Hospitals designated as type: hospital, subtype; rehabilitation.
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 percentage of total Medicare days, per the 2019 Medicare Cost Report.
8. Hospitals designated as type: hospital, subtype: short-term that are an urban public acute care hospital.

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 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 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

New Section R9-22-730 made by exempt rulemaking at 20 A.A.R. 281, effective January 15, 2014 (Supp. 14-1). Amended by exempt rulemaking at 20 A.A.R. 1833, effective July 1, 2014 (Supp. 14-2). Amended by final exempt rulemaking at 21 A.A.R. 637, effective April 15, 2015 (Supp. 15-2). Amended by final exempt rulemaking at 21 A.A.R. 1486, effective July 16, 2015 (Supp. 15-3). Amended by final exempt rulemaking at 22 A.A.R. 2050, effective July 14, 2016 (Supp. 16-4). Amended by final exempt rulemaking at 23 A.A.R. 1945, effective July 1, 2017 (Supp. 17-2). Amended by final exempt rulemaking at 24 A.A.R. 2229, effective July 10, 2018 (Supp. 18-3). Amended by final exempt rulemaking at 25 A.A.R. 1938, effective July 1, 2019 (Supp. 19-3). Amended by final exempt rulemaking at 26 A.A.R. 1702, effective July 1, 2020 (Supp. 20-3). Amended by final exempt rulemaking at 26 A.A.R. 2984, effective October 1, 2020 (Supp. 20-4). Amended by final exempt rulemaking at 27 A.A.R. 2370, effective October 1, 2021 (Supp. 21-3). Amended by final exempt rulemaking 28 A.A.R. 2213 (September 2, 2022), effective October 1, 2022 (Supp. 22-3).

R9-22-731. Health Care Investment Fund - Hospital Assessment

A. For purposes of this Section, terms are the same as defined in A.A.C. R9-22-730 as provided below unless the context specifically requires another meaning.

B. Beginning October 1, 2022, 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, 2022, 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. $211.50 per discharge and 3.5149% 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. $211.50 per discharge and 1.645% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
3. $53.00 per discharge and 1.645% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
4. $53.00 per discharge and 1.645% 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. $169.25 per discharge and 3.8078% 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 2019 Uniform Accounting Report.
6. $190.50 per discharge and 4.3936% 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. $42.50 per discharge and 1.1716% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.
8. $211.50 per discharge and 5.8581% 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, 2022.

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 $53.00 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 24,000 discharges on the hospital's 2019 Medicare Cost Report, discharges in excess of 24,000 are assessed a rate of $21.25 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 10th 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 10th day of the second month of the quarter.

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, 2022:

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".
3. Hospitals designated as type: hospital, subtype: psychiatric that reported fewer than 2,500 discharges on the 2019 Medicare Cost Report.
4. Hospitals designated as type: hospital, subtype; rehabilitation.
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 percentage of total Medicare days, per the 2019 Medicare Cost Report.
8. Hospitals designated as type: hospital, subtype: short-term that are an urban public acute care hospital.

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 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 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.

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 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.

O. 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.

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). Amended by final rulemaking at 27 A.A.R. 2514 (October 29, 2021), with an immediate effective date of October 6, 2021 (Supp. 21-4). Amended by final exempt rulemaking at 28 A.A.R. 3351 (October 21, 2022), effective October 1, 2022 (Supp. 22-3).

ARTICLE 8. REPEALED

Article 8, consisting of 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 subsections (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 R9-22-801 adopted January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-802. 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 R9-22-802 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 29, 1985 (Supp. 85-5). Amended subsections (A), (B), (C) and (D) effective October 14, 1988 (Supp. 88-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-802 repealed, new Section R9-22-802 adopted effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-803. 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 R9-22-803 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-803 repealed, new Section R9-22-803 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-803 renumbered and amended as Section R9-22-804. Adopted effective January 31, 1986 (Supp. 86-1). Amended effective September 29, 1992 (Supp. 92-3). Former Section R9-22-803 repealed, new Section R9-22-803 adopted January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-804. 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 R9-22-804 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Former Section R9-22-804 repealed, former Section R9-22-803 renumbered and amended as Section R9-22-804 effective October 29, 1985 (Supp. 85-5). Amended effective October 14, 1988 (Supp.88-4). Amended subsections (B) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-804 repealed, new Section R9-22-804 adopted effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

Exhibit A. Repealed

Historical Note

New Exhibit adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Exhibit repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-805. Repealed

Historical Note

Former Section R9-22-805 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective January 31, 1986 (Supp. 86-1).

ARTICLE 9. REPEALED

R9-22-901. 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 R9-22-901 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). 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). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-902. Repealed

Historical Note

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-902 renumbered and amended as Section R9-22-904, former Section R9-22-903 renumbered and amended as Section R9-22-902 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-902 repealed, new Section R9-22-902 adopted effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). 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). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-903. Repealed

Historical Note

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-903 renumbered and amended as Section R9-22-902, former Section R9-22-904 renumbered and amended as Section R9-22-903 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-903 repealed, new Section R9-22-903 adopted effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-904. Repealed

Historical Note

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-904 renumbered and amended as Section R9-22-903, former Section R9-22-902 renumbered and amended as Section R9-22-904 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-905. Repealed

Historical Note

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-905 renumbered without change as Section R9-22-908, former Section R9-22-907 renumbered and amended as Section R9-22-905 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-906. Repealed

Historical Note

Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-907. Repealed

Historical Note

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-907 renumbered and amended as Section R9-22-905, former Section R9-22-908 renumbered and amended as Section R9-22-907 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-908. Repealed

Historical Note

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-908 renumbered and amended as Section R9-22-907, former Section R9-22-905 renumbered without change as Section R9-22-908 effective October 1, 1986 (Supp. 86-5). Former R9-22-908 repealed effective May 30, 1989 (Supp. 89-2). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-909. Repealed

Historical Note
New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES

R9-22-1001. Definitions

In addition to the definitions in A.R.S. §§ 36-2901, 36-2923 and 9 A.A.C. 22, Article 1, the following definitions apply to this Article:

"Absent parent" means an individual who is absent from the home and is legally responsible for providing financial and/or medical support for a dependent child.

"Cost avoid" means to deny a claim and return the claim to the provider for a determination of the amount of first- or third-party liability.

"First-party liability" means the obligation of any insurance plan or other coverage obtained directly or indirectly by a member that provides benefits directly to the member to pay all or part of the expenses for medical services incurred by AHCCCS or a member.

"Third-party" means a person, entity, or program that is, or may be, liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.

"Third-party liability" means any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a member under a state plan.

Historical Note
Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). Amended subsections (E) through (H) effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E), and (F) effective December 22, 1987 (Supp. 87-4). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

R9-22-1002. General Provisions

AHCCCS is the payor of last resort unless specifically prohibited by applicable state or federal law. AHCCCS is not the payor of last resort when the following entities are the third-party:

1. Indian Health Services (IHS/638), contract health,
2. Title IV-E,
3. Arizona Early Intervention Program (AZEIP),
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300,
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et seq., and
6. The Arizona Refugee Resettlement Program operated under 45 CFR Part 400, Subpart (G).

Historical Note
Section R9-22-529 adopted effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5). Amended subsections (C) and (D) effective October 1, 1986 (Supp. 86-5). Amended effective December 22, 1987 (Supp. 87-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

R9-22-1003. Cost Avoidance

A. The Administration's reimbursement responsibility.
1. The Administration shall pay no more than the difference between the Capped Fee-For-Service schedule and the amount of the third-party liability, unless Medicare is the third-party.
2. If Medicare is the third-party that is liable, the Administration shall pay the Medicare copayment, coinsurance, and deductible regardless of the Capped Fee-For-Service Schedule, as described under 9 A.A.C. 29, Article 3.

B. The Contractor's reimbursement responsibility.
1. If the contract between the contractor and the provider does not state otherwise, a contractor shall pay no more than the difference between the contracted rate and the amount of the third-party liability.
2. If the provider does not have a contract with the contractor, a contractor shall pay no more than the difference between the Capped Fee-For-Service rate and the amount of the third-party liability.

C. The following parties shall take reasonable measures to identify potentially legally liable first- or third-party sources:
1. AHCCCS, the Administration, or a contractor;
2. A provider;
3. A noncontracting provider; and
4. A member.

D. Except as specified under subsection (E), the Administration or a contractor shall cost avoid a claim for AHCCCS covered services under Article 2 if the Administration or a contractor has established the probable existence of a liable party at the time the claim is filed. Establishing liability takes place when the Administration or the contractor receives confirmation that another party is legally responsible for payment of a health care service under Article 2.

E. The Administration or contractor shall pay the full amount of the claim according to the Capped-Fee-For-Service Schedule or the contracted rate as described under subsection (B), and then seek reimbursement from any liable parties if the claim is for:
1. Prenatal care for pregnant women,

2. Preventive pediatric services, including E.P.S.D.T. and administration of vaccines to children under the Vaccines for Children (VFC) program; or
3. Services covered by third-party liability that is derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 3012, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

R9-22-1004. Member Participation
A member shall cooperate in identifying potentially legally liable first- or third-parties and timely assist the Administration and a contractor, provider, or noncontracting provider in pursuing any first- or third-party who may be liable to pay for covered services.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1005. Collections
A. Parties that notify AHCCCS. A provider or noncontracting provider shall cooperate with AHCCCS by identifying all potential sources of first- or third-party liability and notify AHCCCS of these sources.
B. Parties that pursue collection or reimbursement. AHCCCS, a provider, or noncontracting provider shall pursue collection or reimbursement from all potential sources of first- or third-party liability.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

R9-22-1006. AHCCCS Monitoring Responsibilities
AHCCCS shall monitor first- or third-party liability payments to a provider or noncontracting provider, which include but are not limited to payments by or for:
1. Private health insurance;
2. Employment-related disability and health insurance;
3. Long-term care insurance;
4. Other federal programs not excluded by statute from recovery;
5. Court ordered or non-court ordered medical support from an absent parent;
6. State worker's compensation;
7. Automobile insurance, including underinsured and uninsured motorists insurance;
8. Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
9. First-party probate estate recovery;
10. Adoption-related payment; or
11. A tortfeasor.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

R9-22-1007. Notification for Perfection, Recording, and Assignment of AHCCCS Liens
A. Hospital requirements. A hospital providing medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall within 30 days after a member's discharge:
1. Notify AHCCCS via facsimile or mail under R9-22-1008, or
2. Mail AHCCCS a copy of the lien the hospital proposes to record or has recorded under A.R.S. § 33-932.

B. Provider and noncontracting provider requirements. A provider or noncontracting provider, other than a hospital, rendering medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall notify AHCCCS via facsimile or mail under R9-22-1008 within 30 days after providing the service.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1008. Notification Information for Liens
A. Except as provided in subsection (B), a hospital, provider, and noncontracting provider identified in R9-22-1007 shall provide the following information to AHCCCS in writing:
1. Name of the hospital, provider or noncontracting provider;
2. Address of the hospital, provider or noncontracting provider;
3. Name of member;
4. Member's Social Security Number or AHCCCS identification number;
5. Address of member;
6. Date of member's admission or date service is provided;
7. Amount estimated to be due for care of member;
8. Date of discharge, if member has been discharged;
9. Name of county in which injuries were sustained; and
10. Name and address of all persons, firms, and corporations and their insurance carriers identified by the member or legal representative as being liable for damages.

B. If the date of discharge is not known at the time the information in subsection (A) is provided, a party identified in subsection (A) shall notify AHCCCS of the date of discharge within 30 days after the member has been discharged.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1009. Notification of Health Insurance Information
A provider or noncontracting provider shall notify AHCCCS, in writing, of the following health insurance information within 10 days of receipt of the health insurance information:
1. Name of member,
2. Member's Social Security Number or AHCCCS identification number,
3. Insurance carrier name,
4. Insurance carrier address,
5. Policy number or insurance holder's Social Security Number,
6. Policy begin and end dates, and
7. Insurance holder's name.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS

R9-22-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims; Definitions

A. Scope. This Article applies to prohibited acts as described under A.R.S. § 36-2918(A), and submissions of encounters to the Administration. The Administration considers a person who aids and abets a prohibited act affecting any of the AHCCCS programs or Health Care Group to be engaging in a prohibited act under A.R.S. § 36-2918(A).

B. Purpose. This Article describes the circumstances AHCCCS considers and the process that AHCCCS uses to determine the amount of a penalty, assessment, or penalty and assessment as required under A.R.S. § 36-2918. This Article includes the process and time-frames used by a person to request a State Fair Hearing.

C. Definitions. The following definitions apply to this Article:

1. "Assessment" means a monetary amount that does not exceed twice the dollar amount claimed by the person for each service.
2. "Claim" means a request for payment submitted by a person for payment for a service or line item of service, including a submission of an encounter.
3. "Day" means calendar day unless otherwise specified.
4. "File" means the date that AHCCCS receives a written acceptance, request for compromise, request for a counter proposal, or a request for a State Fair Hearing as established by a date stamp on the written document or other record of receipt.
5. "Penalty" means a monetary amount, based on the number of items of service claimed or reported, that does not exceed $2,000 times the number of line items of service.
6. "Person" means an individual or entity as described under A.R.S. § 1-215.
7. "Reason to know" or "had reason to know" means that a person, acts in deliberate ignorance of the truth or falsity of, or with reckless disregard of the truth or falsity of information. No proof of specific intent to defraud is required.

Historical Note
Adopted effective October 1, 1986 (Supp. 86-5). Amended subsection A. effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective June 9, 1998 (Supp. 98-2). Amended by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1102. Determining the Amount of a Penalty and an Assessment

A. AHCCCS shall determine the amount of a penalty and assessment according to A.R.S. § 36-2918(B) and (C), R9-22-1104, and R9-22-1105.

B. AHCCCS shall include in the amount of the penalty and assessment the cost incurred by AHCCCS for conducting the following;

1. An investigation,
2. Audit, or
3. Inquiry.

Historical Note
Adopted effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1103. Repealed

Historical Note
Adopted effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Section repealed by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1104. Mitigating Circumstances

AHCCCS shall consider any of the following to be mitigating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. Nature and circumstances of a claim. The following are mitigating circumstances:
   a. All the services are of the same type,
   b. All the dates of services occurred within six months or less,
   c. The number of claims submitted is less than 25,
   d. The nature and circumstances do not indicate a pattern of inappropriate claims for the services, and
   e. The total amount claimed for the services is less than $1,000.
2. Degree of culpability. The degree of culpability of a person who presents or causes to present a claim is a mitigating circumstance if:
   a. Each service is the result of an unintentional and unrecognized error in the process that the person followed in presenting or in causing to present the service,
   b. Corrective steps were taken promptly by the person after the error was discovered, and
   c. The person had a fraud and abuse control plan that was operating effectively at the time each claim was presented or caused to be presented.
3. Financial condition. The financial condition of a person who presents or causes to present a claim is a mitigating circumstance if the imposition of a penalty, assessment, or penalty and assessment without reduction will render the provider incapable to continue providing services. AHCCCS shall consider the resources available to the person when determining the amount of the penalty, assessment, or penalty and assessment.
4. Other matters as justice may require. AHCCCS shall take into account other circumstances of a mitigating nature, if in the interest of justice, the circumstances require a reduction of the penalty, assessment, or penalty and assessment.

Historical Note
Adopted effective October 1, 1986 (Supp. 86-5). Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1105. Aggravating Circumstances

AHCCCS shall consider any of the following to be aggravating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. Nature and circumstances of each claim. The nature and circumstances of each claim and the circumstances under which the claim is presented or caused to be presented are aggravating circumstances if:
   a. A person has forged, altered, recreated, or destroyed records;
   b. The person refuses to provide pertinent documentation to AHCCCS for a claim or refuses to cooperate with investigators;
   c. The services are of several types;
   d. All the dates of services did not occur within six months or less;
   e. The number of claims submitted is greater than 25;
   f. The nature and circumstances indicate a pattern of inappropriate claims for the services; and
   g. The total amount claimed for the services is $5,000 or greater.
2. Degree of culpability. The degree of culpability of a person who presents or causes to present each claim is an aggravating circumstance if:
   a. The person knows or had reason to know that each service was not provided as claimed,
   b. The person knows or had reason to know that no payment could be made because the person had been excluded from reimbursement by AHCCCS, or
   c. The person knows or had reason to know that the payment would violate the terms of an agreement between the person and AHCCCS system.
3. Prior offenses. The prior offenses of a person who presents or causes to present each claim are an aggravating circumstance if:
   a. At any time before the submittal of the claim the person was held criminally or civilly liable for any act, or
   b. The person had received an administrative sanction in connection with:
      i. A Medicaid program,
      ii. A Medicare program, or
      iii. Any other public or private program of reimbursement for medical services.
4. Effect on patient care. The adverse effect on patient care that resulted, or could have resulted, from the failure to provide medically necessary care by a person in connection with a claim.
5. Other matters as justice may require. AHCCCS shall take into account other circumstances of an aggravating nature, if in the interest of justice, the circumstances require an increase of the penalty, assessment, or penalty and assessment.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1106. Notice of Intent

If AHCCCS imposes a penalty, assessment, or a penalty and assessment, AHCCCS shall hand deliver or send by certified mail return receipt requested or Federal Express to the person, a written Notice of Intent to impose a penalty, assessment, or a penalty and assessment. The Notice of Intent shall include:

1. The statutory basis for the penalty, assessment, or the penalty and assessment;
2. Identification of the state or federal regulation and state or federal law that AHCCCS alleges has been violated;
3. The factual basis for AHCCCS' determination that the penalty, assessment, or the penalty and assessment should be imposed;
4. The amount of the penalty, assessment, or penalty and assessment;
5. The process for the person to accept or request a compromise of the penalty, assessment, or penalty and assessment; and
6. The process for requesting a State Fair Hearing.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1107. Reserved

R9-22-1108. Request for a Compromise

A. To request a compromise, the person shall file a written request with AHCCCS within 30 days from the date of receipt of the Notice of Intent. The written request for compromise shall contain the person's reasons for the reduction or modification of the penalty, assessment, or penalty and assessment.

B. Within 30 days from the date of receipt of the request for compromise from the person, AHCCCS shall send a Notice of Compromise Decision that accepts, denies, or offers a counter proposal to the person's request for compromise. If AHCCCS offers a counter proposal the amount of the counter proposal shall represent the penalty, assessment, or penalty and assessment.
   1. If AHCCCS does not withdraw the Notice of Intent under R9-22-1112 or denies the request for compromise the original penalty, assessment, or penalty and assessment is upheld.
   2. To dispute the Compromise Decision, the person shall file a request for a State Fair Hearing under R9-22-1110 within 30 days from the date of receipt of the Notice of Compromise Decision.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1109. Failure to Respond to the Notice of Intent

If a person fails to respond timely to the Notice of Intent, AHCCCS shall uphold the original penalty, assessment, or penalty and assessment.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1110. Request for State Fair Hearing

A. To request a State Fair Hearing regarding a dispute concerning a penalty, assessment, or penalty and assessment, the person

shall file a written request for a State Fair Hearing with AHCCCS within 60 days from the date of the receipt of the Notice of Intent under R9-22-1106 or within 30 days from the date of receipt of the Notice of Compromise Decision under R9-22-1108, if applicable.

B. AHCCCS shall mail a Notice of Hearing under A.R.S. § 41-1092.05 if AHCCCS receives a timely request for a State Fair Hearing from the person.

C. AHCCCS shall mail a Director's Decision to the person no later than 30 days after the date the Administrative Law Judge sends the decision of the Office of Administrative Hearings (OAH) to AHCCCS.

D. AHCCCS shall accept a written request for withdrawal of a hearing request if the written request for withdrawal is received from the person before AHCCCS mails a Notice of Hearing under A.R.S. § 41-1092 et seq. If AHCCCS mailed a Notice of Hearing under A.R.S. § 41-1092 et seq., a person may withdraw the hearing request only by sending a written request for withdrawal to OAH.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1111. Issues and Burden of Proof

A. Preponderance of evidence. In any State Fair Hearing conducted under R9-22-1110, AHCCCS shall prove by a preponderance of the evidence that a person presented or caused to be presented each claim in violation of this Article and any aggravating circumstances under R9-22-1105. A person shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty, assessment, or penalty and assessment.

B. Statistical sampling.

1. In meeting the burden of proof described in subsection (A), AHCCCS may introduce the results of a statistical sampling study as evidence of the number and amount of claims that were presented or caused to be presented by the person. A statistical sampling study constitutes prima facie evidence of the number and amount of claims if computed by valid statistical methods.
2. The burden of proof shall shift to the person to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once AHCCCS has made a prima facie case as described in subsection (B)(1). AHCCCS shall be given the opportunity to rebut this evidence.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1112. Withdrawal and Continuances

AHCCCS may withdraw the Notice of Intent at any time. Prior to referring a matter to the Office of Administrative Hearings the parties may mutually agree to a continuance.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-22-1201. Definitions

Definitions. The following definitions apply to this Article:

"Adult behavioral health therapeutic home" as defined in 9 A.A.C. 10, Article 1.

"Agency" for the purposes of this Article means a behavioral health facility, a classification of a health care institution, including a mental health treatment agency defined in A.R.S. § 36-501, that is licensed to provide behavioral health services according to A.R.S. Title 36, Chapter 4.

"Assessment" means an analysis of a patient's need for physical health services or behavioral health services to determine which services a health care institution will provide to the patient.

"Behavior management services" means services that assist the member in carrying out daily living tasks and other activities essential for living in the community, including personal care services.

"Behavioral health therapeutic home care services" means interactions that teach the client living, social, and communication skills to maximize the client's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services indicated by the client's treatment plan, as appropriate.

"Behavioral health services" means medical services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's behavioral health issue.

"Behavioral health technician" means an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and

Are provided with clinical oversight by a behavioral health professional.

"Case management" for the purposes of this Article, means services and activities that enhance treatment, compliance, and effectiveness of treatment.

"Certified psychiatric nurse practitioner" means a registered nurse practitioner who meets the psychiatric specialty area requirements under A.A.C. R4-19-505(C).

"Clinical oversight" means as described under 9 A.A.C. 10.

"Cost avoid" means to avoid payment of a third-party liability claim when the probable existence of third-party liability has been established under 42 CFR 433.139(b).

"Court-ordered evaluation" has the same meaning as "evaluation" in A.R.S. § 36-501.

"Court-ordered pre-petition screening" has the same meaning as "pre-petition screening" in A.R.S. § 36-501.

"Court-ordered treatment" means treatment provided according to A.R.S. Title 36, Chapter 5.

"Crisis services" means immediate and unscheduled behavioral health services provided to a patient to address an acute behavioral health issue affecting the patient.

"Direct supervision" has the same meaning as "supervision" in A.R.S. § 36-401.

"Emergency medical services provider" has the same meaning as in A.R.S. § 36-2201.

"Health care institution" has the same meaning as defined in A.R.S. § 36-401.

"Health care practitioner" means a:

Physician;

Physician assistant;

Nurse practitioner; or

Other individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. § 32-1901.

"Licensee" means the same as in 9 A.A.C. 10, Article 1.

"Medical practitioner" means a physician, physician assistant, or nurse practitioner.

"Partial care" means a day program of services provided to individual members or groups that is designed to improve the ability of a person to function in a community, and includes basic, therapeutic, and medical day programs.

"Physician assistant" means the same as in A.R.S. § 32-2501 except that when providing a behavioral health service, the physician assistant shall be supervised by an AHCCCS-registered psychiatrist.

"Psychiatrist" means a physician who meets the licensing requirements under A.R.S. § 32-1401 or a doctor of osteopathy who meets the licensing requirements under A.R.S. § 32-1800, and meets the additional requirements of a psychiatrist under A.R.S. § 36-501.

"Psychologist" means a person who meets the licensing requirements under A.R.S. §§ 32-2061 and 36-501.

"Qualified behavioral health service provider" means a behavioral health service provider that meets the requirements of R9-22-1206.

"Respite" means a period of care and supervision of a member to provide rest or relief to a family member or other person caring for the member. Respite provides activities and services to meet the social, emotional, and physical needs of the member during respite.

"TRBHA" or "Tribal Regional Behavioral Health Authority" means a Native American tribe under contract with ADHS/DBHS to coordinate the delivery of behavioral health services to eligible and enrolled members of the federally-recognized tribal nation.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

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

A. ADHS responsibilities. ADHS is responsible for payment of behavioral health services provided to members, except as specified under subsection (D). ADHS' responsibility for payment of behavioral health services includes claims for inpatient hospital services, which may include physical health services, when the principal diagnosis on the hospital claim is a behavioral health diagnosis. Behavioral health diagnoses are identified as "mental disorders" in the latest International Classification of Diseases (ICD) code set as required by AHCCCS claims and encounters.

B. ADHS/DBHS may contract with a TRBHA for the provision of behavioral health services for American Indian members. American Indian members may receive covered behavioral health services:

1. From an IHS or tribally operated 638 facility,
2. From a TRBHA, or
3. From a RBHA.

C. Contractor responsibilities. A contractor shall:

1. Refer a member to a RBHA under the contract terms;
2. Provide EPSDT developmental and behavioral health screening as specified in R9-22-213;
3. Coordinate a member's transition of care and medical records; and
4. Be responsible for providing covered inpatient hospital services, which may include behavioral health inpatient hospital services, when the principal diagnosis on the hospital claim is not a behavioral health diagnosis.

D. Administration and CRS responsibilities.

1. The Administration shall be responsible for payment of behavioral health services provided to an ALTCS FFS or an FES member and for behavioral health services provided by IHS and tribally operated 638 facilities. The Administration is also responsible for payment of behavioral health services provided to these members during prior quarter coverage.
2. CRS shall be responsible for payment of behavioral health services provided to members enrolled with CRS.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effec-

tive October 1, 2001 (Supp. 01-3). Amended to correct typographical errors, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4). Amended by final rulemaking at 21 A.A.R. 1225, effective July 7, 2015 (Supp. 15-3).

R9-22-1203. Eligibility for Covered Services

Title XIX members. A member determined eligible under A.R.S. § 36-2901(6)(a) or (g) except for the failure to meet U.S. citizenship or qualified alien status requirements, shall receive medically necessary covered services under Article 12 and Article 2.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1204. General Service Requirements

A. Services. Behavioral health services include mental health, substance abuse, and physical services. Medically necessary services shall be covered and service requirements met as described under Article 2 and Article 5.

B. Notification to Administration for American Indians enrolled with a tribal contractor. A provider shall notify the Administration no later than 72 hours after an American Indian member enrolled with a tribal contractor presents to a behavioral health hospital for inpatient emergency behavioral health services.

C. Restrictions and limitations. Room and board is not a covered service unless provided in a behavioral health inpatient facility under R9-22-1205.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective January 1, 1996; filed with the Secretary of State December 22, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1205. Scope and Coverage of Behavioral Health Services

A. Inpatient behavioral health services. The following inpatient services are covered subject to the limitations and exclusions in this Article and Article 2.

1. Covered inpatient behavioral health services include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment, if the service is provided under the direction of a physician in a Medicare-certified:
   a. General acute care hospital,
   b. Inpatient psychiatric unit in a general acute care hospital, or
   c. Behavioral health hospital.
2. Inpatient service limitations:
   a. Inpatient services, other than emergency services specified in this Section, are not covered unless prior authorization is obtained.
   b. Inpatient services and room and board are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
      i. A licensed psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A licensed physician assistant,
      iv. A licensed psychologist,
      v. A licensed clinical social worker,
      vi. A licensed marriage and family therapist,
      vii. A licensed professional counselor,
      viii. A licensed independent substance abuse counselor, and
      ix. A medical practitioner.

B. Behavioral Health Inpatient facility for children. Services provided in a Behavioral Health Inpatient facility for children as defined in 9 A.A.C. 10, Article 3 are covered subject to the limitations and exclusions under this Article.

1. Behavioral Health Inpatient facility for children services are not covered unless provided under the direction of a licensed physician in a licensed Behavioral Health Inpatient facility for children accredited by an AHCCCS-approved accrediting body as specified in contract.
2. Covered Behavioral Health Inpatient facility for children services include room and board and treatment services for behavioral health and substance abuse conditions.
3. Inpatient Behavioral Health Inpatient facility for children service limitations.
   a. Services are not covered unless prior authorized, except for emergency services as specified in this Section.
   b. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
      i. A licensed psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A licensed physician assistant,
      iv. A licensed psychologist,
      v. A licensed clinical social worker,

vi. A licensed marriage and family therapist,
vii. A licensed professional counselor,
viii. A licensed independent substance abuse counselor, and
ix. A medical practitioner.

4. The following may be billed independently if prescribed by a provider as specified in this Section who is operating within the scope of practice:
   a. Laboratory services, and
   b. Radiology services.

C. Covered Inpatient sub-acute agency services. Services provided in a inpatient sub-acute facility as defined in 9 A.A.C. 10, Article 1 are covered subject to the limitations and exclusions under this Article.

1. Inpatient sub-acute facility services are not covered unless provided under the direction of a licensed physician in a licensed inpatient sub-acute facility that is accredited by an AHCCCS-approved accrediting body.
2. Covered Inpatient sub-acute facility services include room and board and treatment services for behavioral health and substance abuse conditions.
3. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
   a. A licensed psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A licensed physician assistant,
   d. A licensed psychologist,
   e. A licensed clinical social worker,
   f. A licensed marriage and family therapist,
   g. A licensed professional counselor,
   h. A licensed independent substance abuse counselor, and
   i. A medical practitioner.
4. The following may be billed independently if prescribed by a provider specified in this Section who is operating within the scope of practice:
   a. Laboratory services, and
   b. Radiology services.

D. Behavioral health residential facility services. Services provided in a licensed behavioral health residential facility as defined in 9 A.A.C. 10, Article 1 are covered subject to the limitations and exclusions under this Article.

1. Behavioral health residential facility services are not covered unless provided by a licensed behavioral health residential facility.
2. Covered services include all non-prescription drugs as defined in A.R.S. § 32-1901, non-customized medical supplies, and clinical oversight or direct supervision of the behavioral health residential facility staff, whichever is applicable. Room and board are not covered services.
3. The following licensed and certified providers may bill independently for services:
   a. A licensed psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A licensed physician assistant,
   d. A licensed psychologist,
   e. A licensed clinical social worker,
   f. A licensed marriage and family therapist,
   g. A licensed professional counselor,
   h. A licensed independent substance abuse counselor, and

E. Partial care. Partial care services are covered subject to the limitations and exclusions in this Article.

1. Partial care services are not covered unless provided by a licensed and AHCCCS-registered behavioral health agency that provides a regularly scheduled day program of individual member, group, or family activities that are designed to improve the ability of the member to function in the community. Partial care services include basic, therapeutic, and medical day programs.
2. Partial care services. Educational services that are therapeutic and are included in the member's behavioral health treatment plan are included in per diem reimbursement for partial care services.

F. Outpatient services. Outpatient services are covered subject to the limitations and exclusions in this Article and Article 2.

1. Outpatient services include the following:
   a. Screening provided by a behavioral health professional or a behavioral health technician as defined in R9-22-1201;
   b. A behavioral health assessment provided by a behavioral health professional or a behavioral health technician;
   c. Counseling including individual therapy, group therapy, and family therapy provided by a behavioral health professional or a behavioral health technician;
   d. Behavior management services as defined in R9-22-1201; and
   e. Psychosocial rehabilitation services as defined in R9-22-201.
2. Outpatient service limitations.
   a. The following licensed or certified providers may bill independently for outpatient services:
      i. A licensed psychiatrist;
      ii. A certified psychiatric nurse practitioner;
      iii. A licensed physician assistant as defined in R9-22-1201;
      iv. A licensed psychologist;
      v. A licensed clinical social worker;
      vi. A licensed professional counselor;
      vii. A licensed marriage and family therapist;
      viii. A licensed independent substance abuse counselor;
      ix. A medical practitioner; and
      x. An outpatient treatment center or substance abuse transitional facility licensed under 9 A.A.C. 10, Article 14, that is an AHCCCS-registered provider.
   b. A behavioral health practitioner not specified in subsections (F)(2)(a)(i) through (x), who is contracted with or employed by an AHCCCS-registered behavioral health agency shall not bill independently.

G. Emergency behavioral health services are covered subject to the limitations and exclusions under this Article. In order to be covered, behavioral health services shall be provided by qualified service providers under R9-22-1206. ADHS/DBHS shall ensure that emergency behavioral health services are available 24 hours per day, seven days per week in each GSA for an emergency behavioral health condition for a non-FES member as defined in R9-22-201.

H. Other covered behavioral health services. Other covered behavioral health services include:

1. Case management as defined in 9 A.A.C. 10, Article 1;
2. Laboratory and radiology services for behavioral health diagnosis and medication management;

3. Medication;
4. Monitoring, administration, and adjustment for psychotropic medication and related medications;
5. Respite care as described within subsection (J);
6. Behavioral health therapeutic home care services provided by a RBHA in a professional foster home defined in 6 A.A.C. 5, Article 58 or in an adult behavioral health therapeutic home as defined in 9 A.A.C. 10, Article 1;
7. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.

I. Transportation services. Transportation services are covered under R9-22-211.

J. Limited Behavioral Health services. Respite services are limited to no more than 600 hours per benefit year.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by exempt rulemaking at 17 A.A.R. 1870, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1206. Repealed

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Repealed by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1207. General Provisions for Payment

A. Claims submissions.

1. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member to the appropriate RBHA.
2. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member to the appropriate RBHA.
3. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.
4. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.
5. A provider of emergency behavioral health services, that are the responsibility of ADHS/DBHS or a contractor, shall submit a claim to the entity responsible for emergency behavioral health services under R9-22-210.01(A).
6. A provider shall comply with the time-frames and other payment procedures in Article 7 of this Chapter, if applicable, and A.R.S. § 36-2904.
7. ADHS/DBHS or a contractor, whichever entity is responsible for covering behavioral health services, shall cost avoid any behavioral health service claims if it establishes the existence or probable existence of first-party liability or third-party liability.

B. Prior authorization. Payment to a provider for behavioral health services or items requiring prior authorization may be denied if a provider does not obtain prior authorization from a RBHA, ADHS/DBHS, a TRBHA, the Administration or a contractor.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1208. Repealed

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4).

ARTICLE 13. CHILDREN'S REHABILITATIVE SERVICES (CRS)

Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3).

Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Exemption to promulgate rules repealed under Laws 2012, Chapter 299, Section 7 (Supp. 13-3).

Article 13, consisting of Sections R9-22-1301 through R9-22-

1309, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).

R9-22-1301. Children's Rehabilitative Services (CRS) 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:

"Active treatment" means there is a current need for treatment of the CRS qualifying condition(s) or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for treatment of any CRS qualifying condition.

"CRS application" means a submitted form with any additional documentation required by the Administration to determine whether an individual is medically eligible for CRS.

"CRS condition" means a list of medical condition(s) in R9-22-1303 and which are referred to as covered conditions in A.R.S. § 36-2912.

"Functionally limiting" means a restriction having a significant effect on an individual's ability to perform an activity of daily living as determined by a provider.

"Medically eligible" means meeting the medical eligibility requirements of R9-22-1303.

"Redetermination" means a decision made by the Administration regarding whether a member continues to meet the requirements in R9-22-1302.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2022, effective October 1, 2015 (Supp. 15-3).

R9-22-1302. Children's Rehabilitative Services (CRS) Eligibility Requirements

Beginning October 1, 2013, an AHCCCS member who needs active treatment for one or more of the qualifying medical condition(s) in R9-22-1303 shall be given a CRS Designation. An American Indian member can choose to receive CRS services through an American Indian Health Plan or a contractor. A member enrolled in CMDP shall obtain CRS services through CMDP. The contractor shall provide covered services necessary to treat the condition(s) and other services described within the contract. The effective date of the CRS Designation shall be as specified in contract.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

R9-22-1303. Medical Eligibility

The following lists identify those medical condition(s) that do qualify for CRS services as well as those that do not qualify for CRS services. The list of condition(s) that qualify for a CRS Designation is all inclusive. The list of condition(s) that do not qualify for a CRS Designation is not an all-inclusive list.

1. Cardiovascular System
   a. CRS condition(s) that qualify for CRS medical eligibility:
      i. Arrhythmia,
      ii. Arteriovenous fistula,
      iii. Cardiomyopathy,
      iv. Conduction defect,
      v. Congenital heart defect other than isolated small Ventricular Septal Defects (VSD), Patent Ductus Arteriosus (PDA), Atrial Septal Defects (ASD),
      vi. Coronary artery and aortic aneurysm,
      vii. Renal vascular hypertension,
      viii. Rheumatic heart disease, and
      ix. Valvular disorder.
   b. Condition(s) not medically eligible for CRS:
      i. Arteriovenous fistula that is not expected to cause cardiac failure or threaten loss of function;
      ii. Benign heart murmur;
      iii. Branch artery pulmonary stenosis;
      iv. Essential hypertension;
      v. Patent foramen ovale (PFO);
      vi. Peripheral pulmonary stenosis;
      vii. Postural orthopedic tachycardia; and
      viii. Premature atrial, nodal or ventricular contractions that are of no hemodynamic significance.
2. Endocrine system:
   a. CRS condition(s) that qualify for CRS medical eligibility:
      i. Addison's disease,
      ii. Adrenogenital syndrome,
      iii. Cystic fibrosis (including atypical cystic fibrosis),
      iv. Diabetes insipidus,
      v. Hyperparathyroidism,
      vi. Hyperthyroidism,
      vii. Hypoparathyroidism, and
      viii. Panhypopituitarism.
   b. Condition(s) not medically eligible for CRS
      i. Diabetes mellitus,
      ii. Hypopituitarism associated with a malignancy and requiring treatment of less than 90 days,
      iii. Isolated growth hormone deficiency, and
      iv. Precocious puberty.
3. Genitourinary system medical condition(s):
   a. CRS condition(s) that qualify for CRS medical eligibility:
      i. Ambiguous genitalia,
      ii. Bladder extrophy,
      iii. Deformity and dysfunction of the genitourinary system secondary to trauma 90 days or more after the trauma occurred,

iv. Ectopic ureter,
v. Hydronephrosis, that is not resolved with antibiotics,
vi. Polycystic and multicystic kidneys,
vii. Pyelonephritis when treatment with drugs or biologicals has failed to cure or ameliorate and surgical intervention is required,
viii. Ureteral stricture, and
ix. Vesicoureteral reflux, at a grade 3 or higher.

b. Condition(s) not medically eligible for CRS:
i. Enuresis,
ii. Hydrocele,
iii. Hypospadias,
iv. Meatal stenosis,
v. Nephritis, infectious or noninfectious,
vi. Nephrosis,
vii. Phimosis, and
viii. Undescended testicle.

4. Ear, nose, or throat medical condition(s):
a. CRS condition(s) that qualify for CRS medical eligibility:
i. Cholesteatoma,
ii. Congenital/Craniofacial anomaly that is functionally limiting,
iii. Deformity and dysfunction of the ear, nose, or throat secondary to trauma, 90 days or more after the trauma occurred,
iv. Mastoiditis that continues 90 days or more after the first diagnosis of the condition,
v. Microtia that requires multiple surgical interventions,
vi. Neurosensory hearing loss, and
vii. Significant conductive hearing loss due to an anomaly in one ear or both ears equal to or greater than a pure tone average of 30 decibels that despite medical treatment, requires a hearing aid.

b. Condition(s) not medically eligible for CRS:
i. A craniofacial anomaly that is not functionally limiting,
ii. Adenoiditis,
iii. Cranial or temporal mandibular joint syndrome,
iv. Hypertrophic lingual frenum,
v. Isolated preauricular tag or pit,
vi. Nasal polyp,
vii. Obstructive apnea,
viii. Perforation of the tympanic membrane,
ix. Recurrent otitis media,
x. Simple deviated nasal septum,
xi. Sinusitis,
xii. Tonsillitis, and
xiii. Uncontrolled salivation.

5. Musculoskeletal system medical condition(s):
a. CRS condition(s) that qualify for CRS medical eligibility:
i. Achondroplasia,
ii. Arthrogryposis (multiple joint contractures),
iii. Bone infection that continues 90 days or more after the initial diagnosis,
iv. Chondrodysplasia,
v. Chondroectodermal dysplasia,
vi. Clubfoot,
vii. Collagen vascular disease, including but not limited to, ankylosis spondylitis, polymyositis, dermamyositis, polyarteritis nodosa, psoriatic arthritis, scleroderma, rheumatoid arthritis and lupus,
viii. Congenital or developmental cervical spine abnormality,
ix. Congenital spinal deformity,
x. Diastrophic dysplasia,
xi. Enchondromatosis,
xii. Femoral anteversion and tibial torsion,
xiii. Fibrous dysplasia,
xiv. Hip dysplasia,
xv. Hypochondroplasia,
xvi. Joint infection that continues 90 days or more after the initial diagnosis,
xvii. Juvenile rheumatoid arthritis,
xviii. Kyphosis (Scheurmann's Kyphosis) 50 degrees or over,
xix. Larsen syndrome,
xx. Leg length discrepancy of two centimeters or more,
xxi. Legg-Calve-Perthes disease,
xxii. Limb amputation or limb malformation,
xxiii. Metaphyseal and epiphyseal dysplasia,
xxiv. Metatarsus adductus,
xxv. Muscular dystrophy,
xxvi. Orthopedic complications of hemophilia,
xxvii. Osgood Schlatter's disease that requires surgical intervention,
xxviii. Osteogenesis imperfecta,
xxix. Rickets,
xxx. Scoliosis when 25 degrees or greater, or when there is a need for bracing or surgery,
xxxi. Seronegative spondyloarthropathy such as Reiters, psoriatic arthritis, and ankylosing spondylitis,
xxxii. Slipped capital femoral epiphysis,
xxxiii. Spinal muscle atrophy,
xxxiv. Spondyloepiphyseal dysplasia, and
xxxv. Syndactyly.

b. Condition(s) not medically eligible for CRS:
i. Back pain with no structural abnormality,
ii. Benign bone tumor,
iii. Bunion,
iv. Carpal tunnel syndrome,
v. Deformity and dysfunction secondary to trauma or injury,
vi. Ehlers Danlos,
vii. Flat foot,
viii. Fracture,
ix. Ganglion cyst,
x. Ingrown toenail,
xi. Kyphosis under 50 degrees,
xii. Leg length discrepancy of less than two centimeters at skeletal maturity,
xiii. Polydactyly without bone involvement,
xiv. Popliteal cyst,
xv. Trigger finger, and
xvi. Varus and valgus deformities.

6. Gastrointestinal system medical condition(s):
a. CRS condition(s) that qualify for CRS medical eligibility:
i. Anorectal atresia,

ii. Biliary atresia,
iii. Cleft lip,
iv. Cleft palate,
v. Congenital atresia, stenosis, fistula, or rotational abnormalities of the gastrointestinal tract,
vi. Deformity and dysfunction of the gastrointestinal system secondary to trauma, 90 days or more after the trauma occurred,
vii. Diaphragmatic hernia,
viii. Gastroschisis,
ix. Hirschsprung's disease,
x. Omphalocele, and
xi. Tracheoesophageal fistula.

b. Condition(s) not medically eligible for CRS:
i. Celiac disease,
ii. Crohn's disease,
iii. Hernia other than a diaphragmatic hernia,
iv. Intestinal polyp,
v. Malabsorption syndrome, also known as short bowel syndrome,
vi. Pyloric stenosis,
vii. Ulcer disease, and
viii. Ulcerative colitis.

7. Nervous system medical condition(s):
a. CRS condition(s) that qualify for CRS medical eligibility:
i. Benign intracranial tumor,
ii. Benign intraspinal tumor,
iii. Central nervous system degenerative disease,
iv. Central nervous system malformation or structural abnormality,
v. Cerebral palsy,
vi. Craniosynostosis requiring surgery,
vii. Deformity and dysfunction secondary to trauma in an individual that continues 90 days or more after the incident,
viii. Hydrocephalus,
ix. Muscular dystrophy or other myopathy,
x. Myelomeningocele, also known as spina bifida,
xi. Myoneural disorder, including but not limited to, amyotrophic Lateral Sclerosis or ALS, myasthenia gravis, Eaton-Lambert syndrome, muscular dystrophy, troyer sclerosis, polymyositis, dermamyositis, progressive bulbar palsy, polio,
xii. Neurofibromatosis,
xiii. Neuropathy/polyneuropathy, hereditary or idiopathic,
xiv. Residual dysfunction that continues 90 days or more after a vascular accident, inflammatory condition, or infection of the central nervous system,
xv. Residual dysfunction that continues 90 days or more after near drowning,
xvi. Residual dysfunction that continues 90 days or more after the spinal cord injury, and
xvii. Uncontrolled seizure disorder, in which there have been more than two seizures with documented compliance of one or more medications.

b. Condition(s) not medically eligible for CRS:
i. Central apnea secondary to prematurity,
ii. Febrile seizures,
iii. Headaches,
iv. Near sudden infant death syndrome,
v. Plagiocephaly, and
vi. Spina bifida occulta.

8. Ophthalmology:
a. CRS condition(s) that qualify for CRS medical eligibility:
i. Cataracts,
ii. Disorder of the iris, ciliary bodies, retina, lens, or cornea,
iii. Disorder of the optic nerve,
iv. Glaucoma,
v. Non-malignant enucleation and post-enucleation reconstruction, and
vi. Retinopathy of prematurity.

b. Condition(s) not medically eligible for CRS:
i. Astigmatism,
ii. Ptosis,
iii. Simple refraction error, and
iv. Strabismus.

9. Respiratory system medical condition(s):
a. CRS condition(s) that qualify for CRS medical eligibility:
i. Anomaly of the larynx, trachea, or bronchi that requires surgery, and
ii. Nonmalignant obstructive lesion of the larynx, trachea, or bronchi.

b. Condition(s) not medically eligible for CRS:
i. Allergies,
ii. Asthma,
iii. Bronchopulmonary dysplasia,
iv. Chronic obstructive pulmonary disease,
v. Emphysema, and
vi. Respiratory distress syndrome.

10. Dermatological system medical condition(s):
a. CRS condition(s) that qualify for CRS medical eligibility:
i. A burn scar that is functionally limiting,
ii. A hemangioma that is functionally limiting that requires laser or surgery,
iii. Complicated nevi requiring multiple procedures,
iv. Cystic hygroma such as lymphangioma, and
v. Malocclusion that is functionally limiting.

b. Condition(s) not medically eligible for CRS:
i. A deformity that is not functionally limiting,
ii. Ectodermal dysplasia,
iii. Isolated malocclusion that is not functionally limiting,
iv. Pilonidal cyst,
v. Port wine stain,
vi. Sebaceous cyst,
vii. Simple nevi, and
viii. Skin tag.

11. Metabolic CRS condition(s) that qualify for CRS medical eligibility:
a. Amino acid or organic acidopathy,
b. Biotinidase deficiency,
c. Homocystinuria,
d. Inborn error of metabolism,
e. Maple syrup urine disease,
f. Phenylketonuria, and

g. Storage disease.
12. Hemoglobinopathies CRS condition(s) that qualify for CRS medical eligibility:
a. Sickle cell anemia, and
b. Thalassemia.
13. Additional medical/behavioral condition(s) which are not medically eligible for CRS:
a. Allergies,
b. Anorexia nervosa or obesity,
c. Attention deficit disorder,
d. Autism,
e. Cancer,
f. Depression or other mental illness,
g. Developmental delay,
h. Dyslexia or other learning disabilities,
i. Failure to thrive,
j. Hyperactivity, and
k. Immunodeficiency, such as AIDS and HIV.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2022, effective October 1, 2015 (Supp. 15-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

R9-22-1304. Referral and Disposition of CRS Medical Eligibility Determination

A. To refer an individual for a CRS medical eligibility determination a person shall submit to the Administration the following information:
1. CRS application;
2. Documentation from a specialist who diagnosed the individual, stating the individual's diagnosis;
3. Diagnostic test results that support the individual's diagnosis; and
4. Documentation of the individual's need for specialized treatment of the CRS condition through medical, surgical, or therapy modalities.

B. The Administration shall notify the CRS applicant, member or authorized representative of the outcome of the determination within 60 days of receipt of information required under subsection (A). The member may appeal the determination under Chapter 34.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2022, effective October 1, 2015 (Supp. 15-3).

R9-22-1305. CRS Redetermination

A. Continued eligibility for CRS services shall be redetermined by verifying active treatment status of the CRS qualifying medical condition(s) as follows:
1. The contractor is responsible for notifying the AHCCCS Administration of the date when a member with a CRS Designation is no longer in active treatment for the qualifying condition(s).
2. The Administration may request, at any time, that the contractor submit the medical documentation to the Administration for a CRS medical redetermination within the specified time-frames in contract.
3. The Administration shall notify the member or authorized representative of the outcome of the redetermination.

B. If the Administration determines that a member is no longer medically eligible for a CRS Designation, the Administration shall provide the member or authorized representative a written notice that informs the member that the Administration is ending the member's CRS Designation. The member may appeal the redetermination under A.A.C. Title 9, Chapter 34.

C. Upon reaching his or her 21st birthday, the member's CRS Designation will be ended.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

R9-22-1306. Repealed

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Repealed by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

R9-22-1307. Covered Services

The Administration will cover medically necessary services as described within Article 2 unless otherwise specified in contract.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3).

R9-22-1308. Repealed

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-1309. Repealed

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR HOUSEHOLDS

R9-22-1401. General Information

A. Scope. This Article contains eligibility criteria to determine whether a household or individual is eligible for AHCCCS medical coverage. Eligibility criteria described under Article 3 applies to this Article.

B. Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article, Article 3 and Article 15 have the following meanings unless the context explicitly requires another meaning:

"Burial plot" means a space reserved in a cemetery, crypt, vault, or mausoleum for the remains of a deceased person.

"Caretaker relative" means:

A parent of a dependent child with whom the child is living;

When the dependent child does not live with a parent or the parent in the home is incapacitated, another relative of the child by blood, adoption, or marriage in the home who assumes primary responsibility for the child's care; or

A woman in her third trimester of pregnancy with no other dependent children.

"Cash assistance" means a program administered by the Department that provides assistance to needy families with dependent children under 42 U.S.C. 601 et seq.

"Dependent child" means a child under the age of 18, or if age 18 is a full-time student in secondary school or equivalent vocational or technical training, if reasonably expected to complete such school or training before turning age 19.

"MAGI – based income" means Modified Adjusted Gross Income as defined under 42 CFR 435.603(e).

"Medical expense deduction" or "MED" means the cost of the following expenses if incurred in the United States:

A medical service or supply that would be covered if provided to an AHCCCS member of any age under Articles 2 and 12 of this Chapter;

A medical service or supply that would be covered if provided to an Arizona Long-term Care System member under 9 A.A.C. 28, Articles 2 and 11;

Other necessary medical services provided by a licensed practitioner or physician;

Assistance with daily living if the assistance is documented in an individual plan of care by a nurse, social service worker, registered therapist, or dietitian under the supervision of a physician except when provided by the spouse of an applicant or the parent of a minor child;

Medical services provided in a licensed nursing home or in an alternative HCBS setting under R9-28-101;

Purchasing and maintaining an animal guide or service animal for the assistance of a member of the MED family unit under R9-22-1436; and

Health insurance premiums, deductibles, and coinsurance, if the insured is a member of the MED family unit.

"Monthly income" means the gross countable income received or projected to be received during the month or the monthly equivalent.

"Monthly equivalent" means a monthly countable income amount established by averaging, prorating, or converting a person's income.

"Spendthrift restriction" means a legal restriction on the use of a resource that prevents a payee or beneficiary from alienating the resource.

"Tax dependent" is described under 42 CFR 435.4.

"Taxpayer" means a person who expects to file a tax return, and does not expect to be claimed as a tax dependent by another person.

"Title IV-D" means Title IV-D of the Social Security Act, 42 U.S.C. 651-669, the statutes establishing the child support enforcement and paternity program.

"Title IV-E" means Title IV-E of the Social Security Act 42 U.S.C. 670-679, the statutes establishing the foster care and adoption assistance programs.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1). Punctuation error corrected with a parenthesis added at the beginning of the definition "Caretaker" (Supp. 20-4).

R9-22-1402. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1403. Agency Responsible for Determining Eligibility
The Administration or its designee shall determine eligibility under the provisions of this Article. The Administration or its designee shall not discriminate against an applicant or member because of race, color, creed, religion, ancestry, national origin, age, sex, or physical or mental disability.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1404. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1405. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1406. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1407. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 19 A.A.R. 3309, November 30, 2013 (Supp. 13-4). Section repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; this Section was slated to be codified as repealed in Supp. 14-1. Due to a clerical error the Section wasn't repealed in this Chapter until Supp. 20-4.

R9-22-1408. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1409. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1410. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1411. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1412. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

Amended by exempt rulemaking at 10 A.A.R. 23, effective December 9, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1413. Time-frames, Reinstatement of an Application

A. The Administration or its designee shall complete an eligibility determination under R9-22-306(A)(1) unless:
1. The applicant is pregnant. The Administration or its designee shall complete an eligibility determination for a pregnant woman within 20 days after the application date unless additional information is required to determine eligibility; or
2. The applicant is in a hospital as an inpatient at the time of application. Within seven days of the Administration or its designee's receipt of a signed application the Administration or its designee shall complete an eligibility determination if the Administration or its designee does not need additional information or verification to determine eligibility.

B. The Administration or its designee shall reopen or reinstate eligibility of an individual who is discontinued for failure to submit the renewal form or necessary information, without requiring a new application, if the individual submits the renewal form or necessary information within 90 days after the date of discontinuance.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1414. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1415. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1416. Effective Date of Eligibility

A. Except as provided in R9-22-303 and subsections (B), (C) and (D), the effective date of eligibility is the first day of the month that the applicant files an application if the applicant is eligible that month, or the first day of the first eligible month following the application month except for:
1. The MED program under R9-22-1439, and
2. Eligibility for a newborn under R9-22-1429.

B. The effective date of eligibility for an applicant who moves into Arizona is no sooner than the date Arizona residency is established.

C. The effective date of eligibility for an inmate applying for medical coverage is the date the applicant no longer meets the definition of an inmate of a public institution.

D. The effective date of eligibility for a newborn is no sooner than the date of birth.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1417. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1418. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1419. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final

rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1419.01. Repealed

Historical Note
New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1419.02. Repealed

Historical Note
New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1419.03. Repealed

Historical Note
New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1419.04. Repealed

Historical Note
New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1420. Income Eligibility Criteria

A. Evaluation of income. In determining eligibility, the Administration or its designee shall evaluate the following types of income received by a person identified in subsection (B):
1. Earned income, including in-kind income, before any deductions. For purposes of this Section, in-kind income means room, board, or provision for other needs in exchange for work performed. The person identified in subsection (B) shall ensure that the provider of the in-kind income establishes and verifies the monetary value of the item provided. The provider may be, but is not limited to:
   a. A landlord who provides all or a portion of rent or utilities in exchange for services;
   b. A store owner who gives goods such as groceries, clothes, or furniture in exchange for services; or
   c. An individual who trades goods such as a car, tools, trailer, building material, or gasoline in exchange for services;
2. Self-employment income under R9-22-1424, including gross business receipts minus business expenses; and
3. Unearned income, including deemed income under R9-22-317 from the sponsor of a non-citizen applicant.

B. MAGI income group. The Administration or its designee shall include the following persons in the MAGI income group:
1. When the applicant is a taxpayer include:
   a. The applicant,
   b. Everyone the applicant expects to claim as a tax dependent for the current year, and
   c. The applicant's spouse, when living with the applicant.
2. Except as provided in subsection (B)(3), when the applicant expects to be claimed as a tax dependent for the current year include:
   a. The taxpayer claiming the applicant,
   b. Everyone else the taxpayer expects to claim as a tax dependent,
   c. The taxpayer's spouse when living with the taxpayer, and
   d. The applicant's spouse, when living with the applicant.
3. When any of the following apply, determine the persons whose income is included as described in subsection (4)(a) or (4)(b) based on the applicant's age:
   a. The applicant expects to be claimed as a tax dependent by someone other than a spouse or natural, adopted or step-parent;
   b. The applicant is under age 19, expects to be claimed as a tax dependent by a natural, adopted or step-parent, lives with more than one such parent and the parents do not expect to file a joint tax return; or
   c. The applicant is under age 19 and expects to be claimed as a tax dependent by a non-custodial parent.
4. When the applicant is not a taxpayer, does not expect to be claimed as a tax dependent and is:
   a. Under age 19. Include the income of the applicant and when living with the applicant, the applicant's:
      i. Spouse;
      ii. Natural, adopted and step-children;
      iii. Natural, adopted and step-parents;
      iv. Natural, adopted and step-siblings; and
   b. Age 19 or older. Include the income of the applicant and when living with the applicant, the applicant's:
      i. Spouse;
      ii. Natural, adopted and step-children under age 19.
5. When the applicant is a pregnant woman, the Administration or its designee shall also include the number of expected babies only for the pregnant woman's income group.
6. When the taxpayer cannot reasonably establish that a person is the taxpayer's tax dependent, inclusion of the person in the taxpayer's MAGI income group is determined as provided in subsection (B)(4).

C. A person whose income is counted. The Administration or its designee shall count the MAGI-based income of all members of an applicant's MAGI income group with the following exceptions:
1. The income of an individual who is included in the MAGI income group of his or her natural, adoptive or step parent and is not expected to be required to file a tax return for the year in which eligibility for Medicaid is being determined, is not counted whether or not the individual files a tax return.
2. The income of a tax dependent other than the taxpayer's spouse or biological, adopted or stepchild who is not expected to be required to file a tax return for the year in which eligibility for Medicaid is being determined is not counted when the tax dependent is included in the taxpayer's MAGI income group, whether or not the tax dependent files a tax return.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section

repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1421. MAGI based Income Eligibility

A. In determining eligibility, if an individual would otherwise be ineligible under this Article due to excess income, the Administration or its designee shall subtract an amount equivalent to five percentage points of the Federal Poverty Level (FPL) from the household income.

B. A person is eligible under this Article when:
1. Subject to subsection (A), the monthly household income does not exceed the appropriate FPL;
2. If ineligible under (B)(1), the household income determined in accordance with 26 CFR 1.36B–1(e) is below 100 percent FPL; or
3. For eligibility under R9-22-1437, the person's income during the period defined in R9-22-1437(C) does not exceed the FPL under R9-22-1437(B).

C. The Administration or its designee shall consider the following factors when determining the income period to use to determine monthly income:
1. Type of income,
2. Frequency of income,
3. If source of income is new or terminated, or
4. Income fluctuation.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1422. Methods for Calculating Monthly Income

A. Projecting income.
1. Description. Projecting income is a method of determining the amount of income that a person will receive.
2. Calculation. The Administration or its designee shall project income by:
   a. Converting income to a monthly equivalent,
   b. Using unconverted income, or
   c. Prorating income to determine a monthly equivalent.
3. Exclusion. When calculating projected monthly income, the Administration or its designee shall exclude an unusual variation in income under R9-22-1424(E), except for a month in which the variation is anticipated to occur.

B. Averaged income.
1. Description. Averaging income proportionally distributes the person’s income received on a regular basis.
2. Calculation. To average income, the Administration or its designee shall add the amount of the income and divide by the total number of pay periods. If the amount of income received per pay period fluctuates, and the fluctuation is expected to continue, the Administration or its designee shall:
   a. Use the averaged weekly or bi-weekly amounts to convert weekly or bi-weekly income to a monthly equivalent;
   b. Use the averaged monthly or semi-monthly amounts to project monthly income; and
   c. Use the averaged hours worked and multiply the average by the current rate of pay. If there is a change in the rate of pay, use the new rate of pay when calculating projected income under subsection (A).

C. Prorated income.
1. Description. Prorated income evenly distributes a person's income over the period the income is intended to cover to calculate a monthly equivalent.
2. Calculation. To prorate income, the Administration or its designee shall divide the total amount of the person's income received during the period by the number of months that the income is intended to cover.

D. Converted income.
1. Description. Converted income is income received weekly or biweekly that is changed to a monthly equivalent.
2. Calculation.
   a. The Administration or its designee shall average the weekly or bi-weekly income amounts before converting to the monthly equivalent if the person's past income fluctuates and the fluctuation is expected to recur.
   b. To convert income paid weekly to a monthly equivalent, the Administration or its designee shall multiply the weekly average by 4.3 weeks.
   c. To convert income paid bi-weekly to a monthly equivalent, the Administration or its designee shall multiply the bi-weekly average by 2.15 weeks.

E. Unconverted income.
1. Description. Unconverted income is the actual amount of income received or projected to be received during a month.
2. Calculation. The Administration or its designee shall sum the actual amount of income received or projected to be received during a month.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1423. Calculations and Use of Methods Listed in R9-22-1422 Based on Frequency of Income

A. Monthly income. If otherwise countable income is received monthly or in a lump sum, the Administration or its designee shall use the unconverted method for calculating monthly income.
1. Lump sum means a nonrecurring payment that serves as a complete payment.
2. Lump sum payments include but are not limited to: rebates or credits; inheritances; insurance settlements; and payments for prior months from such sources as Social Security, Railroad Retirement, or other benefits.

3. A lump sum payment may include a portion intended for the current month.

B. Weekly income. If income is received weekly, the Administration or its designee shall convert the income to a monthly equivalent under R9-22-1422(D).

C. Bi-weekly income. If income is received bi-weekly, the Administration or its designee shall convert the income to a monthly equivalent under R9-22-1422(D).

D. Semi-monthly or daily income. If income is received semi-monthly or daily, the Administration or its designee shall use the unconverted method for calculating monthly income under R9-22-1422(E).

E. Bimonthly, quarterly, semi-annual, or annual income. If income is received bimonthly, quarterly, semi-annually, or annually, the Administration or its designee shall prorate the income received or projected to be received under R9-22-1422(C).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1424. Use of Methods Listed in R9-22-1423 Based on Type of Income

A. New income.
1. Description. New income is income received from a new source during the first calendar month that the income is received from the source.
2. Calculating monthly income.
   a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
   b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

B. Terminated income.
1. Terminated income is income received during the last calendar month when no more income is expected to be received from that source.
2. Calculating monthly income.
   a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
   b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

C. Break in income.
1. Description. A break in income is a break in established frequency of income of one calendar month or more.
2. Calculating monthly income.
   a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
   b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

D. Contract or regular seasonal income.
1. Descriptions.
   a. Contract income is income a person earns under a contract that specifies a length of time the contract covers, the amount of income to be paid, and the frequency of payment.
   b. Regular seasonal income is income that fluctuates based on season or is only received during a certain season, and can reasonably be anticipated based on history or other verification.
2. Calculating monthly income.
   a. When the contract or regular seasonal income will not fluctuate over the 12-month period beginning with the month the application or renewal is submitted, the Administration or its designee shall use the appropriate income calculation method in R9-22-1423 for the frequency of receipt.
   b. When the contract or regular seasonal income is anticipated to fluctuate over the 12-month period beginning with the month the application or renewal is submitted, the Administration or its designee shall calculate the monthly income as follows:
      i. For a one-time contract that ends between the month the application or renewal is submitted and the end of the calendar year, divide the income that will be received from the application or renewal month through the end of the calendar year by the number of months in that period to get a monthly equivalent;
      ii. For contracts that extend into the next calendar year, contracts that are anticipated to be renewed and regular seasonal income, the Administration or its designee shall divide the income that will be received in the 12-month period beginning with the application or renewal month by 12 to get the monthly equivalent.

E. Unusual variation in the amount of income.
1. Description. Unusual variation is an amount of income that is different from the established amount received and is not projected to continue or recur.
2. Calculating monthly income.
   a. When calculating income for the month in which an unusual variation in income occurs, the Administration or its designee shall include the unusual variation in the income calculation.
   b. When an unusual variation in income occurs during the month, the Administration or its designee shall use the converted method for calculating monthly income if income is received weekly or bi-weekly.
   c. When projecting income for the months following the month in which the unusual variation occurs, the Administration or its designee shall exclude the unusual variation in income from the income calculation.

F. Self-employment income.
1. Description. Self-employment income is income a person earns from the person’s own trade or business less allowable expenses.

2. Calculating monthly income. The Administration or its designee shall prorate the income under R9-22-1422.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1425. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1426. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1427. Eligibility Under MAGI

A. Caretaker Relatives. An individual is eligible for AHCCCS medical coverage as a Caretaker Relative when the individual meets the following requirements:
1. Is a caretaker relative as defined in R9-22-1401.
2. The total countable income under R9-22-1420(B) does not exceed 106 percent of the FPL for the number of people in the MAGI income group.

B. Continued medical coverage.
1. A caretaker relative eligible under subsection (A) and all dependent children eligible under subsection (D) in the caretaker relative's MAGI income group are entitled to continued AHCCCS coverage for up to 12 months if eligible under subsection (B)(1)(c)(i) and up to four months if eligible under subsection (B)(1)(c)(ii) if the MAGI income group's income exceeds the limit for the income group's size and the following conditions are met:
   a. The caretaker relative still lives with a dependent child;
   b. A caretaker relative in the income group received AHCCCS medical coverage under this Section for three calendar months out of the most recent six months; and
   c. The loss of AHCCCS coverage under this Section is due to:
      i. Increased earned income of a caretaker relative, or
      ii. Increased spousal support.
2. An applicant may be added to the continued medical coverage under subsection (B)(1), if the applicant did not reside in the household at the time continued medical coverage under this Section was determined and the applicant is:
   a. The spouse or dependent child of a caretaker relative receiving continued medical coverage, or
   b. The parent of a dependent child who is receiving continued medical coverage.

C. Pregnant Women. A pregnant woman is eligible for AHCCCS medical coverage when the total countable income under R9-22-1420(B) does not exceed 156 percent of the FPL for the number of people in the MAGI income group. A pregnant woman who applies for AHCCCS medical coverage during the pregnancy or postpartum period and is determined eligible, remains eligible throughout the postpartum period. The postpartum period begins the day the pregnancy terminates and ends the last day of the month in which the 60th day following pregnancy termination occurs.

D. Children. A child less than 19 years of age is eligible for AHCCCS medical coverage when the total countable income under R9-22-1420(B) does not exceed the following percentage of the FPL for the number of people in the MAGI income group:
1. 147 percent for a child under one year of age,
2. 141 percent for a child age one through five years of age, or
3. 133 percent for all other persons.

E. Adults. An individual is eligible for AHCCCS medical coverage when the individual meets the following eligibility requirements:
1. Is 19 years of age or older but less than 65 years of age;
2. Is not pregnant;
3. Is not eligible for AHCCCS Medical Coverage under any other coverage group listed in 42 U.S.C. 1396a(a)(10)(A)(i);
4. Is not entitled to or enrolled for Medicare benefits under Part A or Part B;
5. The total countable income under R9-22-1420(B) does not exceed 133 percent of the FPL for the number of people in the MAGI income group; and
6. When the individual is a caretaker relative, but has income exceeding the limit in subsection (A)(2), each child under age 19 living with the individual is receiving AHCCCS medical coverage or KidsCare, or is enrolled in minimum essential coverage as defined in 42 CFR 435.4.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Section R9-22-1427 repealed; new Section R9-22-1427 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1428. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking

at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1429. Eligibility for a Newborn

A child born to a mother eligible for and receiving medical coverage under this Article, Article 15 of the Chapter, or 9 A.A.C. 28, is automatically eligible for AHCCCS medical coverage for a period not to exceed 12 months. Automatic eligibility begins on the child's date of birth and ends with the last day of the month in which the child turns age one.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1430. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1431. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 2633, effective July 10, 2007 (Supp. 07-3). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1). Repealed by final rulemaking at 21 A.A.R. 1241, effective September 5, 2015 (Supp. 15-3).

R9-22-1432. Young Adult Transitional Insurance

An individual is eligible for AHCCCS medical coverage when the individual meets all of the following eligibility requirements:

1. Is 18 through 25 years of age;
2. Was in the custody of the Department of Economic Security under A.R.S. Title 8, Chapter 5 or Chapter 10 on the individual's 18th birthday;
3. Was eligible for and receiving AHCCCS Medical Coverage on the individual's 18th birthday; and
4. Is not eligible for AHCCCS Medical Coverage under 42 U.S.C. 1396a(a)(10)(A)(i)(I) - (VII).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1433. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1434. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4).

R9-22-1435. Eligibility for a Person With Medical Expenses Whose Income is Over 100 Percent FPL

An applicant who is not eligible for AHCCCS medical coverage due to excess income may become AHCCCS eligible by deducting medical expenses from the applicant's income. This coverage is called Medical Expense Deduction (MED).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1436. MED Family Unit

A. For the purpose of this Section, a child is an unmarried person under age 18.

B. The Department shall consider each of the following to be a family when living together:

1. A parent and the parent's children;
2. A married couple without children;
3. A married couple and the children of either or both spouses;
4. Unmarried parents who live with at least one child in common, and the parents' other children, whether in common or not; and
5. A person without children.

C. If an applicant is pregnant, the family unit includes the number of unborn children.

D. A child of the children included in subsections (B)(1), (B)(3), or (B)(4) is considered part of the family unit when living together.

E. The Department shall not include a SSI-cash recipient in the MED family unit even if the SSI-cash recipient is a parent, spouse, or child.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1437. MED Income Eligibility Requirements

A. Income exclusions. The exclusions in R9-22-1420(C) apply to the MED family unit.

B. Income standard.
1. The Department shall divide the annual FPL for the MED family unit that is in effect during each month of the income period by 12 to determine the monthly FPL.
2. The Department shall add the monthly FPLs for the income period and multiply the resulting amount by 40 percent.
3. Changes to the annual FPL are implemented in April of each year.

C. Income period. The income period is the month of application and the next two months. The Department shall add together the three months' income to establish the MED family unit's income amount.

D. Medical expense deduction period. The medical expense deduction period is a three-month period consisting of:
1. For a new application, the month before the application month, the month of application, and month following the application month; or
2. For a MED eligibility review, the last month of the prior MED eligibility period and the following two months.

E. The Department shall calculate the amount of countable monthly income as follows:
1. Subtract a $90 cost of employment allowance from the gross amount of earned income for each person whose earned income is counted;
2. Disregard from the remaining earned income an amount billed by the provider for the care of each dependent child under age 18 or incapacitated adult member of the MED family unit if the care is for the purpose of allowing the person to work. If more than one person in the household is responsible for and billed for the care of a dependent child, the disregard may be split between the wage earners if splitting the disregard is to the benefit of the family, but shall not exceed the maximum disregards as follows:
   a. A maximum of $200 for a child under age two and $175 for other dependents for a wage-earner employed full-time (86 or more hours per month); and
   b. A maximum of $100 for a child under age two, and $88 for other dependents for a wage earner employed part-time (less than 86 hours a month);
3. Add the remaining earned income for each MED family member to the unearned income of all MED family members;
4. Compare the MED family's unit countable income amount to the income standard in subsection (B). The difference is the amount of medical expenses the family shall incur during the medical expense deduction period to become eligible;
5. Subtract allowable medical expense deductions that were incurred by:
   a. A member of the MED family unit;
   b. A deceased spouse or minor child of a MED family unit if this person would have been a member of the MED unit during the MED expense deduction period;
   c. A person who was a minor child of a MED family unit member when the expense was incurred but who is no longer a minor child; or
   d. A minor child, including a child who is a runaway, who left home before the date of application to live with someone other than a parent; and
6. Compare the net MED family income to the income standard listed in subsection (B).

F. The family is eligible if the net income in subsection (E)(6) does not exceed the income standard in subsection (B).

Historical Note
New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1438. MED Resource Eligibility Requirements

A. Including countable resources. The Department shall include the resources not excluded that belong to and are available to members of the family of a qualified alien under A.R.S. § 36-2903.03 and the sponsor and sponsor's spouse of a person who is a qualified alien.

B. Ownership and availability. The Department shall evaluate the ownership of resources to determine the availability of resources to a person listed in subsection (A).
1. Jointly owned resources with ownership records containing the words "and" or "and/or" between the owners' names are available to each owner except if one of the owners refuses to sell. A consent to sale is not required if all owners are members of the MED family unit.
2. Jointly owned resources with ownership records containing the word "or" between the owners' names are presumed to be available in full to each owner. The applicant or member may rebut the presumption by providing clear and convincing evidence of intent to establish a different type of ownership. If the presumption is rebutted, the resource is available to the owners:
   a. Consistent with the intent of the owners, or
   b. Based on each owner's proportionate net contribution if there is not clear and convincing evidence of a different allocation.
3. The Department shall establish availability of a trust under 42 U.S.C. 1396p(d)(4)(A) or (C).

C. Unavailability. The Department shall consider the following resources unavailable:
1. Property subject to spendthrift restriction, such as:
   a. Accounts established by the SSA, Veteran's Administration, or similar sources that mandate that the funds in the account be used for the benefit of a person not residing with the MED family unit; or
   b. Trusts established by a will or funded solely by the income and resources of someone other than a member of the MED family unit.
2. A resource being disputed in a divorce proceeding or probate matter;
3. Real property located on a Native American reservation;

4. A resource held by a conservator to the extent court-imposed restrictions make the resource unavailable to the applicant, member, or member of the family unit for:
   a. Medical care,
   b. Food,
   c. Clothing, or
   d. Shelter.

D. Resource exclusion. The Department shall exclude the following resources from the calculation of resources under subsection (E):
1. One burial plot for each person listed in R9-22-1436;
2. Household furnishings and personal items that are necessary for day-to-day living;
3. Up to $1500 of the value of one prepaid funeral plan for each person listed in R9-22-1436 that specifically covers only funeral-related expenses as evidenced by a written contract;
4. The value of one motor vehicle regularly used for transportation. If the MED family unit owns more than one vehicle, the exclusion is applied to the vehicle with the highest equity value;
5. The value of a vehicle used to earn income and not used simply for transportation to and from employment;
6. The value of a vehicle in which a SSI-cash recipient has an ownership interest; and
7. The value of any vehicle used for medical treatment, employment, or transportation of a SSI-cash disabled child, and that is excluded by SSI for that reason.
8. Funds set aside in an Individual Development Account under 6 A.A.C. 12, Article 4; and
9. Any other resource specifically excluded by federal law.

E. Calculation of resources. The Department shall determine the value of all household resources as follows:
1. Calculate the total amount of countable liquid resources;
2. Calculate the equity value of each countable non-liquid resource. The Department shall determine the equity value of a countable non-liquid resource by subtracting the amount of valid encumbrances on that resource from:
   a. The market value of real property if there is no assessor's evaluation of the property,
   b. The market value of real property if the assessor's value of the real property does not include the value of permanent structures on that property,
   c. The assessor's full cash value if subsections (E)(2)(a) and (E)(2)(b) do not apply, and
   d. The market value of a non-liquid resource that is not real property;
3. Not assign an equity value to a resource that is less than zero; and
4. Determine the MED family unit's resources by adding the totals determined in subsections (1) and (2).

F. Resource standard to be eligible for MED. A person is not eligible for MED if the resources determined in subsection (E) exceed $100,000 or if more than $5,000 are liquid resources.

Historical Note
New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1439. MED Effective Date of Eligibility

A. A MED family unit is eligible on the day the income and resource eligibility requirements are met but no earlier than the first day of the month of application. If the family unit meets the income requirements in the application month but does not meet the resource limit until the following month, the family unit's effective date of eligibility is the first day of the month following the month of application.

B. The Department shall adjust the effective date of eligibility under subsection (A) to an earlier date if:
1. A member presents verification of additional allowable medical expenses incurred on an earlier date during the medical expense deduction period that allow the member to meet the income requirements, and
2. The member presents the verification within 60 days of approval of eligibility under this Section.

C. The Department shall not adjust an effective date of eligibility more than one time per application.

D. The Department shall adjust the effective date no later than 30 days after the end of the 60-day period under subsection (B)(2).

E. The Department shall deny an application and provide the applicant a denial notice when the applicant does not meet the MED requirements under this Article during the month of application or the month following the month of application.

Historical Note
New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1440. MED Eligibility Period

The Department shall approve eligibility for six months. Changes in circumstances do not affect eligibility for the first three months.

Historical Note
New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1441. Eligibility Appeals

A. Adverse actions. An applicant or member may appeal by requesting a hearing from the Department concerning any of the following adverse actions:
1. Complete or partial denial of eligibility under R9-22-1413;
2. Suspension, termination, or reduction of AHCCCS medical coverage under R9-22-1415;
3. Delay in the eligibility determination beyond the timeframes under this Article;
4. The imposition of or increase in a premium or copayment; or
5. The effective date of eligibility.

B. Notice of Adverse Action. The Department shall personally deliver or send, by regular mail, a Notice of Adverse Action to the person affected by the action. For the purpose of this Section, the date of the Notice of Adverse Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.

C. Automatic change and hearing rights.
1. An applicant or a member is not entitled to a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
2. An applicant or a member is entitled to a hearing if a federal or state law requires an automatic change and the applicant or member timely files an appeal that alleges a misapplication of the facts to the law.

Historical Note
New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1442. Cessation of MED Coverage

The Department shall not approve any individual or family who has applied on or after May 1, 2011 as eligible for MED coverage. With

respect to any applications that are pending as of May 1, 2011, the Department shall not approve any individual or family as eligible for MED coverage who has not met all eligibility requirements prior to May 1, 2011.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 1028, effective May 1, 2011 (Supp. 11-2).

R9-22-1443. Repealed

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 1345, effective July 8, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 2624, effective July 8, 2011 (Supp. 11-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED

R9-22-1501. General Information

A. General. The Administration shall determine eligibility for AHCCCS medical coverage for the following applicants or members using the eligibility criteria and requirements in this Article and Article 3:

1. A person who is aged, blind, or disabled and does not receive SSI cash; and
2. A person terminated from the SSI cash program under R9-22-1505.

B. Definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Aged" means a person who is 65 years of age or older as specified in 42 U.S.C. 1382c(a)(1)(A).

"Blind" means a person who has been determined blind by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2) and 42 CFR 435.530 as of October 1, 2012, which are 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 incorporated by reference contains no future editions or amendments.

"Disabled" means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E) and 42 CFR 435.540 as of October 1, 2012, which are 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.

C. Eligibility effective date.

1. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the period described under R9-22-303.
2. The effective date of eligibility for an applicant who moves into Arizona is no sooner than the date Arizona residency is established.
3. The effective date of eligibility for an inmate applying for medical coverage is the date the applicant no longer meets the definition of an inmate of a public institution.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 23, effective December 9, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). Section amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; amendments to this Section were slated to be codified in Supp. 14-1 but due to a clerical error, were not published. The amendments to this Section were published in Supp. 20-4 and no additional amendments have been made to this Section since January 7, 2014 (Supp. 20-4).

R9-22-1502. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1503. Financial Eligibility Criteria

A. General income eligibility. Except as provided under subsection (B) of this rule, the Administration or its designee shall count the identified income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K.

B. Exceptions.

1. In-kind support and maintenance under 42 U.S.C. 1382a(a)(2)(A) is excluded.
2. For a person living with a spouse, the Administration or its designee calculates net income for an eligible couple under 20 CFR 416.1160 as of April 1, 2013, 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, even if the spouse is not eligible for or applying for SSI or coverage under this Article.
3. In determining the net income of a married couple living with a child or the net income of a person who is not living with a spouse but living with a child, a child allocation is allowed as a deduction from the combined net income of the couple for each child regardless of whether the child is ineligible or eligible. For the purposes of this Section, a child means a person who is unmarried, natural or adopted, and under age 18 or under age 22 if a full-time student. Each child's allocation deduction is reduced by that child's income, including public income maintenance payments, using the methodology under 20 CFR 416.1163(b)(1) and (2) as of April 1, 2013, which is incorporated by reference and on file with the Adminis-

tration, 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.

4. In determining the income deemed available to an applicant who is a child from an ineligible parent or parents, an allocation for each eligible or ineligible child of the parent is allowed as a deduction from the parent's income under 20 CFR 416.1165(b). The child's allocation is reduced by that child's income, including public income maintenance payments.
5. In determining the income of a person who receives an annual Title II Cost of Living Allowance (COLA) increase, the COLA amount is disregarded from January until the Administration applies the effective income limits under R9-22-1504 based on the FPL for the calendar year.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1504. Eligibility For A Person Who is Aged, Blind, or Disabled

A. To be eligible for AHCCCS medical coverage, an applicant shall meet the conditions of eligibility and requirements in this Article and:
1. Meet one of the income tests described in subsection (B) or (C), or
2. The special requirements in R9-22-1505.

B. The Administration shall determine whether the applicant's countable income, as described in R9-22-1503, is less than or equal to 100 percent of the SSI FBR, as adjusted annually.

C. The Administration shall determine whether the applicant's countable income, as described in R9-22-1503, without deducting the amount from earned income under 42 U.S.C. 1382a(b)(4)(B)(iii), is less than or equal to 100 percent FPL as adjusted annually.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1505. Eligibility for Special Groups

A. The following are considered special groups:
1. A person meeting the requirements in A.R.S. § 36-2903.03 who:
   a. Is aged, blind, or disabled under 42 CFR 435.520, 42 CFR 435.530, or 42 CFR 435.540 as of October 1, 2012, which are 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. Received SSI cash or AHCCCS medical coverage under this subsection, or subsections (A)(2), (A)(3), or (A)(4) on or before August 21, 1996;
   c. Was residing in the United States under color of law on or before August 21, 1996; and
   d. Meets the requirements under this Article;
2. A disabled child (DC) under 42 U.S.C. 1396a(a)(10)(A)(i)(II). A disabled child is a child who:
   a. Was receiving SSI cash benefits as a disabled child on August 22, 1996;
   b. Lost SSI cash benefits effective July 1, 1997, or later, due to a disability determination under Section 211(d) of Subtitle B of P.L. 104-193;
   c. Continues to meet the disability requirements for a child that were in effect on August 21, 1996; and
   d. Meets the requirements under this Article;
3. A disabled adult child (DAC), under 42 U.S.C. 1383c(c) who:
   a. Was determined disabled by the Social Security Administration before attaining the age of 22 years,
   b. Became entitled to or received an increase in child's insurance benefits under Title II of the Act on the basis of blindness or disability,
   c. Was terminated from SSI cash benefits due to entitlement to or an increase in income under Title II of the Act,
   d. Meets the requirements under this Article, and
   e. Is 18 years of age or older;
4. A disabled widow or widower (DWW) under 42 U.S.C. 1383c(b) and (d) who:
   a. Is blind or disabled,
   b. Is ineligible for Medicare Part A benefits,
   c. Received SSI cash benefits the month before Title II of the Act benefit payments began,
   d. Meets the requirements under this Article;
   e. Is at least 50 years of age but under age 65; and
   f. Is unmarried.
5. Under 42 CFR 435.135, a person who:
   a. Is aged, blind, or disabled;
   b. Receives benefits under Title II of the Act;
   c. Received SSI cash benefits in the past;
   d. Received SSI cash benefits and Title II of the Social Security Act benefits concurrently for at least one month anytime after April 1977;
   e. Became ineligible for SSI cash benefits while receiving SSI and benefits under Title II of the Act concurrently; and
   f. Meets the requirements under this Article.

B. Income for special groups.
1. Except as provided in subsection (B)(2), income eligibility is determined using the income criteria in R9-22-1503.
2. Exceptions to income for special groups.
   a. For a person in the DAC coverage group under subsection (A)(3), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(c).
   b. For a person in the DWW coverage group, under subsection (A)(4), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(b) and (d).
   c. For an applicant or member in the coverage group under subsection (A)(5), the portion of the appli-

cant's or member's Title II of the Social Security Act benefits attributed to cost-of-living adjustments received by the applicant since the effective date of SSI ineligibility is disregarded in determining income eligibility under 42 CFR 435.135.

C. 100 percent FBR. As a condition of eligibility for all special groups, countable income shall be equal to or less than 100 percent of the SSI FBR, as adjusted annually.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1506. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1507. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1508. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

ARTICLE 16. HOSPITAL PRESUMPTIVE ELIGIBILITY

R9-22-1601. General Eligibility Requirements

A. Notwithstanding Article 3, a qualified hospital may determine Hospital Presumptive Eligibility (HPE), on the basis of preliminary information, that an individual is eligible for AHCCCS medical coverage during the presumptive eligibility period described in this section, if the individual is a United States citizen or eligible qualified alien, and the individual is:
1. Pregnant with gross household income that does not exceed 156% of the FPL;
2. An adult who meets the requirements of R9-22-1427(E);
3. A caretaker relative as defined in R9-22-1401(B) with gross household income that does not exceed 106% of the FPL;
4. Under age 19 with gross household income that does not exceed the limit set in R9-22-1427(D) for the child's age;
5. A woman screened for breast or cervical cancer by an Arizona program of the National Breast and Cervical Cancer Early Detection Program who meets the requirements of R9-22-2003(A); or
6. A former foster care child who meets the requirements of R9-22-1432.

B. Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning: "Qualified hospital" means a hospital that has signed an agreement with the Administration to process HPE applications and has not been disqualified.

C. Application Process:
1. Right to apply. A person may apply for presumptive eligibility for AHCCCS medical coverage by submitting an Administration-approved application to the qualified hospital.
2. Application. To initiate the application process, the qualified hospital will accept an application from the applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in section 36B(d)(1) of the Internal Revenue Service (IRS) Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant by submitting a written or online application under 42 CFR 435.907.

D. To establish presumptive eligibility, an applicant must complete and submit an AHCCCS-approved presumptive eligibility application signed under penalty of perjury to a qualified hospital. The applicant must attest to the name(s), relationship(s), and income of all persons in the household. In addition, the applicant must provide and attest to the following information regarding each household member on whose behalf AHCCCS medical coverage is sought:
1. The individual's date of birth;
2. Whether the individual is pregnant;
3. Whether the individual has been determined eligible for Breast and Cervical Cancer Treatment Program, described under Article 20;
4. Whether the individual is a former foster child, described under R9-22-1432;
5. The U.S. citizenship status or eligible qualified alien status under A.R.S. 36-2903.03 of the individual; and
6. The individual's permanent and mailing addresses;
7. The individual's Arizona residency status; and
8. Whether the individual has Medicare coverage.

E. Presumptive eligibility begins on the date the hospital determines an individual's presumptive eligibility and ends with the earlier of:
1. In the case of an individual on whose behalf an application has been submitted to AHCCCS or its designee under Article 3, the day on which AHCCCS or its designee makes a determination on that application; or
2. In the case of an individual on whose behalf an application has not been submitted to AHCCCS or its designee under Article 3, on the last day of the following month in which the determination of presumptive eligibility was made by the qualified hospital.

F. An individual may not be determined presumptively eligible more often than once every two years.

G. Coverage and reimbursement of services.
1. The Administration shall provide coverage of medically necessary services described under Article 2 to persons determined eligible for HPE on a fee-for-service basis.
2. Providers shall submit claims for services provided to persons determined eligible for HPE to the Administration as described under Article 7.

H. A member may withdraw from HPE coverage by notifying the Administration or its designee.

I. Upon determining an individual presumptively eligible, the qualified hospital shall:

1. Notify the applicant at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of the determination for each individual on whose behalf presumptive eligibility was requested and the effective date of the presumptive eligibility;
2. Provide the applicant with a regular AHCCCS-approved application form and inform the applicant that the applicant may file an application for Medicaid with the Administration or its designee;
3. Notify AHCCCS of the presumptive eligibility determination;
4. Notify the applicant at the time the determination is made that presumptive eligibility ends with the earlier of:
   a. In the case of an individual on whose behalf an application has been submitted to AHCCCS or its designee under Article 3, the day on which AHCCCS or its designee makes a determination on that application; or
   b. In the case of an individual on whose behalf an application has not been submitted to AHCCCS or its designee under Article 3, on the last day of the following month in which the determination of presumptive eligibility was made by the qualified hospital.

J. A determination by a qualified hospital that an individual is not presumptively eligible is not appealable under Chapter 34. If a qualified hospital denies an individual presumptive eligibility, the individual may apply for coverage by submitting an application to the Administration or its designee.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4). New Section made by final rulemaking at 20 A.A.R. 3436, effective January 1, 2015 (Supp. 14-4).

R9-22-1602. Expired

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1603. Expired

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1604. Expired

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1605. Expired

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1606. Expired

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1607. Expired

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1608. Expired

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1609. Expired

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section

expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1610. Expired

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1611. Expired

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1612. Expired

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1613. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1614. Expired

Historical Note

New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1615. Expired

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1616. Expired

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1617. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1618. Expired

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1619. Expired

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1620. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1621. Reserved

R9-22-1622. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1623. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1624. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1625. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1626. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1627. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1628. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1629. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1630. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1631. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1632. Reserved

R9-22-1633. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1634. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1635. Reserved

R9-22-1636. Repealed

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

ARTICLE 17. ENROLLMENT

R9-22-1701. Enrollment-Related Definitions
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Annual enrollment choice" means the annual opportunity for a person to change contractors.

"Auto-assignment algorithm" or "Algorithm" means a formula used by the Administration to assign to a contractor a member who did not make a timely choice under R9-22-1702.

"CMDP" means Comprehensive Medical and Dental Program.

"Disenrollment" means the discontinuance of a person's entitlement to receive covered services from a contractor of record.

"Enrollment" means the process by which an eligible person becomes a member of a contractor's plan.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct a typographical error, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1702. Enrollment of a Member with an AHCCCS Contractor

A. General enrollment requirements. The Administration shall enroll a member with a contractor as described in this Section, unless the member has pre-selected a contractor on the application:

1. Except as provided in subsections (A)(3), (A)(5), and (C), a member who is determined to be eligible under this Chapter and resides in an area served by more than one contractor, may choose an available contractor serving the member's GSA within 30 days from the date of notice

of enrollment. A Native American member may select IHS or another available contractor.

2. If the member does not make a choice under subsection (A)(1), the Administration shall immediately auto-assign the member to:
   a. IHS if the member is a Native American living on a reservation,
   b. A contractor based on family continuity, or
   c. A contractor by using the auto-assignment algorithm.
3. If the member's period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days, the Administration shall enroll the member with the member's most recent contractor of record, if available, except if:
   a. The member no longer resides in the contractor's GSA;
   b. The contractor's contract is suspended or terminated;
   c. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child;
   d. The member chooses another contractor or chooses IHS, if available to the member, during the annual enrollment choice period; or
   e. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.
4. When the member's disenrollment period is more than 90 days, the member may select a contractor as described in subsection (A)(1).
5. The Administration shall not enroll a member with a contractor if a member:
   a. Is eligible for the FESP under R9-22-1419;
   b. Is eligible for less than 30 days from the date the Administration receives notification of a member's eligibility, except for a member who is enrolled with CMDP or IHS;
   c. Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with CMDP or IHS; or
   d. Resides in an area not served by a contractor.

B. Fee-for-service coverage. A member not enrolled with a contractor under subsection (A)(5) shall obtain covered medical services from an AHCCCS-registered provider on a fee-for-service basis under Article 7.

C. Foster care child. The Administration shall enroll a member with CMDP if the member is a foster care child under A.R.S. § 8-512.

D. Family Planning Services Extension Program. A member eligible for the Family Planning Services Extension Program under R9-22-1431, shall remain enrolled with the member's contractor of record or IHS.

E. Contractor or IHS enrollment change for a member.

1. The Administration shall change a member's enrollment if the member requests a change to an available contractor or IHS during an annual enrollment period. A Native American may change from an available contractor to IHS or from IHS to an available contractor at any time.
2. The Administration shall approve a change in enrollment for any member if the change is a result of the final outcome of a grievance under 9 A.A.C. 34.
3. A member may choose a different contractor if the member moves into a GSA not served by the current contractor or if the contractor is no longer available. If the member does not select a contractor, the Administration shall auto-assign the member as provided in subsection (A)(2).
4. The Administration shall provide the member 60-day advance notice of the member's option to change plans by the member's annual enrollment date.
5. A member may disenroll from a plan if:
   a. The member moves out of the GSA;
   b. The plan does not, because of moral or religious objections, cover the service a member seeks; or
   c. The member needs related services to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.
6. For exceptions to this Article, the Administration shall approve a change for an enrolled member as determined by the Director.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1703. Effective Date of Enrollment with a Contractor

A. Effective date of enrollment. A member's date of enrollment is the date enrollment action is taken by the Administration. However, if a plan change occurs for an annual enrollment choice, the effective date is the month of the member's enrollment anniversary date.

B. Financial liability of the contractor. The contractor shall be financially liable for an enrolled member's care as specified in contract.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1704. Newborn Enrollment

A. General.

1. The Administration shall enroll a newborn child of an eligible mother with an available contractor or IHS, based on the mother's enrollment.
2. The Administration shall auto-assign a newborn child of an eligible mother who is not enrolled with a contractor or IHS or who is enrolled with CMDP. When a mother enrolled in CMDP has a newborn and the newborn is surrendered to Administration on Children, Youth and Families (ACYF), the newborn is then enrolled with CMDP.
3. The Administration shall notify the mother of the right to choose a different contractor for her newborn child. The mother may make her choice within 30 days from the date of notice of enrollment.

B. Financial liability for newborns. The contractor shall be financially liable for the medical care of a newborn as specified in contract.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct a typographical error, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1705. Guaranteed Enrollment Period

A. General. Except for members enrolled with IHS or CMDP, the Administration shall provide a guaranteed enrollment period for a one-time period that begins on the effective date of the member's initial enrollment with a contractor and ends on the last day of the fifth full calendar month after the date of the member's initial enrollment.

B. Exceptions to guaranteed period. The Administration shall not grant a guaranteed enrollment period or shall terminate a guaranteed enrollment period as provided in subsection (C), if the member:

1. Did not meet the conditions of eligibility when initially enrolled with the contractor;
2. Except as provided in 9 A.A.C. 22, Article 12, is an inmate of a public institution as defined in 42 CFR 435.1010;
3. Dies;
4. Moves out-of-state;
5. Voluntarily withdraws from the AHCCCS program;
6. Is adopted; or
7. Has whereabouts that are unknown.

C. Disenrollment effective date. The Administration shall terminate any guaranteed enrollment period to which the member is not entitled effective on:

1. The date the member is admitted to a public institution under subsection (B);
2. The member's date of death;
3. The last day of the month in which the Administration receives notification that a member moved out-of-state;
4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program;
5. The last day of the month in which the Administration receives notification that a member's adoption proceedings are finalized; or
6. The last day of the month in which the Administration receives notification that a member's whereabouts are unknown.

D. Retroactive adjustments. The Administration shall adjust the member's eligibility and enrollment retroactively under subsection (C).

Historical Note

New Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

ARTICLE 18. RESERVED

ARTICLE 19. FREEDOM TO WORK

Article 19, consisting of Sections R9-22-1901 through R9-22-1922, made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1901. General Freedom to Work Requirements

Under 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI), the Administration shall determine eligibility for AHCCCS medical services, under Article 2 of this Chapter, using the eligibility criteria and requirements under this Article for an applicant or member who is:

1. At least 16 years of age, but less than 65 years of age,
2. Employed, and
3. Not income eligible under A.R.S. § 36-2901(6)(a).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1902. General Administration Requirements

The Administration shall comply with the confidentiality rule under R9-22-512(C).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1903. Application for Coverage

A. A person may apply by submitting an application to an Administration office.

B. The application date is the date the application is received at an Administration office or outstation location approved by the Director as described under R9-22-1406(A).

C. The provisions in R9-22-1406(B) and (D) apply to this Section.

D. The applicant or representative who files the application may withdraw the application for coverage either orally or in writing. An applicant withdrawing an application shall receive a denial notice under R9-22-1904.

E. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 45 days.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1904. Notice of Approval or Denial

The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the action, and:

1. If approved, the notice shall contain:
   a. The effective date of eligibility,
   b. The amount the person shall pay, and
   c. An explanation of the person's hearing rights specified in 9 A.A.C. 34.
2. If denied, R9-22-1501(G)(3) applies.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1905. Reporting and Verifying Changes

An applicant or member shall report and verify changes, as described under R9-22-1501(H), to the Administration.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1906. Actions that Result from a Redetermination or Change

The processing of a redetermination or change shall result in one of the following actions:

1. No change in eligibility or premium,
2. Discontinuance of eligibility if a condition of eligibility is no longer met,
3. A change in premium amount, or
4. A change in the coverage group under which a person receives AHCCCS medical coverage.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1907. Notice of Adverse Action Requirements

A. The requirements under R9-22-1501(K)(1) apply.

B. Advance notice of a change in eligibility or premium amount. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (C), advance notice shall be issued whenever an adverse action is taken to discontinue eligibility, or increase the premium amount.

C. Exceptions from advance notice. A notice shall be issued to the member to discontinue eligibility no later than the effective date of action if:

1. A member provides a clearly written statement, signed by that member, that services are no longer wanted.
2. A member provides information that requires termination of eligibility or reduction of services, indicates that the member understands that this must be the result of supplying that information, and the member signs a written statement waiving advance notice;
3. A member cannot be located and mail sent to the member's last known address has been returned as undeliverable subject to reinstatement of discontinued services under 42 CFR 431.231(d);
4. A member has been admitted to a public institution where a person is ineligible for coverage;
5. A member has been approved for Medicaid in another state; or
6. The Administration receives information confirming the death of a member.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1908. Request for Hearing

An applicant or member may request a hearing under 9 A.A.C. 34.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1909. Conditions of Eligibility

An applicant or member shall meet the following conditions to qualify for the Freedom to Work program:

1. Furnish a valid Social Security Number (SSN);
2. Be a resident of Arizona;
3. Be a citizen of the United States, or meet requirements for a qualified alien under A.R.S. § 36-2903.03(B);
4. Be at least 16 years of age, but less than 65 years of age;
5. Have countable income that does not exceed 250 percent of FPL. The Administration shall count the income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K with the following exceptions:
   a. The unearned income of the applicant or member shall be disregarded,
   b. The income of a spouse or other family member shall be disregarded, and
   c. The deduction for a minor child shall not apply;
6. Comply with the member responsibility provisions under R9-22-1502(D) and (F).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Section repealed; new Section made by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1910. Prior Quarter Eligibility

A person may be made eligible during a prior quarter period when applying for the Freedom to Work program, as described under Article 3.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). New Section made by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

R9-22-1911. Repealed

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1912. Repealed

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1913. Premium Requirements

A. As a condition of eligibility, an applicant or member shall:

1. Pay the premium required under subsection (B).
2. Not have any unpaid premiums for more than one month's premium amount.

B. The Administration shall process premiums under 9 A.A.C. 31, Article 14 with the following exceptions:

1. A member who has countable income:
   a. Under $500, the monthly premium payment shall be $0.
   b. Over $500 but not greater than $750, the monthly premium payment shall be $10.
2. The premium for a member shall be increased by $5 for each $250 increase in countable income above $750.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1914. Repealed

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1915. Institutionalized Person
A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution if federal financial participation (FFP) is not available, or
2. Age 21 through age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except when allowed under the Administration's Section 1115 IMD waiver or allowed under a managed care contract approved by CMS.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1916. Repealed

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1917. Repealed

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1918. Additional Eligibility Criteria for the Basic Coverage Group
An applicant or member shall meet the following eligibility criteria:

1. Disabled. As a condition of eligibility, an applicant or member shall be disabled. Disabled means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E), except employment activity, earnings, and substantial gainful activity shall not be considered in determining whether the individual meets the definition of disability.
2. Employed. As a condition of eligibility, an applicant or member shall be employed. Employed means that an applicant or member is paid for working and Social Security or Medicare taxes are paid on the applicant or member's work.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1919. Additional Eligibility Criteria for the Medically Improved Group
As a condition of eligibility for the Medically Improved Group, a member shall:

1. Be employed. Under this Section, employed means an individual who:
   a. Earns at least the minimum wage and works at least 40 hours per month, or
   b. Has gross monthly earnings at least equal to those earned by an individual who is earning the minimum wage working 40 hours per month.
2. Cease to be eligible for medical coverage under R9-22-1918 or a similar Basic Coverage Group program administered by another state because the member, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be disabled; and
3. Continues to have a severe medically determinable impairment, as determined under Social Security Act section 1902(a)(10)(A)(ii)(XVI).

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1920. Repealed

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1921. Enrollment
The Administration shall enroll members under Article 17 of this Chapter. If a member has not paid a required premium, the Administration shall not grant a guaranteed enrollment period.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1922. Redetermination of Eligibility

A. Redetermination. Except as provided in subsection (B), the Administration shall complete a redetermination of eligibility at least once a year.

B. Change in circumstance. The Administration may complete a redetermination of eligibility if there is a change in the member's circumstances, including a change in disability or employment that may affect eligibility.

C. Medical Improvement. If a member is no longer disabled under R9-22-1918, the Administration shall determine if the member is eligible under other coverage groups including the medically improved group.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

ARTICLE 20. BREAST AND CERVICAL CANCER TREATMENT PROGRAM

R9-22-2001. Breast and Cervical Cancer Treatment Program Related Definitions
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meaning unless the context explicitly requires another meaning:

"AZ-NBCCEDP" means the Arizona programs of the National Breast and Cervical Cancer Early Detection Program. AZ-NBCCEDP provides breast and cervical cancer screening and diagnosis in Arizona.

"Cryotherapy" means the destruction of abnormal tissue using an extremely cold temperature.

"LEEP" means the loop electrosurgical excision procedure that passes an electric current through a thin wire loop.

"Peer-reviewed study" means that, prior to publication, a medical study has been subjected to the review of medical experts who:

Have expertise in the subject matter of the study,
Evaluate the science and methodology of the study,
Are selected by the editorial staff of the publication, and
Review the study without knowledge of the identity or qualifications of the author.

"WWHP" means the Well Women Healthcheck Program administered by the Arizona Department of Health Services. The WWHP is one of the programs within AZ-NBCCEDP that provides breast and cervical cancer screening and diagnosis.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2002. General Requirements

A. Confidentiality. The Administration shall maintain the confidentiality of a woman's records and shall not disclose a woman's financial, medical, or other confidential information except as allowed under R9-22-512.

B. Covered services. A woman who is eligible under this Article receives all medically necessary services under Articles 2 and 12 of this Chapter.

C. Choice of health plan. A woman who is eligible under this Article shall be enrolled with a contractor under Article 17 of this Chapter.

D. A Native American woman who receives services through Indian Health Service (IHS) or through a tribal health program qualifies for services provided under this Article if all eligibility requirements are met.

E. A woman qualified under this Article shall pay co-pays as described in R9-22-711.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2003. Eligibility Criteria

A. General. To be eligible under this Article, a woman shall meet the requirements of this Article and:

1. Be screened for breast and cervical cancer through AZ-NBCCEDP;
2. Be less than 65 years of age;
3. Be ineligible for Title XIX under Articles 14 and 15 in this Chapter;
4. Receive a positive screen under subsection (A)(1), a confirmed diagnosis through AZ-NBCCEDP, and need treatment for breast cancer or cervical cancer, including a pre-cancerous cervical lesion, as specified in R9-22-2004;
5. Not be covered under creditable coverage as specified in Section 2701(c) of the Public Health Services Act, 42 U.S.C. 300gg(c). For purposes of this Article, IHS or Tribal health coverage is not considered creditable coverage as specified in 42 U.S.C. 1396a(a)(10)(A)(ii), as amended by the Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2002; and
6. Meet the requirements under R9-22-1417 and R9-22-1418.

B. Ineligible woman. A woman is ineligible under this Article if the woman:

1. Is an inmate of a public institution and federal financial participation (FFP) is not available,
2. Is at least age 21 but less than age 65 and resides in an Institution for Mental Disease (IMD) as defined in R9-22-112, except if allowed under the Administration's Section 1115 waiver, or
3. No longer meets an eligibility requirement under this Article.

C. Metastasized cancer. The AHCCCS Chief Medical Officer may continue a woman's eligibility under this Article if a metastasized cancer is found in another part of the woman's body and that metastasized cancer is a known or a presumed complication of the breast or cervical cancer as determined by the treating physician.

D. Reoccurrence of cancer. A woman shall have eligibility reestablished after eligibility under this Article ends if the woman is screened under the AZ-NBCCEDP program and additional breast cancer or cervical cancer, including a pre-cancerous cervical lesion, is found.

E. Ineligible male. A male is precluded from receiving screening and diagnostic services under the AZ-NBCCEDP program and is ineligible under this Article.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2004. Treatment

A. Breast cancer. Coverage for treatment for breast cancer under this Article shall conclude on the last provider visit for the specific treatment of the cancer or at the end of hormonal therapy for the cancer, whichever is later. For purposes of this subsection treatment means:

1. Lumpectomy or surgical removal of breast cancer;
2. Chemotherapy;
3. Radiation therapy; and
4. A treatment for breast cancer that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

B. Pre-cancerous cervical lesion. Coverage for treatment for a pre-cancerous cervical lesion under this Article, including moderate or severe cervical dysplasia or carcinoma in situ, shall conclude on the last provider visit for specific treatment for the pre-cancerous lesion. For purposes of this subsection treatment means:

1. Conization;
2. LEEP;
3. Cryotherapy; and
4. A treatment for pre-cancerous cervical lesion that, as determined by the AHCCCS Chief Medical Officer, is

considered the standard of care as supported by a peer-reviewed study published in a medical journal.

C. Cervical cancer. Coverage for treatment for cervical cancer under this Article shall conclude on the last provider visit for the specific treatment for the cancer. For purposes of this subsection treatment means:
1. Surgery;
2. Radiation therapy;
3. Chemotherapy; and
4. A treatment for cervical cancer that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

Historical Note
New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2005. Application Process

A. Application. A woman may apply for eligibility under this Article by submitting a complete application as specified in R9-22-1406.

B. Submitting the application. The woman may complete and submit an application at the time of the AZ-NBCCEDP screening. The AZ-NBCCEDP staff may mail or fax the application directly to the Administration.

C. Date of application. The date of the application is the date of the diagnostic procedure that results in a positive diagnosis for breast cancer or cervical cancer, including a pre-cancerous cervical lesion.

D. Responsibility of a woman who is applying or who is a member. A woman who is applying or who is a member shall:
1. Provide medical insurance information, including any changes in medical insurance; and
2. Inform the Administration about a change in address, residence, and alienage status.

Historical Note
New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2006. Approval, Denial, or Discontinuance of Eligibility

A. Eligibility determination. The Administration shall determine eligibility under this Article and send the notice under subsection (B) or (C) within seven days of receiving a complete application.

B. Approval. If a woman meets all the eligibility requirements in this Article, the Administration shall provide the woman with an approval notice. The approval notice shall contain:
1. The name of the eligible woman, and
2. The effective date of eligibility.

C. Denial. If the Administration denies eligibility, the Administration shall provide the woman with a denial notice. The denial notice shall contain:
1. The name of the ineligible woman,
2. The specific reason why the woman is ineligible,
3. The legal citations supporting the reason for the denial,
4. The location where the woman can review the legal citations, and
5. Information regarding the woman's appeal and request for hearing rights.

D. Discontinuance.
1. Except as specified in subsection (D)(2), if a woman no longer meets an eligibility requirement under this Article, the Administration shall provide the woman a Notice of Action no later than 10 days before the effective date of the discontinuance.
2. The Administration may mail the Notice of Action no later than the effective date of the discontinuance if the Administration:
   a. Receives a written statement from the woman voluntarily withdrawing from AHCCCS,
   b. Receives information confirming the death of the woman,
   c. Receives returned mail with no forwarding address from the post office and the woman's whereabouts are unknown, or
   d. Receives information confirming that the woman has been approved for Title XIX services outside the state of Arizona.
3. The Notice of Action shall contain the:
   a. Name of the ineligible woman,
   b. Effective date of the discontinuance,
   c. Specific reason why the woman is discontinued,
   d. Legal citations supporting the reason for the discontinuance,
   e. Location where the woman can review the legal citations, and
   f. Information regarding the woman's appeal and request for hearing rights.

E. Request for hearing. A woman who is denied, or discontinued for the Breast and Cervical Cancer Treatment Program may request a hearing under Chapter 34.

Historical Note
New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2007. Effective and End Date of Eligibility

A. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the period described under R9-22-303.

B. The end date of eligibility:
1. For breast cancer, is 12 months after the last provider visit for a treatment specified in R9-22-2004 for the cancer or at the end of hormonal therapy for the cancer, whichever is later.
2. For pre-cancerous cervical lesion, is four months after the last provider visit for a treatment specified in R9-22-2004 for the pre-cancerous lesion.
3. For cervical cancer, is 12 months after the last provider visit for a treatment specified in R9-22-2004 for the cancer.

Historical Note
New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4). Section amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

R9-22-2008. Redetermination of Eligibility

A. Redetermination. Except as provided in subsection (B), the Administration shall redetermine eligibility at least once a

year. If a woman continues to meet the requirements of eligibility for the Breast and Cervical Cancer Treatment Program under this Article, the Administration shall notify the woman of continued eligibility. A woman is not required to be screened for breast and cervical cancer through AZ-NBCCEDP at redetermination.

B. Change in circumstance. The Administration shall complete a redetermination of eligibility if there is a change in the woman's circumstances that may affect eligibility, including a change in treatment.

Historical Note
New Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

ARTICLE 21. TRAUMA AND EMERGENCY SERVICES FUND

Article 21, consisting of Sections R9-22-2101 through R9-22-2103, made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).

R9-22-2101. General Provisions

A. A.R.S. § 36-2903.07 establishes the Administration as the authority to administer the Trauma and Emergency Services Fund.

B. The Administration shall distribute 90% of monies from the trauma and emergency services fund to a level I trauma center, as defined in subsection (F) of this Section, for unrecovered trauma center readiness costs as defined in subsection (F) of this Section. Reimbursement is limited to no more than the amount of unrecovered trauma center readiness costs as determined in subsections (D) and (E) of this Section. Unexpended funds may be used to reimburse unrecovered emergency room costs under subsection (C) of this Section.

C. The Administration shall distribute 10% of monies from the trauma and emergency services fund, for unrecovered emergency services costs, to a hospital having an emergency department, using criteria under R9-22-2103. Reimbursement is limited to no more than the amount of unrecovered emergency services costs as determined in R9-22-2103. The Administration may distribute more than 10% of the monies for unrecovered emergency room costs when there are unexpended monies under subsection (B) of this Section.

D. The Administration shall distribute a reporting tool and guidelines to level I trauma centers to determine, on an annual basis, the unrecovered trauma center readiness costs for level I trauma centers as defined in subsection (F) of this Section. The reporting time-frame is July 1 of the prior year through June 30 of the reporting year. A level I trauma center shall submit the requested data and a copy of the most recently completed uniform accounting report under A.R.S. § 36-125.04 to the Administration no later than October 31 of each reporting year.

E. When a level I trauma center closes in a county where there are one or more level I trauma center(s) remaining in operation, the following shall occur:
1. The closing level I trauma center shall submit the requested data under subsection (D) of this Section for the months of the reporting time-frame in which it met the definition of a level I trauma center, and
2. The data under subsection (D) of this Section, which is submitted by the closing level I trauma center, shall be added to the remaining level I trauma center(s) in that county for the current reporting time-frame only.

F. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:
1. "Level I trauma center" means any acute care hospital designated by the Arizona Department of Health Services as a level I trauma center, a provisional level I trauma center, a pediatric level 1 trauma center or an initial level I trauma center.
2. "Unrecovered trauma center readiness costs" means losses incurred treating trauma patients:
   a. Determined in accordance with Generally Accepted Accounting Principles,
   b. Based on both clinical and professional costs incurred by a level I trauma center necessary for the provision of level I trauma care, and
   c. Based on administrative and overhead costs directly associated with providing level I trauma care.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

R9-22-2102. Distribution of Trauma and Emergency Services Fund: Level I Trauma Centers

A. On or after November 1, 2003, the Administration shall distribute monies, under R9-22-2101(B), to level I trauma centers using monies available in the trauma and emergency services fund at the time of payment. The Administration shall take into consideration the proportion of those hospitals' trauma case volume. The Administration shall:
1. Recalculate the November 2003 payments in July 2004 using the formula in subsection (B) of this Section;
2. Recoup November 2003 overpayments by reducing the July 2004 distributions under subsection (C) as appropriate; and
3. Redistribute recouped funds, with the July 2004 payment, to level I trauma centers underpaid in November 2003.

B. On or after January 31 of each year, the Administration shall distribute monies, under R9-22-2101(B), to level I trauma centers using monies available in the trauma and emergency services fund at the time of payment. The Administration shall determine each hospital's unrecovered trauma center readiness costs for the current fiscal year using data from the most recent reporting year as provided under R9-22-2101(D) and (E). The proportion of each hospital's share of the fund for unrecovered trauma center readiness costs is determined after considering:
1. The professional, clinical, administrative, and overhead costs directly associated with providing level I trauma care, and
2. The volume and acuity of trauma care provided by each hospital.

C. On or after July 31 of each year, the Administration shall distribute monies to level I trauma centers using monies, under R9-22-2101(B), available in the trauma and emergency services fund at the time of payment according to the proportions calculated and used for the January payments in the same year, under subsection (B) of this Section.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).

R9-22-2103. Distribution of Trauma and Emergency Ser-

vices Fund: Emergency Services
On or after June 30 of each year, the Administration shall distribute monies available in the trauma and emergency services fund at the time of payment as follows:

1. As allocated under R9-22-2101(C),
2. To hospitals that had an emergency department from July 1 through June 30 of the prior year, and
3. On a pro rata share of each hospital's cost of uncompensated emergency care as a percentage of the total statewide cost of uncompensated emergency care provided by hospitals under subsection (2) as reported in the uniform accounting reports to the Arizona Department of Health Services under A.R.S. § 36-125.04.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by exempt rulemaking at 18 A.A.R. 1748, effective July 1, 2012 (Supp. 12-2).

R9-22-2104. Additional Trauma and Emergency Services Payments under the Section 1115 Waiver

A. Notwithstanding R9-22-2101(D), for the reporting years ending June 30, 2011 and June 30, 2012, the Administration shall distribute an amount equal to the balance of the Trauma and Emergency Services fund in the following manner:
1. Ninety percent of the amount shall be distributed to Level I trauma centers based upon each center's pro rata share of each center's acuity-adjusted volume as a percentage of the total acuity-adjusted volume for all centers in the state. The acuity-adjusted volume is calculated by multiplying the Injury Severity Score employed by trauma.org by the number of trauma cases at that level treated at the center during the reporting year. Hospitals shall report trauma scores and case volume on a worksheet prescribed by the Administration.
2. Ten percent of the amount shall be distributed proportionately to hospitals that had an emergency department from July 1 through June 30 of the reporting year based the pro rata share of each hospital's cost of emergency care as a percentage of the total statewide cost of emergency care provided by hospitals as reported on the Worksheet B, column 27, line 61 of the hospital's most current Medicare Cost Report as of January 31 following the end of each reporting year.

B. For the reporting years ending June 30, 2011 and June 30, 2012, the Administration shall distribute an amount equal to the federal financial participation made available under the section 1115 waiver for the purpose of making payments for unrecovered trauma and emergency services as follows:
1. Thirty percent of such funds to a Level I trauma center, in amounts calculated in the same manner as described in subsection (A)(1) of this Section, for any unrecovered trauma center readiness costs not reimbursed under subsection (A) of this Section;
2. Thirty percent of such funds to a hospital having an emergency department from July 1 through June 30 of the reporting year, in amounts calculated in the same manner as described in subsection (A)(2) of this Section, for any unrecovered emergency services costs not reimbursed under subsection (A) of this Section; and
3. Forty percent of such funds to rural hospitals, as defined in R9-22-718 that are not Level 1 trauma centers as defined in R9-22-2101(F), having an emergency department from July 1 through June 30 of the reporting year, in amounts calculated in the same manner as described in subsection (A)(2) of this Section, for any unrecovered emergency services costs not reimbursed under subsections (A) and (B)(2) of this Section.

C. For the reporting years ending June 30, 2011 and June 30, 2012, payments made under this Article shall not be made in an amount that results in aggregate payments to the hospital by the Administration and contractors exceeding of the upper payment limit for the hospital services as calculated in accordance with 42 CFR 447.

D. For the reporting years ending June 30, 2011 and June 30, 2012, to ensure compliance with subsection (C), payments under this Article shall be reconciled to the federal fiscal year that is two years subsequent to the payment.

E. Any payments that are determined under subsection (D) to exceed the limit in subsection (C) shall be distributed as described in this Article to hospitals that have not received payments in excess of the limit in subsection (C).

Historical Note
New Section made by exempt rulemaking at 18 A.A.R. 1748, effective July 1, 2012 (Supp. 12-2).

DEPARTMENT OF HEALTH SERVICES
Title 9, Chapter 6, Article 3

Amend: R9-6-303, R9-6-305, R9-6-338, R9-6-361, R9-6-362, R9-6-381

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - EXPEDITED RULEMAKING

MEETING DATE: August 1, 2023

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

FROM: Council Staff

DATE: **July 14, 2023**

SUBJECT: **Department of Health Services**
Title 9, Chapter 6, Article 3

Amend: R9-6-303, R9-6-305, R9-6-338, R9-6-361, R9-6-361, R9-6-362, R9-6-381

Summary:

This expedited rulemaking from the Department of Health Services seeks to amend rules in Title 9, Chapter 6, Article 3 regarding Control Measures for Communicable Disease and Infestations. Specifically, this rulemaking seeks to amend rules to address issues identified in a Five-Year-Review Report approved by the Council on February 7, 2023. The Department indicates this expedited rulemaking will improve the effectiveness of the rules and reduce regulatory burden.

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

Yes, the Department meets the criteria for expedited rulemaking pursuant to A.R.S. § 41-1027(A)(6).

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

The Department cites both general and specific statutory authority for these rules.

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 relating to this rulemaking

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

No changes were made 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?

There are no corresponding federal laws to the rules.

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 regulatory permit.

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 indicates it did not review and does not propose to rely on any study relevant to this rulemaking.

9. Conclusion

As mentioned above, this expedited rulemaking seeks to amend rules in response to a Five-Year-Review Report approved by the Council in February 2023. The Department indicates this expedited rulemaking will improve the effectiveness of the rules and reduce regulatory burden.

This rulemaking will become effective the day the Notice of Final Rulemaking is filed with the Secretary of State's Office. Council staff recommends approval of this expedited rulemaking.

ARIZONA DEPARTMENT
OF HEALTH SERVICES
POLICY & INTERGOVERNMENTAL AFFAIRS

May 24, 2023

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. 6, Article 3, Expedited Rulemaking

Dear Ms. Sornsin:

1. The close of record date: April 3, 2023

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. The rulemaking amends rules to address issues identified in a five-year-review report approved by the Council on February 7, 2023, as specified in A.R.S. § 41-1027(A)(6). The Department plans to clarify the rules through expedited rulemaking, under A.R.S. § 41-1027, consistent with the five-year review report. The Department believes that making these changes will improve the effectiveness of the rules and reduce regulatory burden.

3. 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. 6, Article 3, relates to a five-year-review report approved by the Council on February 7, 2023.

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

The Department is requesting that the rules be heard at the Council meeting on August 1, 2023.

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,

Stacie Gravito
Director's Designee

SG:rms

Enclosures

NOTICE OF FINAL EXPEDITED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 6. DEPARTMENT OF HEALTH SERVICES

COMMUNICABLE DISEASES AND INFESTATIONS

ARTICLE 3. CONTROL MEASURES FOR COMMUNICABLE DISEASES AND INFESTATIONS

PREAMBLE

1.	Article, Part, of Section Affected (as applicable)	Rulemaking Action
	R9-6-303	Amend
	R9-6-305	Amend
	R9-6-338	Amend
	R9-6-361	Amend
	R9-6-362	Amend
	R9-6-381	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. § 36-136(I)(1)

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: 29 A.A.R. 618, February 24, 2023

Notice of Proposed Expedited Rulemaking: 29 A.A.R. 705, March 10, 2023

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

Name: Ken Komatsu, State Epidemiologist

Address: Arizona Department of Health Services
Public Health Preparedness
150 N. 18th Ave., Suite 100
Phoenix, AZ 85007-3248

Telephone: (602) 364-3587

Fax: (602) 364-3199
E-mail: Ken.Komatsu@azdh
or
Name: Stacie Gravito, Office 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: Stacie.Gravito@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.) § 36-136(I)(1) requires the Arizona Department of Health Services (Department) to make rules defining and prescribing "reasonably necessary measures for detecting, reporting, preventing, and controlling communicable and preventable diseases." The Department has adopted in Arizona Administrative Code (A.A.C.) Title 9, Chapter 6, Article 3, rules related to control measures for communicable diseases and infestations. As part of a five-year-review report for 9 A.A.C. 6, Article 3, the Department identified several issues with the current rules and proposed making changes to the rules. After receiving rulemaking approval according to A.R.S. § 41-1039(A), the Department is clarifying the rules through expedited rulemaking, under A.R.S. § 41-1027, consistent with the five-year review report. The Department believes that making these changes will improve effectiveness and reduce regulatory burden.

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:

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.

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 the issuance of a regulatory permit. Therefore, 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 do not apply to 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 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:

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:

The rule was not previously made as an emergency rule.

15. The full text of the rule follows:

TITLE 9. HEALTH SERVICES

CHAPTER 6. DEPARTMENT OF HEALTH SERVICES - COMMUNICABLE DISEASES AND INFESTATIONS

ARTICLE 3. CONTROL MEASURES FOR COMMUNICABLE DISEASES AND INFESTATIONS

Section

ARTICLE 3. CONTROL MEASURES FOR COMMUNICABLE DISEASES AND INFESTATIONS

R9-6-303. Isolation, Quarantine, Exclusion, and Other Control Measures

A. When a local health agency is required by this Article to isolate or quarantine an individual or group of individuals, the local health agency:

1. Shall issue a written order:
    a. For isolation or quarantine and other control measures;
    b. To each individual or group of individuals and, for each individual who is a minor or incapacitated adult, the individual's parent or guardian, except as provided in subsection (A)(2);
    c. That specifies:
        i. The isolation or quarantine and other control measure requirements being imposed, including, if applicable, requirements for physical examinations and medical testing to ascertain and monitor each individual's health status;
        ii. The identity of each individual or group of individuals subject to the order;
        iii. The premises at which each individual or group of individuals is to be isolated or quarantined;
        iv. The date and time at which isolation or quarantine and other control measure requirements begin; and
        v. The justification for isolation or quarantine and other control measure requirements, including, if known, the disease for which the individual or individuals are believed to be cases, suspect cases, or contacts; and
    d. That may provide information about existing medical treatment, if available and necessary to render an individual less infectious, and the consequences of an individual's failure to obtain the medical treatment; and
2. May post the written order in a conspicuous place at the premises at which a group of individuals is to be isolated or quarantined if:
    a. The written order applies to the group of individuals, and
    b. It would be impractical to provide a copy to each individual in the group.

B. A local health agency may issue a written order for additional control measures:

1. Except as provided in subsection (A)(2), to each affected individual, group of individuals, or person and, for each individual who is a minor or incapacitated adult, the individual's parent or guardian;
2. That specifies:
    a. The control measure requirements being imposed, including, if applicable, requirements for:
        i. Being excluded from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a school or child care establishment;
        ii. Avoiding other locations where the individual or an individual in the group of individuals may pose a health risk to other individuals;
        iii. Observing airborne precautions, droplet precautions, or contact precautions and the methods by which the individual shall comply with the requirement;
        iv. Prophylaxis or immunization, as applicable, as an alternative to or to reduce the length of exclusion;
        v. Physical examinations and medical testing to ascertain and monitor the individual's health status; or
        vi. Not creating a situation where additional individuals may be exposed to the communicable disease;
    b. The identity of each individual, group of individuals, or person subject to the order;
    c. The date and time at which the control measure requirements begin; and
    d. The justification for the control measure requirements, including:
        i. If known, the disease for which the individual or individuals are believed to be cases, suspect cases, or contacts; and
        ii. If applicable, the possible consequences of the individual, group of individuals, or person failing to follow the recommendations of the Department or the local health agency to control the spread of the communicable disease; and
3. That may provide information about the disease, existing medical treatment, if applicable, and the consequences of an individual's failure to comply with the order.

C. Within 10 calendar days after the issuing of a written order described in subsection (A) or (B), if a local health agency determines that isolation, quarantine, or other control measure requirements

need to continue for more than 10 calendar days after the date of the order, the local health agency shall file a petition for a court order that:

1. Authorizes the continuation of isolation, quarantine, or other control measure requirements pertaining to an individual, a group of individuals, or a person;
2. Includes the following:
    a. The isolation, quarantine, or other control measure requirements being imposed, including, if applicable, requirements for physical examinations and medical testing to ascertain and monitor an individual's health status;
    b. The identity of each individual, group of individuals, or person subject to isolation, quarantine, or other control measure requirements;
    c. If applicable, the premises at which each individual or group of individuals is isolated or quarantined;
    d. The date and time at which isolation, quarantine, or other control measure requirements began; and
    e. The justification for isolation, quarantine, or other control measure requirements, including, if applicable and known, the disease for which the individual or individuals are believed to be cases, suspect cases, or contacts; and
3. Is accompanied by the sworn affidavit of a representative of the local health agency or the Department attesting to the facts asserted in the petition, together with any further information that may be relevant and material to the court's consideration.

D. A local health agency that files a petition for a court order under subsection (C) shall provide notice to each individual, group of individuals, or person identified in the petition according to the Arizona Rules of Civil Procedure, except that notice shall be provided within 24 hours after the petition is filed.

E. In the event of noncompliance with a written order issued under subsection (A) or (B), a local health agency may contact law enforcement to request assistance in enforcing the order.

F. If the Department determines that isolation, quarantine, or other control measure requirements are necessary, the Department, under A.R.S. § ~~36-136(G)~~ 36-136(H), may take any of the actions specified in subsections (A) through (E).

R9-6-305. Control Measures for Multi-drug-resistant Organisms

Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution transferring a case with active infection or colonization of a bacterial or fungal disease, for which the agent is known to be a multi-drug-resistant organism, to another health care

provider or health care institution or to a correctional facility shall, either personally or through a representative, ensure that the receiving health care provider, health care institution, or correctional facility is informed that the ~~patient~~ case is infected or colonized with a multi-drug-resistant organism and the type of isolation precautions being used for the case.

2. An administrator of the correctional facility transferring a case with active infection or colonization of a bacterial disease or fungal, for which the agent is known to be a multi-drug-resistant organism, to another correctional facility or to a health care institution shall, either personally or through a representative, ensure that the receiving correctional facility or health care institution is informed that the ~~individual~~ case is infected or colonized with a multi-drug-resistant organism and the type of isolation precautions being used for the case.

R9-6-338. Gonorrhea

A. Case control measures:

1. For the prevention of gonorrheal ophthalmia, a physician, physician assistant, registered nurse practitioner, or midwife attending the birth of an infant in this state shall treat the eyes of the infant immediately after the birth with one of the following, unless treatment is refused by the parent or guardian:
   a. Erythromycin ophthalmic ointment 0.5%~~,~~; or
   b. ~~Tetracycline ophthalmic ointment 1%~~ If erythromycin ophthalmic ointment is not available, another appropriate antibiotic.
2. A local health agency shall comply with the requirements specified in R9-6-1103 concerning treatment and health education for a gonorrhea case that seeks treatment from the local health agency.

B. Contact control measures: If an individual who may have been exposed to gonorrhea through sexual contact with a gonorrhea case seeks treatment for symptoms of gonorrhea from a local health agency, the local health agency shall comply with the requirements specified in R9-6-1103 concerning treatment and health education for the individual.

R9-6-361. Novel Coronavirus (e.g., SARS or MERS)

A. Case control measures:

1. ~~A~~ In consultation with the Department or the applicable local health agency, a diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute both airborne precautions and contact precautions for a novel coronavirus case or suspect case, including a case or suspect case

of severe acute respiratory syndrome or Middle East respiratory syndrome, until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner or otherwise advised by the Department or the applicable local health agency.

2. A local health agency shall:
   a. Upon receiving a report under R9-6-202 of a novel coronavirus case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
   b. In consultation with the Department, ensure that isolation and both airborne precautions and contact precautions have been instituted for a novel coronavirus case or suspect case to prevent transmission, unless otherwise advised by the Department;
   c. Conduct an epidemiologic investigation of each reported novel coronavirus case or suspect case, unless otherwise advised by the Department; and
   d. For each novel coronavirus case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Contact control measures: A local health agency, in consultation with the Department, shall determine which novel coronavirus contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission.

R9-6-362. Pediculosis (Lice Infestation)

A. Case control measures:

1. An administrator of a school or child care establishment, either personally or through a representative, ~~shall~~ may exclude a pediculosis case from the school or child care establishment until the case is treated with a pediculocide.
2. An administrator of a shelter shall ensure that a pediculosis case is treated with a pediculocide and that the case's clothing and personal articles are disinfested.

B. Contact control measures: An administrator of a school or child care establishment that ~~excludes~~ has knowledge of a pediculosis case from the school or child care establishment, either personally or through a representative, shall ensure that a parent or guardian of a child who is a contact is notified that a pediculosis case was identified at the school or child care establishment.

R9-6-381. Syphilis

A. Case control measures:

1. A syphilis case shall obtain serologic testing for syphilis three months, six months, and one year after initiating treatment, unless more frequent or longer testing is recommended by a local health agency.
2. A health care provider for a pregnant syphilis case shall order serologic testing for syphilis at 28 to 32 weeks gestation and at delivery.
3. A local health agency shall:
    a. Conduct an epidemiologic investigation, including a review of medical records, of each reported syphilis case or suspect case, confirming the stage of the disease;
    b. For each syphilis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D);
    c. If the syphilis case is pregnant, ensure that the syphilis case obtains the serologic testing for syphilis required in ~~subsection~~ subsections (A)(1) and (A)(2); and
    d. Comply with the requirements specified in R9-6-1103 concerning treatment and health education for a syphilis case.
4. The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of syphilis, as required under A.R.S. § 32-1483 and 21 CFR 630.6.

B. Contact control measures: When a syphilis case has named a contact, a local health agency shall comply with the requirements specified in R9-6-1103 concerning notification, testing, treatment, and health education for the contact.

C. Outbreak control measures: A local health agency shall:
1. Conduct an epidemiologic investigation of each reported syphilis outbreak; and
2. For each syphilis outbreak, submit to the Department the information required under R9-6-206(E).

TITLE 9. HEALTH SERVICES
CHAPTER 6. DEPARTMENT OF HEALTH SERVICES - COMMUNICABLE DISEASES AND INFESTATIONS

ARTICLE 3. CONTROL MEASURES FOR COMMUNICABLE DISEASES AND INFESTATIONS

R9-6-301. Definitions

In this Article, unless otherwise specified:

1. "Aquatic venue" means an artificially constructed structure or modified natural structure that:
   a. Is used:
      i. For water contact recreation, as defined in A.A.C. R9-8-801; or
      ii. To treat a diagnosed injury, illness, or medical condition under the supervision of a health professional, as defined in A.R.S. § 32-3201;
   b. Is open to all individuals or to all residents of a community, members of a club or camp, individuals being treated by a specific health professional, or patrons of other such establishments; and
   c. Includes a:
      i. Natural bathing place as defined in A.A.C. R18-5-201,
      ii. Public spa as defined in A.A.C. R18-5-201,
      iii. Public swimming pool as defined in A.A.C. R18-5-201,
      iv. Semi-artificial bathing place as defined in A.A.C. R18-5-201,
      v. Semi-public spa as defined in A.A.C. R18-5-201,
      vi. Semi-public swimming pool as defined in A.A.C. R18-5-201, and
      vii. Water-play area, an artificially constructed depression in which water issues from showers or other nozzles and drains away to leave little or no standing water.
2. "Blood bank" means a facility where human whole blood or a blood component is collected, prepared, tested, processed, or stored, or from which human whole blood or a blood component is distributed.
3. "Blood center" means a mobile or stationary facility that procures human whole blood or a blood component that is transported to a blood bank.
4. "Contact precautions" means, in addition to use of standard precautions:
   a. Placing an individual in a private room or a cohort room with a distance of three or more feet separating the individual's bed from the bed of another individual; and
   b. Ensuring the use of a gown and gloves by other individuals when entering the room in which the individual is located.
5. "Contaminated" means to have come in contact with a disease-causing agent or toxin.
6. "Disinfection" means killing or inactivating communicable-disease-causing agents on inanimate objects by directly applied chemical or physical means.
7. "Disinfestation" means any physical, biological, or chemical process to reduce or eliminate undesired arthropod or rodent populations.
8. "Droplet precautions" means, in addition to use of standard precautions:
   a. Placing an individual in a private room or a cohort room with a distance of three or more feet and a curtain separating the individual's bed from the bed of another individual;
   b. Ensuring that the individual wears a mask covering the individual's mouth and nose, if medically appropriate, when not in the room described in subsection (8)(a); and
   c. Ensuring the use of a mask covering the mouth and nose by other individuals when entering the room in which the individual is located.
9. "Follow-up" means the practice of investigating and monitoring cases, carriers, contacts, or suspect cases to detect, treat, or prevent disease.
10. "Incapacitated adult" means an individual older than 18 years of age for whom a guardian has been appointed by a court of competent jurisdiction.
11. "Isolation precautions" means methods to limit the transmission of an infectious agent, based on the infectious agent and the location of infection in or on the infected individual or animal, that includes isolation of the infected individual or animal and may include any one or combination of the following:
    a. Standard precautions,
    b. Contact precautions,
    c. Droplet precautions, or
    d. Airborne precautions.
12. "Midwife" has the same meaning as in A.R.S. § 36-751.
13. "Multi-drug-resistant organism" means a bacterial agent on a Department-provided list that is known to not be killed or whose growth is not slowed by specific classes of antibiotics.
14. "Pediculocide" means a shampoo or cream rinse manufactured and labeled for controlling head lice.

15. "Person in charge" means the individual present at a food establishment who is responsible for the food establishment's operation at the time in question.
16. "Plasma center" means a facility where the process of plasmapheresis or another form of apheresis is conducted.
17. "State health officer" means the Director of the Department or the Director's designee.
18. "Vector" means a living animal, usually a mosquito, tick, flea, or other arthropod, that may transmit an infectious agent to an individual.

R9-6-302. Local Health Agency Control Measures

A local health agency shall:

1. Review each report received under Article 2 for completeness and accuracy;
2. Confirm each diagnosis;
3. Conduct epidemiologic and other investigations required by this Chapter or in cooperation with the Department;
4. Facilitate notification of known contacts;
5. Conduct surveillance;
6. Determine trends;
7. Implement control measures, quarantines, isolations, and exclusions as required by the Arizona Revised Statutes and this Chapter;
8. Disseminate surveillance information to health care providers;
9. Provide health education to a disease case or contact to reduce the risk of transmission of the respective disease; and
10. Report to the Department, as specified in R9-6-206 and this Article.

R9-6-303. Isolation, Quarantine, Exclusion, and Other Control Measures

A. When a local health agency is required by this Article to isolate or quarantine an individual or group of individuals, the local health agency:

1. Shall issue a written order:
    a. For isolation or quarantine and other control measures;
    b. To each individual or group of individuals and, for each individual who is a minor or incapacitated adult, the individual's parent or guardian, except as provided in subsection (A)(2);
    c. That specifies:
        i. The isolation or quarantine and other control measure requirements being imposed, including, if applicable, requirements for physical examinations and medical testing to ascertain and monitor each individual's health status;
        ii. The identity of each individual or group of individuals subject to the order;
        iii. The premises at which each individual or group of individuals is to be isolated or quarantined;
        iv. The date and time at which isolation or quarantine and other control measure requirements begin; and
        v. The justification for isolation or quarantine and other control measure requirements, including, if known, the disease for which the individual or individuals are believed to be cases, suspect cases, or contacts; and
    d. That may provide information about existing medical treatment, if available and necessary to render an individual less infectious, and the consequences of an individual's failure to obtain the medical treatment; and
2. May post the written order in a conspicuous place at the premises at which a group of individuals is to be isolated or quarantined if:
    a. The written order applies to the group of individuals, and
    b. It would be impractical to provide a copy to each individual in the group.

B. A local health agency may issue a written order for additional control measures:

1. Except as provided in subsection (A)(2), to each affected individual, group of individuals, or person and, for each individual who is a minor or incapacitated adult, the individual's parent or guardian;
2. That specifies:
    a. The control measure requirements being imposed, including, if applicable, requirements for:
        i. Being excluded from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a school or child care establishment;
        ii. Avoiding other locations where the individual or an individual in the group of individuals may pose a health risk to other individuals;
        iii. Observing airborne precautions, droplet precautions, or contact precautions and the methods by which the individual shall comply with the requirement;
        iv. Prophylaxis or immunization, as applicable, as an alternative to or to reduce the length of exclusion;
        v. Physical examinations and medical testing to ascertain and monitor the individual's health status; or
        vi. Not creating a situation where additional individuals may be exposed to the communicable disease;
    b. The identity of each individual, group of individuals, or person subject to the order;
    c. The date and time at which the control measure requirements begin; and
    d. The justification for the control measure requirements, including:

i. If known, the disease for which the individual or individuals are believed to be cases, suspect cases, or contacts; and
ii. If applicable, the possible consequences of the individual, group of individuals, or person failing to follow the recommendations of the Department or the local health agency to control the spread of the communicable disease; and

3. That may provide information about the disease, existing medical treatment, if applicable, and the consequences of an individual's failure to comply with the order.

C. Within 10 calendar days after the issuing of a written order described in subsection (A) or (B), if a local health agency determines that isolation, quarantine, or other control measure requirements need to continue for more than 10 calendar days after the date of the order, the local health agency shall file a petition for a court order that:

1. Authorizes the continuation of isolation, quarantine, or other control measure requirements pertaining to an individual, a group of individuals, or a person;
2. Includes the following:
   a. The isolation, quarantine, or other control measure requirements being imposed, including, if applicable, requirements for physical examinations and medical testing to ascertain and monitor an individual's health status;
   b. The identity of each individual, group of individuals, or person subject to isolation, quarantine, or other control measure requirements;
   c. If applicable, the premises at which each individual or group of individuals is isolated or quarantined;
   d. The date and time at which isolation, quarantine, or other control measure requirements began; and
   e. The justification for isolation, quarantine, or other control measure requirements, including, if applicable and known, the disease for which the individual or individuals are believed to be cases, suspect cases, or contacts; and
3. Is accompanied by the sworn affidavit of a representative of the local health agency or the Department attesting to the facts asserted in the petition, together with any further information that may be relevant and material to the court's consideration.

D. A local health agency that files a petition for a court order under subsection (C) shall provide notice to each individual, group of individuals, or person identified in the petition according to the Arizona Rules of Civil Procedure, except that notice shall be provided within 24 hours after the petition is filed.

E. In the event of noncompliance with a written order issued under subsection (A) or (B), a local health agency may contact law enforcement to request assistance in enforcing the order.

F. If the Department determines that isolation, quarantine, or other control measure requirements are necessary, the Department, under A.R.S. § 36-136(G), may take any of the actions specified in subsections (A) through (E).

R9-6-304. Food Establishment Control Measures

The person in charge of a food establishment shall ensure compliance with all food handler exclusion requirements in this Article or as ordered by a local health agency or the Department.

R9-6-305. Control Measures for Multi-drug-resistant Organisms

Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution transferring a case with active infection of a bacterial disease, for which the agent is known to be a multi-drug-resistant organism, to another health care provider or health care institution or to a correctional facility shall, either personally or through a representative, ensure that the receiving health care provider, health care institution, or correctional facility is informed that the patient is infected with a multi-drug-resistant organism.
2. An administrator of the correctional facility transferring a case with active infection of a bacterial disease, for which the agent is known to be a multi-drug-resistant organism, to another correctional facility or to a health care institution shall, either personally or through a representative, ensure that the receiving correctional facility or health care institution is informed that the individual is infected with a multi-drug-resistant organism.

R9-6-306. Amebiasis

Case control measures: A local health agency shall:

1. Exclude an amebiasis case or suspect case with diarrhea from:
   a. Working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
      i. Either:
         (1) Treatment with an amebicide is initiated, and
         (2) A stool specimen negative for amoebae is obtained from the amebiasis case or suspect case; or
      ii. The local health agency has determined that the amebiasis case or suspect case is unlikely to infect other individuals; and
   b. Using an aquatic venue for two weeks after diarrhea has resolved;

2. Conduct an epidemiologic investigation of each reported amebiasis case or suspect case; and
3. For each amebiasis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-307. Anaplasmosis

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported anaplasmosis case or suspect case; and
2. For each anaplasmosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-308. Anthrax

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of an anthrax case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported anthrax case or suspect case;
3. For each anthrax case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that an isolate or a specimen, as available, from each anthrax case or suspect case is submitted to the Arizona State Laboratory.

B. Environmental control measures: A local health agency shall, in conjunction with the Department and applicable federal agencies, provide or arrange for disinfection of areas or objects contaminated by *Bacillus anthracis* through sterilization by dry heating, incineration of objects, or other appropriate means.

R9-6-309. Arboviral Infection

A. Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported arboviral infection case or suspect case;
2. For each arboviral infection case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
3. Ensure that each arboviral infection case is provided with health education that includes measures to:
   a. Avoid mosquito bites, and
   b. Reduce mosquito breeding sites.

B. Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each arboviral infection case or suspect case and implement vector control measures as necessary.

R9-6-310. Babesiosis

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported babesiosis case or suspect case; and
2. For each babesiosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-311. Basidiobolomycosis

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported basidiobolomycosis case or suspect case; and
2. For each basidiobolomycosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-312. Botulism

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a botulism case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported botulism case or suspect case; and
3. For each botulism case or suspect case:
   a. Submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and

b. Ensure that one or more specimens from each botulism case or suspect case are submitted to the Arizona State Laboratory.

B. Environmental control measures: An individual in possession of:

1. Food known to be contaminated by *Clostridium botulinum* or *Clostridium botulinum* toxin shall boil the contaminated food for 10 minutes and then discard it, and
2. Utensils known to be contaminated by *Clostridium botulinum* or *Clostridium botulinum* toxin shall boil the contaminated utensils for 10 minutes before reuse or disposal.

R9-6-313. Brucellosis

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported brucellosis case or suspect case;
2. For each brucellosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
3. Ensure that an isolate or a specimen, as available, from each brucellosis case is submitted to the Arizona State Laboratory.

R9-6-314. Campylobacteriosis

Case control measures: A local health agency shall:

1. Exclude a campylobacteriosis case or suspect case with diarrhea from:
   a. Working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
      i. Diarrhea has resolved,
      ii. A stool specimen negative for *Campylobacter* spp. is obtained from the campylobacteriosis case or suspect case, or
      iii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
   b. Using an aquatic venue until diarrhea has resolved;
2. Conduct an epidemiologic investigation of each reported campylobacteriosis case or suspect case; and
3. For each campylobacteriosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-315. Carbapenem-resistant Enterobacteriaceae

A. Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall:
   a. Institute isolation precautions as necessary for a carbapenem-resistant enterobacteriaceae case or carrier to prevent transmission; and
   b. If a carbapenem-resistant enterobacteriaceae case or carrier is being transferred to another health care provider or health care institution or to a correctional facility, comply with R9-6-305.
2. An administrator of a correctional facility, either personally or through a representative, shall:
   a. Institute isolation precautions as necessary for a carbapenem-resistant enterobacteriaceae case or carrier to prevent transmission; and
   b. If a carbapenem-resistant enterobacteriaceae case or carrier is being transferred to another correctional facility or to a health care institution, comply with R9-6-305.
3. A local health agency, in consultation with the Department, shall:
   a. Ensure that a case or carrier of carbapenem-resistant enterobacteriaceae is isolated as necessary to prevent transmission; and
   b. Upon request, ensure that an isolate or a specimen, as available, from each case or carrier of carbapenem-resistant enterobacteriaceae is submitted to the Arizona State Laboratory.

B. Outbreak control measures: A local health agency shall:

1. Conduct an epidemiologic investigation for each outbreak or suspected outbreak of carbapenem-resistant enterobacteriaceae; and
2. For each outbreak or suspected outbreak of carbapenem-resistant enterobacteriaceae, submit to the Department the information required under R9-6-206(E).

R9-6-316. Chagas Infection and Related Disease *(American Trypanosomiasis)*

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported Chagas infection or disease case or suspect case; and
2. For each Chagas infection or disease case:

a. Submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
b. Provide to the Chagas infection or disease case or ensure that another person provides to the Chagas infection or disease case health education that includes:
   i. The treatment options for Chagas infection or disease,
   ii. Where the Chagas infection or disease case may receive treatment for Chagas infection or disease, and
   iii. For women of childbearing age, the risks of transmission of Chagas infection or disease to a fetus.

R9-6-317. Chancroid *(Haemophilus ducreyi)*

A. Case control measures: A local health agency shall:
1. Conduct an epidemiologic investigation of each reported chancroid case or suspect case;
2. For each chancroid case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
3. Comply with the requirements specified in R9-6-1103 concerning treatment and health education for a chancroid case.

B. Contact control measures: When a chancroid case has named a contact, a local health agency shall comply with the requirements specified in R9-6-1103 concerning notification, testing, treatment, and health education for the contact.

R9-6-318. Chikungunya

A. Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a chikungunya case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported chikungunya case or suspect case;
3. For each chikungunya case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that each chikungunya case is provided with health education that includes measures to:
   a. Avoid mosquito bites, and
   b. Reduce mosquito breeding sites.

B. Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each chikungunya case or suspect case and implement vector control measures as necessary.

R9-6-319. *Chlamydia trachomatis* Infection

A. Case control measures:

A local health agency shall comply with the requirements specified in R9-6-1103 concerning treatment and health education for a *Chlamydia trachomatis* infection case that seeks treatment from the local health agency.

B. Contact control measures: If an individual who may have been exposed to chlamydia through sexual contact with a *Chlamydia trachomatis* infection case seeks treatment for symptoms of chlamydia infection from a local health agency, the local health agency shall comply with the requirements specified in R9-6-1103 concerning treatment and health education for the individual.

R9-6-320. Cholera

A. Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a cholera case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Exclude a cholera case or suspect case from:
   a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until a stool specimen negative for toxigenic *Vibrio cholerae* is obtained from the cholera case or suspect case; and
   b. Using an aquatic venue until diarrhea has resolved;
3. Conduct an epidemiologic investigation of each reported cholera case or suspect case; and
4. For each cholera case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Contact control measures: A local health agency shall provide follow-up for each cholera contact for five calendar days after exposure.

R9-6-321. *Clostridium difficile*

Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution transferring a known *Clostridium difficile* case with active infection and diarrhea to another health care provider or health care institution or to a correctional facility shall, either personally or through a representative, ensure that the receiving health care provider, health care institution, or correctional facility is informed that the patient is a known *Clostridium difficile* case.
2. If a known *Clostridium difficile* case with active infection and diarrhea is being transferred from a correctional facility to another correctional facility or to a health care institution, an administrator of the correctional facility, either personally or through a representative, shall ensure that the receiving correctional facility or health care institution is informed that the individual is a known *Clostridium difficile* case.

R9-6-322. Coccidioidomycosis (Valley Fever)

Outbreak control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported outbreak of coccidioidomycosis; and
2. For each outbreak of coccidioidomycosis, submit to the Department the information required under R9-6-206(E).

R9-6-323. Colorado Tick Fever

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported Colorado tick fever case or suspect case; and
2. For each Colorado tick fever case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-324. Conjunctivitis: Acute

A. Case control measures: An administrator of a school or child care establishment, either personally or through a representative, shall exclude an acute conjunctivitis case from attending the school or child care establishment until the symptoms of acute conjunctivitis subside or treatment for acute conjunctivitis is initiated and maintained for 24 hours.

B. Outbreak control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported conjunctivitis outbreak; and
2. For each conjunctivitis outbreak, submit to the Department the information required under R9-6-206(E).

R9-6-325. Creutzfeldt-Jakob Disease

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported Creutzfeldt-Jakob disease case or suspect case; and
2. For each Creutzfeldt-Jakob disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-326. Cryptosporidiosis

A. Case control measures: A local health agency shall:

1. Exclude a cryptosporidiosis case or suspect case with diarrhea from:
   a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until diarrhea has resolved; and
   b. Using an aquatic venue for two weeks after diarrhea has resolved;
2. Conduct an epidemiologic investigation of each reported cryptosporidiosis case or suspect case; and
3. For each cryptosporidiosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Environmental control measures: A local health agency shall conduct a sanitary inspection or ensure that a sanitary inspection is conducted of each facility or location regulated under 9 A.A.C. 8 that is associated with an outbreak of cryptosporidiosis.

R9-6-327. *Cyclospora* Infection

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported *Cyclospora* infection case or suspect case; and
2. For each *Cyclospora* infection case submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-328. Cysticercosis

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported cysticercosis case or suspect case; and
2. For each cysticercosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-329. Dengue

A. Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a dengue case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported dengue case or suspect case;
3. For each dengue case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that each dengue case is provided with health education that includes measures to:
   a. Avoid mosquito bites, and
   b. Reduce mosquito breeding sites.

B. Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each dengue case or suspect case and implement vector control measures as necessary.

R9-6-330. Diarrhea, Nausea, or Vomiting

A. Outbreak control measures: A local health agency shall:
1. Conduct an epidemiologic investigation of each reported outbreak of diarrhea, nausea, or vomiting;
2. Submit to the Department the information required under R9-6-206(E); and
3. Exclude each case that is part of an outbreak of diarrhea, nausea, or vomiting from:
   a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
      i. Diarrhea and vomiting have resolved, or
      ii. The local health agency has determined that the case is unlikely to infect other individuals; and
   b. Using an aquatic venue for two weeks after diarrhea has resolved.

B. Environmental control measures: A local health agency shall conduct a sanitary inspection or ensure that a sanitary inspection is conducted of each facility or location regulated under 9 A.A.C. 8 that is associated with an outbreak of diarrhea, nausea, or vomiting.

R9-6-331. Diphtheria

A. Case control measures:
1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall:
   a. Isolate and institute droplet precautions for a pharyngeal diphtheria case or suspect case until two successive sets of cultures negative for *Cornyebacterium diphtheriae* are obtained from nose and throat specimens collected from the case or suspect case at least 24 hours apart and at least 24 hours after cessation of treatment; and
   b. Isolate and institute contact precautions for a cutaneous diphtheria case or suspect case until two successive sets of cultures negative for *Cornyebacterium diphtheriae* are obtained from skin specimens collected from the case or suspect case at least 24 hours apart and at least 24 hours after cessation of treatment
   .
2. A local health agency shall:
   a. Upon receiving a report under R9-6-202 of a diphtheria case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
   b. Conduct an epidemiologic investigation of each reported diphtheria case or suspect case; and
   c. For each diphtheria case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Contact control measures: A local health agency shall:
1. Exclude each diphtheria contact from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a school or child care establishment until a set of cultures negative for *Cornyebacterium diphtheriae* is obtained from the contact's nose and throat specimens;
2. In consultation with the Department, quarantine a contact of a diphtheria case, if indicated, until two successive sets of cultures negative for *Cornyebacterium diphtheriae* are obtained from nose and throat specimens collected from the contact at least 24 hours apart;
3. Offer each previously immunized diphtheria contact prophylaxis and a vaccine containing diphtheria toxoid; and
4. Offer each unimmunized diphtheria contact prophylaxis and the primary vaccine series.

R9-6-332. Ehrlichiosis

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported ehrlichiosis case or suspect case; and
2. For each ehrlichiosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-333. Emerging or Exotic Disease

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of an emerging or exotic disease case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. In consultation with the Department, isolate an emerging or exotic disease case or suspect case as necessary to prevent transmission;
3. Conduct an epidemiologic investigation of each reported emerging or exotic disease case or suspect case; and
4. For each emerging or exotic disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Contact control measures: A local health agency, in consultation with the Department, shall quarantine or exclude an emerging or exotic disease contact as necessary, according to R9-6-303, to prevent transmission.

R9-6-334. Encephalitis, Viral or Parasitic

Case control measures: A local health agency shall:

1. Upon receiving a report of encephalitis under R9-6-202, notify the Department:
   a. For a case or suspect case of parasitic encephalitis, within 24 hours after receiving the report and provide to the Department the information contained in the report; and
   b. For a case or suspect case of viral encephalitis, within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported viral or parasitic encephalitis case or suspect case; and
3. For each encephalitis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-335. *Escherichia coli,* Shiga Toxin-producing

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 or R9-6-203 of a Shiga toxin-producing *Escherichia coli* case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Exclude a Shiga toxin-producing *Escherichia coli* case or suspect case with diarrhea from:
   a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
      i. Two successive stool specimens, collected from the Shiga toxin-producing *Escherichia coli* case or suspect case at least 24 hours apart, are negative for Shiga toxin-producing *Escherichia coli*;
      ii. Diarrhea has resolved; or
      iii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
   b. Using an aquatic venue for two weeks after diarrhea has resolved;
3. Conduct an epidemiologic investigation of each reported Shiga toxin-producing *Escherichia coli* case or suspect case; and
4. For each Shiga toxin-producing *Escherichia coli* case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Environmental control measures: A local health agency shall:

1. If an animal located in a private residence is suspected to be the source of infection for a Shiga toxin-producing *Escherichia coli* case or outbreak, provide health education for the animal's owner about Shiga toxin-producing *Escherichia coli* and the risks of becoming infected with Shiga toxin-producing *Escherichia coli*; and
2. If an animal located in a setting other than a private residence is suspected to be the source of infection for a Shiga toxin-producing *Escherichia coli* case or outbreak:
   a. Provide health education for the animal's owner about Shiga toxin-producing *Escherichia coli* and the risks of becoming infected with Shiga toxin-producing *Escherichia coli*, and
   b. Require the animal's owner to provide information to individuals with whom the animal may come into contact about Shiga toxin-producing *Escherichia coli* and methods to reduce the risk of transmission.

R9-6-336. Giardiasis

Case control measures: A local health agency shall:

1. Exclude a giardiasis case or suspect case with diarrhea from:
    a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
        i. Treatment for giardiasis is initiated and diarrhea has resolved, or
        ii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
    b. Using an aquatic venue for two weeks after diarrhea has resolved;
2. Conduct an epidemiologic investigation of each reported giardiasis case or suspect case; and
3. For each giardiasis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-337. Glanders

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a glanders case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported glanders case or suspect case;
3. For each glanders case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that an isolate or a specimen, as available, from each glanders case or suspect case is submitted to the Arizona State Laboratory.

R9-6-338. Gonorrhea

A. Case control measures:

1. For the prevention of gonorrheal ophthalmia, a physician, physician assistant, registered nurse practitioner, or midwife attending the birth of an infant in this state shall treat the eyes of the infant immediately after the birth with one of the following, unless treatment is refused by the parent or guardian:
    a. Erythromycin ophthalmic ointment 0.5%, or
    b. Tetracycline ophthalmic ointment 1%.
2. A local health agency shall comply with the requirements specified in R9-6-1103 concerning treatment and health education for a gonorrhea case that seeks treatment from the local health agency.

B. Contact control measures: If an individual who may have been exposed to gonorrhea through sexual contact with a gonorrhea case seeks treatment for symptoms of gonorrhea from a local health agency, the local health agency shall comply with the requirements specified in R9-6-1103 concerning treatment and health education for the individual.

R9-6-339. *Haemophilus influenzae*: Invasive Disease

A. Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute droplet precautions for a *Haemophilus influenzae* meningitis or epiglottitis case or suspect case for 24 hours after the initiation of treatment.
2. A local health agency shall:
    a. Upon receiving a report under R9-6-202 or R9-6-203 of a *Haemophilus influenzae* invasive disease case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
    b. Conduct an epidemiologic investigation of each reported *Haemophilus influenzae* invasive disease case or suspect case; and
    c. For each *Haemophilus influenzae* invasive disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Contact control measures: A local health agency shall evaluate the level of risk of transmission from each contact's exposure to a *Haemophilus influenzae* invasive disease case and, if indicated, shall provide or arrange for each contact to receive immunization or treatment.

R9-6-340. Hansen's Disease (Leprosy)

A. Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported Hansen's disease case or suspect case; and
2. For each Hansen's disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Contact control measures: In consultation with the Department, a local health agency shall examine contacts of a Hansen's disease case, if indicated, for signs and symptoms of leprosy at six-to-twelve month intervals for five years after the last exposure to an infectious case.

R9-6-341. Hantavirus Infection

A. Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a hantavirus infection case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Ensure that a hantavirus infection case or, if the case is a child or incapacitated adult, the parent or guardian of the case receives health education about reducing the risks of becoming reinfected with or of having others become infected with hantavirus;
3. Conduct an epidemiologic investigation of each reported hantavirus infection case or suspect case; and
4. For each hantavirus infection case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Environmental control measures: A local health agency shall conduct an environmental assessment for each hantavirus infection case or suspect case.

R9-6-342. Hemolytic Uremic Syndrome

A. Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a hemolytic uremic syndrome case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported hemolytic uremic syndrome case or suspect case; and
3. For each hemolytic uremic syndrome case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Contact control measures: A local health agency shall exclude a hemolytic uremic syndrome contact with diarrhea of unknown cause from working as a food handler until diarrhea has resolved.

R9-6-343. Hepatitis A

A. Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 or R9-6-203 of a hepatitis A case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Exclude a hepatitis A case or suspect case from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment during the first 14 calendar days of illness or for seven calendar days after onset of jaundice;
3. Conduct an epidemiologic investigation of each reported hepatitis A case or suspect case; and
4. For each hepatitis A case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Contact control measures: A local health agency shall:
1. Exclude a hepatitis A contact with symptoms of hepatitis A from working as a food handler during the first 14 calendar days of illness or for seven calendar days after onset of jaundice;
2. For 45 calendar days after exposure, monitor a food handler who was a contact of a hepatitis A case during the infectious period for symptoms of hepatitis A; and
3. Evaluate the level of risk of transmission from each contact's exposure to a hepatitis A case and, if indicated, provide or arrange for each contact to receive prophylaxis and immunization.

R9-6-344. Hepatitis B and Hepatitis D

A. Case control measures:
1. A local health agency shall:
   a. Evaluate a health care provider identified as the source of hepatitis B virus transmission in the work place and, if indicated, ensure reassignment of the health care provider to a position where the occupational risk of transmission is eliminated;
   b. Conduct an epidemiologic investigation of each reported case or suspect case of hepatitis B or hepatitis B co-infected with hepatitis D; and
   c. For each acute case of hepatitis B or hepatitis B co-infected with hepatitis D or case of perinatal hepatitis B, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).
2. The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of hepatitis B, as required under A.R.S. § 32-1483 and 21 CFR 630.6.

B. Contact control measures: A local health agency shall:
1. Refer each non-immune hepatitis B contact to a health care provider for prophylaxis and initiation of the hepatitis B vaccine series, and
2. Provide health education related to the progression of hepatitis B disease and the prevention of transmission of hepatitis B infection to each non-immune hepatitis B contact.

R9-6-345. Hepatitis C

Outbreak control measures: A local health agency shall:
1. Conduct an epidemiologic investigation of each reported hepatitis C outbreak;
2. For each hepatitis C outbreak, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(E);
3. Evaluate a health care provider identified as the source of hepatitis C virus transmission in the work place and, if indicated, ensure reassignment of the health care provider to a position where the occupational risk of transmission is eliminated; and
4. Ensure that health education related to the progression of hepatitis C disease and the prevention of transmission of hepatitis C infection is provided to each individual who may have been exposed to hepatitis C during the outbreak.

R9-6-346. Hepatitis E

Case control measures: A local health agency shall:
1. Exclude a hepatitis E case or suspect case from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment during the first 14 calendar days of illness or for seven calendar days after onset of jaundice;
2. Conduct an epidemiologic investigation of each reported hepatitis E case or suspect case; and
3. For each hepatitis E case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-347. HIV Infection and Related Disease

A. Case control measures:
1. A local health agency shall:
   a. Conduct an epidemiologic investigation, including a review of medical records, of each reported HIV-infected individual or suspect case; and
   b. For each HIV-infected individual, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).
2. The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of HIV infection, as required under A.R.S. § 32-1483 and 21 CFR 630.6.
3. The Department and a local health agency shall offer anonymous HIV-testing to an individual as specified in R9-6-1005.

B. Contact control measures: The Department or the Department's designee shall confidentially notify an individual reported to be at risk for HIV infection under A.R.S. § 36-664(I) as specified in R9-6-1006(A).

C. Environmental control measures: An employer, as defined under A.R.S. § 23-401, or health care provider shall comply with the requirements specified in A.R.S. § 23-403 and A.A.C. R20-5-602.

R9-6-348. Influenza-Associated Mortality in a Child

Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a case or suspect case of an influenza-associated death of a child, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported case or suspect case of influenza-associated mortality in a child; and
3. For each case of influenza-associated mortality in a child, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-349. Legionellosis (Legionnaires' Disease)

A. Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a legionellosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported legionellosis case or suspect case; and

3. For each legionellosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Environmental control measures: The owner of a water, cooling, or ventilation system or equipment that is determined by the Department or a local health agency to be associated with a case of *Legionella* infection shall comply with the environmental control measures recommended by the Department or local health agency to prevent the exposure of other individuals.

R9-6-350. Leptospirosis

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a leptospirosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported leptospirosis case or suspect case; and
3. For each leptospirosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-351. Listeriosis

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a listeriosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported listeriosis case or suspect case;
3. For each listeriosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that an isolate or a specimen, as available, from each listeriosis case is submitted to the Arizona State Laboratory.

R9-6-352. Lyme Disease

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported Lyme disease case or suspect case; and
2. For each Lyme disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-353. Lymphocytic Choriomeningitis

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a lymphocytic choriomeningitis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported lymphocytic choriomeningitis case or suspect case; and
3. For each lymphocytic choriomeningitis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-354. Malaria

A. Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported malaria case or suspect case; and
2. For each malaria case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each malaria case or suspect case and implement vector control measures as necessary.

R9-6-355. Measles (Rubeola)

A. Case control measures:

1. An administrator of a school or child care establishment, either personally or through a representative, shall:
   a. Exclude a measles case from the school or child care establishment and from school- or child-care-establishment-sponsored events from the onset of illness through the fourth calendar day after the rash appears; and
   b. Exclude a measles suspect case from the school or child care establishment and from school- or child-care-establishment-sponsored events until the local health agency has determined that the suspect case is unlikely to infect other individuals.

2. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute airborne precautions for a measles case from onset of illness through the fourth calendar day after the rash appears.
3. An administrator of a health care institution, either personally or through a representative, shall exclude a measles:
    a. Case from working at the health care institution from the onset of illness through the fourth calendar day after the rash appears; and
    b. Suspect case from working at the health care institution until the local health agency has determined that the suspect case may return to work.
4. A local health agency shall:
    a. Upon receiving a report under R9-6-202 or R9-6-203 of a measles case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
    b. Conduct an epidemiologic investigation of each reported measles case or suspect case;
    c. For each measles case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
    d. Ensure that one or more specimens from each measles case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.
5. An administrator of a correctional facility or shelter, either personally or through a representative, shall comply with the measles control measures recommended by a local health agency or the Department.

B. Contact control measures:

1. When a measles case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
    a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
    b. Comply with the local health agency's recommendations for exclusion.
2. A local health agency shall:
    a. Determine which measles contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission; and
    b. Provide or arrange for immunization of each non-immune measles contact within 72 hours after last exposure, if possible.
3. An administrator of a health care institution shall ensure that a paid or volunteer full-time or part-time worker at a health care institution does not participate in the direct care of a measles case or suspect case unless the worker is able to provide evidence of immunity to measles through one of the following:
    a. A record of immunization against measles with two doses of live virus vaccine given on or after the first birthday and at least one month apart;
    b. A statement signed by a physician, physician assistant, registered nurse practitioner, state health officer, or local health officer affirming serologic evidence of immunity to measles; or
    c. Documentary evidence of birth before January 1, 1957.

R9-6-356. Melioidosis

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a melioidosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported melioidosis case or suspect case;
3. For each melioidosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that an isolate or a specimen, as available, from each melioidosis case or suspect case is submitted to the Arizona State Laboratory.

R9-6-357. Meningococcal Invasive Disease

A. Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute droplet precautions for a meningococcal invasive disease case for 24 hours after the initiation of treatment.
2. A local health agency shall:
    a. Upon receiving a report under R9-6-202 or R9-6-203 of a meningococcal invasive disease case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
    b. Conduct an epidemiologic investigation of each reported meningococcal invasive disease case or suspect case;
    c. For each meningococcal invasive disease case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and

d. Ensure that an isolate or a specimen, as available, from each meningococcal invasive disease case is submitted to the Arizona State Laboratory.

B. Contact control measures: A local health agency shall evaluate the level of risk of transmission from each contact's exposure to a meningococcal invasive disease case and, if indicated, provide or arrange for each contact to receive prophylaxis.

R9-6-358. Methicillin-resistant *Staphylococcus aureus* (MRSA)

A. Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution transferring a known methicillin-resistant *Staphylococcus aureus* case with active infection to another health care provider or health care institution or to a correctional facility shall, either personally or through a representative, ensure that the receiving health care provider, health care institution, or correctional facility is informed that the patient is a known methicillin-resistant *Staphylococcus aureus* case.
2. If a known methicillin-resistant *Staphylococcus aureus* case with active infection is being transferred from a correctional facility to another correctional facility or to a health care institution, an administrator of the correctional facility, either personally or through a representative, shall ensure that the receiving correctional facility or health care institution is informed that the individual is a known methicillin-resistant *Staphylococcus aureus* case.

B. Outbreak control measures:

1. A local health agency, in consultation with the Department, shall:
   a. Conduct an epidemiologic investigation of each reported outbreak of methicillin-resistant *Staphylococcus aureus* in a health care institution or correctional facility; and
   b. For each outbreak of methicillin-resistant *Staphylococcus aureus* in a health care institution or correctional facility, submit to the Department the information required under R9-6-206(E).
2. When an outbreak of methicillin-resistant *Staphylococcus aureus* occurs in a health care institution or correctional facility, the administrator of the health care institution or correctional facility, either personally or through a representative, shall comply with the control measures recommended by a local health agency or the Department.

R9-6-359. Mumps

A. Case control measures:

1. An administrator of a school or child care establishment, either personally or through a representative, shall:
   a. Exclude a mumps case from the school or child care establishment for five calendar days after the onset of glandular swelling; and
   b. Exclude a mumps suspect case from the school or child care establishment and from school- or child-care-establishment-sponsored events until evaluated and determined to be noninfectious by a physician, physician assistant, registered nurse practitioner, or local health agency.
2. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute droplet precautions with a mumps case for five calendar days after the onset of glandular swelling.
3. An administrator of a health care institution, either personally or through a representative, shall exclude a mumps:
   a. Case from working at the health care institution for five calendar days after the onset of glandular swelling; and
   b. Suspect case from working at the health care institution until evaluated and determined to be noninfectious by a physician, physician assistant, registered nurse practitioner, or local health agency.
4. A local health agency shall:
   a. Upon receiving a report under R9-6-202 or R9-6-203 of a mumps case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
   b. Conduct an epidemiologic investigation of each reported mumps case or suspect case;
   c. For each mumps case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
   d. Ensure that one or more specimens from each mumps case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.
5. An administrator of a correctional facility or shelter, either personally or through a representative, shall comply with the mumps control measures recommended by a local health agency or the Department.

B. Contact control measures:

1. When a mumps case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
   a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
   b. Comply with the local health agency's recommendations for exclusion.
2. An administrator of a health care institution shall ensure that a paid or volunteer full-time or part-time worker at a health care institution does not participate in the direct care of a mumps case or suspect case unless the worker is able to provide evidence of immunity to mumps through one of the following:

a. A record of immunization against mumps with two doses of live virus vaccine given on or after the first birthday and at least one month apart; or
b. A statement signed by a physician, physician assistant, registered nurse practitioner, state health officer, or local health officer affirming serologic evidence of immunity to mumps.

3. A local health agency shall determine which mumps contacts will be:
a. Quarantined or excluded, according to R9-6-303, to prevent transmission; and
b. Advised to obtain an immunization against mumps.

R9-6-360. Norovirus

A. Outbreak control measures: A local health agency shall:
1. Conduct an epidemiologic investigation of each reported norovirus outbreak;
2. Submit to the Department the information required under R9-6-206(E); and
3. Exclude each case that is part of a norovirus outbreak from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
a. Diarrhea has resolved, or
b. The local health agency has determined that the case or suspect case is unlikely to infect other individuals.

B. Environmental control measures: A local health agency shall conduct a sanitary inspection or ensure that a sanitary inspection is conducted of each facility or location regulated under 9 A.A.C. 8 that is associated with a norovirus outbreak.

R9-6-361. Novel Coronavirus (e.g., SARS or MERS)

A. Case control measures:
1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute both airborne precautions and contact precautions for a novel coronavirus case or suspect case, including a case or suspect case of severe acute respiratory syndrome or Middle East respiratory syndrome, until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner.
2. A local health agency shall:
a. Upon receiving a report under R9-6-202 of a novel coronavirus case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
b. In consultation with the Department, ensure that isolation and both airborne precautions and contact precautions have been instituted for a novel coronavirus case or suspect case to prevent transmission;
c. Conduct an epidemiologic investigation of each reported novel coronavirus case or suspect case; and
d. For each novel coronavirus case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Contact control measures: A local health agency, in consultation with the Department, shall determine which novel coronavirus contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission.

R9-6-362. Pediculosis (Lice Infestation)

A. Case control measures:
1. An administrator of a school or child care establishment, either personally or through a representative, shall exclude a pediculosis case from the school or child care establishment until the case is treated with a pediculocide.
2. An administrator of a shelter shall ensure that a pediculosis case is treated with a pediculocide and that the case's clothing and personal articles are disinfested.

B. Contact control measures: An administrator of a school or child care establishment that excludes a pediculosis case from the school or child care establishment, either personally or through a representative, shall ensure that a parent or guardian of a child who is a contact is notified that a pediculosis case was identified at the school or child care establishment.

R9-6-363. Pertussis (Whooping Cough)

A. Case control measures:
1. An administrator of a school or child care establishment, either personally or through a representative, shall:
a. Exclude a pertussis case from the school or child care establishment for 21 calendar days after the date of onset of cough or for five calendar days after the date of initiation of antibiotic treatment for pertussis; and
b. Exclude a pertussis suspect case from the school or child care establishment until evaluated and determined to be noninfectious by a physician, physician assistant, registered nurse practitioner, or local health agency.
2. An administrator of a health care institution, either personally or through a representative, shall:
a. Exclude a pertussis case from working at the health care institution for 21 calendar days after the date of onset of cough or for five calendar days after the date of initiation of antibiotic treatment for pertussis; and

b. Exclude a pertussis suspect case from working at the health care institution until evaluated and determined to be noninfectious by a physician, physician assistant, registered nurse practitioner, or local health agency.

3. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and initiate droplet precautions for a pertussis case for five calendar days after the date of initiation of antibiotic treatment for pertussis.
4. A local health agency shall:
   a. Upon receiving a report under R9-6-202 or R9-6-203 of a pertussis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
   b. Conduct an epidemiologic investigation of each reported pertussis case or suspect case; and
   c. For each pertussis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).
5. An administrator of a correctional facility or shelter, either personally or through a representative, shall comply with the pertussis control measures recommended by a local health agency or the Department.

B. Contact control measures:
1. When a pertussis case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
   a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
   b. Comply with the local health agency's recommendations for exclusion.
2. A local health agency shall identify contacts of a pertussis case and shall:
   a. Determine which pertussis contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission; and
   b. If indicated, provide or arrange for a pertussis contact to receive antibiotic prophylaxis.

R9-6-364. Plague

A. Case control measures:
1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute droplet precautions for a pneumonic plague case or suspect case until 72 hours of antibiotic therapy have been completed with favorable clinical response.
2. An individual handling the body of a deceased plague case shall use droplet precautions.
3. A local health agency shall:
   a. Upon receiving a report under R9-6-202 of a plague case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
   b. Conduct an epidemiologic investigation of each reported plague case or suspect case;
   c. For each plague case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
   d. Ensure that an isolate or a specimen, as available, from each plague case or suspect case is submitted to the Arizona State Laboratory.

B. Contact control measures: A local health agency shall provide follow-up to pneumonic plague contacts for seven calendar days after last exposure to a pneumonic plague case.

R9-6-365. Poliomyelitis (Paralytic or Non-paralytic)

Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a poliomyelitis case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported poliomyelitis case or suspect case;
3. For each poliomyelitis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that one or more specimens from each poliomyelitis case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.

R9-6-366. Psittacosis (Ornithosis)

A. Case control measures: A local health agency shall:
1. Conduct an epidemiologic investigation of each reported psittacosis case or suspect case; and
2. For each psittacosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Environmental control measures: A local health agency shall:
1. If a bird infected with *Chlamydia psittaci* or *Chlamydophila psittaci* is located in a private residence:

a. Provide health education for the bird's owner about psittacosis and the risks of becoming infected with psittacosis, and
b. Advise the bird's owner to obtain treatment for the bird; and

2. If a bird infected with *Chlamydia psittaci* or *Chlamydophila psittaci* is located in a setting other than a private residence:
   a. Provide health education for the bird's owner about psittacosis and the risks of becoming infected with psittacosis,
   b. Ensure that the bird is treated or destroyed and any contaminated structures are disinfected, and
   c. Require the bird's owner to isolate the bird from contact with members of the public and from other birds until treatment of the bird is completed or the bird is destroyed.

R9-6-367. Q Fever

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a Q fever case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported Q fever case or suspect case; and
3. For each Q fever case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-368. Rabies in a Human

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a human rabies case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported human rabies case or suspect case;
3. For each human rabies case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that a specimen from each human rabies case or suspect case, as required by the Department, is submitted to the Arizona State Laboratory.

B. Contact control measures: A local health agency shall evaluate the level of risk of transmission from each contact's exposure to a human rabies case and, if indicated, provide or arrange for each contact to receive prophylaxis.

R9-6-369. Relapsing Fever (Borreliosis)

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a borreliosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported borreliosis case or suspect case; and
3. For each borreliosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-370. Respiratory Disease in a Health Care Institution or Correctional Facility

Outbreak control measures:

1. A local health agency shall:
   a. Conduct an epidemiologic investigation of each reported outbreak of respiratory disease in a health care institution or correctional facility; and
   b. For each outbreak of respiratory disease in a health care institution or correctional facility, submit to the Department the information required under R9-6-206(E).
2. When an outbreak of respiratory disease occurs in a health care institution or correctional facility, the administrator of the health care institution or correctional facility, either personally or through a representative, shall comply with the control measures recommended by a local health agency.

R9-6-371. Rubella (German Measles)

A. Case control measures:

1. An administrator of a school or child care establishment, either personally or through a representative, shall:
   a. Exclude a rubella case from the school or child care establishment and from school- or child-care-establishment-sponsored events from the onset of illness through the seventh calendar day after the rash appears; and
   b. Exclude a rubella suspect case from the school or child care establishment and from school- or child-care-establishment-sponsored events until evaluated and determined to be noninfectious by a physician, physician assistant, registered nurse practitioner, or local health agency.

2. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative and in consultation with the local health agency, shall isolate and institute droplet precautions for a rubella case through the seventh calendar day after the rash appears.
3. An administrator of a health care institution, either personally or through a representative, shall exclude a rubella:
   a. Case from working at the health care institution from the onset of illness through the seventh calendar day after the rash appears; and
   b. Suspect case from working at the health care institution until evaluated and determined to be noninfectious by a physician, physician assistant, registered nurse practitioner, or local health agency.
4. A local health agency shall:
   a. Upon receiving a report under R9-6-202 or R9-6-203 of a rubella case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
   b. Conduct an epidemiologic investigation of each reported rubella case or suspect case;
   c. For each rubella case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
   d. Ensure that one or more specimens from each rubella case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.
5. An administrator of a correctional facility or shelter, either personally or through a representative, shall comply with the rubella control measures recommended by a local health agency or the Department.

B. Contact control measures:
1. An administrator of a health care institution shall ensure that a paid or volunteer full-time or part-time worker at a health care institution does not participate in the direct care of a rubella case or suspect case or of a patient who is or may be pregnant unless the worker first provides evidence of immunity to rubella consisting of:
   a. A record of immunization against rubella given on or after the first birthday; or
   b. A statement signed by a physician, physician assistant, registered nurse practitioner, state health officer, or local health officer affirming serologic evidence of immunity to rubella.
2. When a rubella case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
   a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
   b. Comply with the local health agency's recommendations for exclusion.
3. A local health agency shall:
   a. Determine which rubella contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission; and
   b. Provide or arrange for immunization of each non-immune rubella contact within 72 hours after last exposure, if possible.

R9-6-372. Rubella Syndrome, Congenital

A. Case control measures:
1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and implement contact precautions for an infant congenital rubella syndrome case until:
   a. The infant congenital rubella syndrome case reaches one year of age; or
   b. Two successive negative virus cultures, from specimens collected at least one month apart, are obtained from the infant congenital rubella syndrome case after the infant congenital rubella syndrome case reaches three months of age.
2. A local health agency shall:
   a. Upon receiving a report under R9-6-202 of a congenital rubella syndrome case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
   b. Conduct an epidemiologic investigation of each reported congenital rubella syndrome case or suspect case;
   c. For each congenital rubella syndrome case, as specified in Table 2.4, the information required under R9-6-206(D); and
   d. Ensure that one or more specimens from each congenital rubella syndrome case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.

B. Contact control measures: An administrator of a health care institution shall ensure that a paid or volunteer full-time or part-time worker at a health care institution who is known to be pregnant does not participate in the direct care of a congenital rubella syndrome case or suspect case unless the worker first provides evidence of immunity to rubella that complies with R9-6-371(B)(1).

R9-6-373. Salmonellosis

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 or R9-6-203 of a salmonellosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Exclude a salmonellosis case or suspect case with diarrhea from:
    a. Working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
        i. Diarrhea has resolved,
        ii. A stool specimen negative for *Salmonella* spp. is obtained from the salmonellosis case or suspect case, or
        iii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
    b. Using an aquatic venue until diarrhea has resolved;
3. Conduct an epidemiologic investigation of each reported salmonellosis case or suspect case; and
4. For each salmonellosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Environmental control measures: A local health agency shall:
1. If an animal infected with *Salmonella* spp. is located in a private residence, provide health education for the animal's owner about salmonellosis and the risks of becoming infected with *Salmonella* spp.; and
2. If an animal infected with *Salmonella* spp. is located in a setting other than a private residence:
    a. Provide health education for the animal's owner about salmonellosis and the risks of becoming infected with *Salmonella* spp., and
    b. Require the animal's owner to provide information to individuals with whom the animal may come into contact about salmonellosis and methods to reduce the risk of transmission.

R9-6-374. Scabies

A. Case control measures:
1. An administrator of a school or child care establishment, either personally or through a representative, shall exclude a scabies case from the school or child care establishment until treatment for scabies is completed.
2. An administrator of a health care institution or shelter, either personally or through a representative, shall exclude a scabies case from participating in the direct care of a patient or resident until treatment for scabies is completed.
3. An administrator of a shelter, either personally or through a representative, shall ensure that a scabies case receives treatment for scabies and that the case's clothing and personal articles are disinfested.
4. An administrator of a correctional facility, either personally or through a representative, shall ensure that a scabies case receives treatment for scabies and that the case's clothing and personal articles are disinfested.

B. Contact control measures: An administrator of a school, child care establishment, health care institution, or shelter, either personally or through a representative, shall advise a scabies contact with symptoms of scabies to obtain examination and, if necessary, treatment.

C. Outbreak control measures: A local health agency shall:
1. Provide health education regarding prevention, control, and treatment of scabies to individuals affected by a scabies outbreak;
2. When a scabies outbreak occurs in a health care institution, notify the licensing agency of the outbreak; and
3. For each scabies outbreak, submit to the Department the information required under R9-6-202(D).

R9-6-375. Shigellosis

Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 or R9-6-203 of a shigellosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Exclude a shigellosis case or suspect case with diarrhea from:
    a. Working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
        i. Diarrhea has resolved,
        ii. A stool specimen negative for *Shigella* spp. is obtained from the shigellosis case or suspect case, or
        iii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
    b. Using an aquatic venue for one week after diarrhea has resolved;
3. Conduct an epidemiologic investigation of each reported shigellosis case or suspect case; and
4. For each shigellosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-376. Smallpox

A. Case control measures:
1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute both airborne precautions and contact precautions for a smallpox case or suspect

case, until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner.

2. A local health agency shall:
   a. Upon receiving a report under R9-6-202 of a smallpox case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
   b. In consultation with the Department:
      i. Ensure that isolation and both airborne precautions and contact precautions have been instituted for a smallpox case or suspect case to prevent transmission, and
      ii. Conduct an epidemiologic investigation of each reported smallpox case or suspect case;
   c. For each smallpox case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
   d. Ensure that a specimen from each smallpox case or suspect case, as required by the Department, is submitted to the Arizona State Laboratory.

B. Contact control measures: A local health agency, in consultation with the Department, shall:
1. Quarantine or exclude a smallpox contact as necessary, according to R9-6-303, to prevent transmission; and
2. Monitor the contact for smallpox symptoms, including fever, each day for 21 calendar days after last exposure.

R9-6-377. Spotted Fever Rickettsiosis (e.g., Rocky Mountain Spotted Fever)

A. Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a spotted fever rickettsiosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Ensure that a spotted fever rickettsiosis case or, if the case is a child or incapacitated adult, the parent or guardian of the case receives health education about reducing the risks of becoming reinfected with or of having others become infected with spotted fever rickettsiosis;
3. Conduct an epidemiologic investigation of each reported spotted fever rickettsiosis case or suspect case; and
4. For each spotted fever rickettsiosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each spotted fever rickettsiosis case or suspect case and implement vector control measures as necessary.

R9-6-378. Streptococcal Group A Infection

A. Streptococcal group A infection, invasive or non-invasive:

Case control measures: An administrator of a school, child care establishment, or health care institution or a person in charge of a food establishment, either personally or through a representative, shall exclude a streptococcal group A infection case with streptococcal lesions or streptococcal sore throat from working as a food handler, attending or working in a school, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution for 24 hours after the initiation of treatment for streptococcal group A infection.

B. Invasive streptococcal group A infection:

Outbreak control measures: A local health agency shall:
1. Conduct an epidemiologic investigation of each reported outbreak of streptococcal group A invasive infection;
2. For each streptococcal group A invasive infection case involved in an outbreak, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
3. For each outbreak of streptococcal group A invasive infection, submit to the Department the information required under R9-6-206(E).

R9-6-379. Streptococcal Group B Invasive Infection in an Infant Younger Than 90 Days of Age

Case control measures: A local health agency shall:
1. Confirm the diagnosis of streptococcal group B invasive infection for each reported case or suspect case of streptococcal group B invasive infection in an infant younger than 90 days of age; and
2. For each case of streptococcal group B infection in an infant younger than 90 days of age, submit to the Department the information required under R9-6-202(C).

R9-6-380. *Streptococcus pneumoniae* Invasive Infection

Outbreak control measures: A local health agency shall:
1. Conduct an epidemiologic investigation of each reported outbreak of *Streptococcus pneumoniae* invasive infection; and

2. For each outbreak of *Streptococcus pneumoniae* invasive infection, submit to the Department the information required under R9-6-206(E).

R9-6-381. Syphilis

A. Case control measures:
1. A syphilis case shall obtain serologic testing for syphilis three months, six months, and one year after initiating treatment, unless more frequent or longer testing is recommended by a local health agency.
2. A health care provider for a pregnant syphilis case shall order serologic testing for syphilis at 28 to 32 weeks gestation and at delivery.
3. A local health agency shall:
   a. Conduct an epidemiologic investigation, including a review of medical records, of each reported syphilis case or suspect case, confirming the stage of the disease;
   b. For each syphilis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D);
   c. If the syphilis case is pregnant, ensure that the syphilis case obtains the serologic testing for syphilis required in subsection (A)(1) and (A)(2); and
   d. Comply with the requirements specified in R9-6-1103 concerning treatment and health education for a syphilis case.
4. The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of syphilis, as required under A.R.S. § 32-1483 and 21 CFR 630.6.

B. Contact control measures: When a syphilis case has named a contact, a local health agency shall comply with the requirements specified in R9-6-1103 concerning notification, testing, treatment, and health education for the contact.

C. Outbreak control measures: A local health agency shall:
1. Conduct an epidemiologic investigation of each reported syphilis outbreak; and
2. For each syphilis outbreak, submit to the Department the information required under R9-6-206(E).

R9-6-382. Taeniasis

Case control measures: A local health agency shall:
1. Exclude a taeniasis case with *Taenia* spp. from working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until free of infestation;
2. Conduct an epidemiologic investigation of each reported taeniasis case; and
3. For each taeniasis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-383. Tetanus

Case control measures: A local health agency shall:
1. Conduct an epidemiologic investigation of each reported tetanus case or suspect case; and
2. For each tetanus case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-384. Toxic Shock Syndrome

Case control measures: A local health agency shall:
1. Conduct an epidemiologic investigation of each reported toxic shock syndrome case or suspect case; and
2. For each toxic shock syndrome case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-385. Trichinosis

Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a trichinosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported trichinosis case or suspect case; and
3. For each trichinosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-386. Tuberculosis

A. Case control measures:
1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute airborne precautions for:

a. An individual with infectious active tuberculosis until:
   i. At least three successive sputum smears collected at least eight hours apart, at least one of which is taken first thing in the morning as soon as possible after the individual awakens from sleep, are negative for acid-fast bacilli;
   ii. Anti-tuberculosis treatment is initiated with multiple antibiotics; and
   iii. Clinical signs and symptoms of active tuberculosis are improved;
b. A suspect case of infectious active tuberculosis until:
   i. At least two successive tests for tuberculosis, using a product and methodology approved by the U.S. Food and Drug Administration for use when making decisions whether to discontinue isolation and airborne precautions, for the suspect case are negative; or
   ii. At least three successive sputum smears collected from the suspect case as specified in subsection (A)(1)(a)(i) are negative for acid-fast bacilli, anti-tuberculosis treatment of the suspect case is initiated with multiple antibiotics, and clinical signs and symptoms of active tuberculosis are improved; and
c. A case or suspect case of multi-drug resistant active tuberculosis until a tuberculosis control officer has approved the release of the case or suspect case.

2. An administrator of a health care institution, either personally or through a representative, shall notify a local health agency at least one working day before discharging a tuberculosis case or suspect case.
3. A local health agency shall:
   a. Upon receiving a report under R9-6-202 of a tuberculosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
   b. Exclude an individual with infectious active tuberculosis or a suspect case from working, unless the individual's work setting has been approved by a tuberculosis control officer, until the individual with infectious active tuberculosis or suspect case is released from airborne precautions according to the applicable criteria in subsection (A)(1);
   c. Conduct an epidemiologic investigation of each reported tuberculosis case, suspect case, or latent infection in a child five years of age or younger;
   d. For each tuberculosis case or suspect case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D);
   e. Ensure that an isolate or a specimen, as available, from each tuberculosis case is submitted to the Arizona State Laboratory; and
   f. Comply with the requirements specified in R9-6-1202.

B. Contact control measures:
1. A contact of an individual with infectious active tuberculosis shall allow a local health agency to evaluate the contact's tuberculosis status.
2. A local health agency shall comply with the tuberculosis contact control measures specified in R9-6-1202.

C. An individual is not a tuberculosis case if the individual has a positive result from an approved test for tuberculosis but does not have clinical signs or symptoms of disease.

R9-6-387. Tularemia

Case control measures:
1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate a pneumonic tularemia case until 72 hours of antibiotic therapy have been completed with favorable clinical response.
2. A local health agency shall:
   a. Upon receiving a report under R9-6-202 of a tularemia case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
   b. Conduct an epidemiologic investigation of each reported tularemia case or suspect case;
   c. For each tularemia case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
   d. Ensure that an isolate or a specimen, as available, from each tularemia case or suspect case is submitted to the Arizona State Laboratory.

R9-6-388. Typhoid Fever

A. Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a typhoid fever case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported typhoid fever case or suspect case;
3. For each typhoid fever case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D);

4. Exclude a typhoid fever case or suspect case from working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
    a. At least one month after the date of onset of illness; and
    b. After two successive stool specimens, collected from the typhoid fever case at least 24 hours apart and at least 48 hours after cessation of antibiotic therapy, are negative for *Salmonella typhi*;
5. If a stool specimen from a typhoid fever case who has received antibiotic therapy is positive for *Salmonella typhi*, enforce the exclusions specified in subsection (A)(4) until two successive stool specimens, collected from the typhoid fever case at least one month apart and 12 or fewer months after the date of onset of illness, are negative for *Salmonella typhi*;
6. If a positive stool specimen, collected at least 12 months after onset of illness, is obtained from a typhoid fever case who has received antibiotic therapy, redesignate the case as a carrier; and
7. Exclude a typhoid fever carrier from working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until three successive stool specimens, collected from the typhoid fever carrier at least one month apart, are negative for *Salmonella typhi*.

B. Contact control measures: A local health agency shall exclude a typhoid fever contact from working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until two successive stool specimens, collected from the typhoid fever contact at least 24 hours apart, are negative for *Salmonella typhi*.

R9-6-389. Typhus Fever

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a typhus fever case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported typhus fever case or suspect case; and
3. For each typhus fever case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-390. Vaccinia-related Adverse Event

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a case or suspect case of a vaccinia-related adverse event, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported case or suspect case of a vaccinia-related adverse event; and
3. For each case of a vaccinia-related adverse event, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-391. Vancomycin-Resistant or Vancomycin-Intermediate *Staphylococcus aureus*

Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and implement contact precautions for a case or suspect case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*.
2. A diagnosing health care provider or an administrator of a health care institution transferring a known case with active infection or a known carrier of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus* to another health care provider or health care institution shall, either personally or through a representative, comply with R9-6-305.
3. A local health agency, in consultation with the Department, shall:
    a. Upon receiving a report under R9-6-202 of a case or suspect case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
    b. Ensure that a case or suspect case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus* is isolated as necessary to prevent transmission;
    c. Conduct an epidemiologic investigation of each reported case or suspect case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*;
    d. For each case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
    e. Ensure that an isolate or a specimen, as available, from each case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus* is submitted to the Arizona State Laboratory.

R9-6-392. Varicella (Chickenpox)

A. Case control measures:

1. An administrator of a school or child care establishment, either personally or through a representative, shall exclude a varicella case from the school or child care establishment and from school- or child-care-establishment-sponsored events until lesions are dry and crusted.
2. An administrator of a health care institution, either personally or through a representative, shall isolate and implement airborne precautions for a varicella case until the case is no longer infectious.
3. A local health agency shall:
   a. Conduct an epidemiologic investigation of each reported case of death due to primary varicella infection; and
   b. For each reported case of death due to varicella infection, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Contact control measures:
1. When a varicella case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
   a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
   b. Comply with the local health agency's recommendations for exclusion.
2. A local health agency shall determine which contacts of a varicella case will be:
   a. Excluded from a school or child care establishment, and
   b. Advised to obtain an immunization against varicella.

R9-6-393. *Vibrio* Infection

Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a *Vibrio* infection case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Exclude a *Vibrio* infection case or suspect case with diarrhea from:
   a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
      i. Diarrhea has resolved, or
      ii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
   b. Using an aquatic venue until diarrhea has resolved;
3. Conduct an epidemiologic investigation of each reported *Vibrio* infection case or suspect case; and
4. For each *Vibrio* infection case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

R9-6-394. Viral Hemorrhagic Fever

A. Case control measures:
1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and implement both droplet precautions and contact precautions for a viral hemorrhagic fever case or suspect case for the duration of the illness.
2. A local health agency shall:
   a. Upon receiving a report under R9-6-202 of a viral hemorrhagic fever case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
   b. Conduct an epidemiologic investigation of each reported viral hemorrhagic fever case or suspect case;
   c. For each viral hemorrhagic fever case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
   d. Ensure that one or more specimens from each viral hemorrhagic fever case or suspect case are submitted to the Arizona State Laboratory.

B. Contact control measures: A local health agency, in consultation with the Department, shall quarantine a viral hemorrhagic fever contact as necessary to prevent transmission.

R9-6-395. West Nile Virus Infection

A. Case control measures: A local health agency shall:
1. Conduct an epidemiologic investigation of each reported West Nile virus infection case or suspect case;
2. For each case of West Nile virus infection, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
3. Ensure that each West Nile virus infection case is provided with health education that includes measures to:
   a. Avoid mosquito bites, and
   b. Reduce mosquito breeding sites.

B. Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each West Nile virus infection case or suspect case and implement vector control measures as necessary.

R9-6-396. Yellow Fever

A. Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a yellow fever case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported yellow fever case or suspect case;
3. For each yellow fever case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D);
4. Ensure that each yellow fever case is provided with health education that includes measures to:
    a. Avoid mosquito bites, and
    b. Reduce mosquito breeding sites; and
5. Ensure that an isolate or a specimen, as available, from each yellow fever case or suspect case is submitted to the Arizona State Laboratory.

B. Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each yellow fever case or suspect case and implement vector control measures as necessary.

R9-6-397. Yersiniosis (Enteropathogenic *Yersinia*)

Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a yersiniosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Exclude a yersiniosis case or suspect case with diarrhea from:
    a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
        i. Diarrhea has resolved,
        ii. A stool specimen negative for enteropathogenic *Yersinia* is obtained from the case or suspect case, or
        iii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
    b. Using an aquatic venue for two weeks after diarrhea has resolved;
3. Conduct an epidemiologic investigation of each reported yersiniosis case or suspect case;
4. For each yersiniosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
5. Ensure that an isolate or a specimen, as available, from each yersiniosis case is submitted to the Arizona State Laboratory.

R9-6-398. Zika Virus Infection

A. Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a Zika virus infection case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported Zika virus infection case or suspect case;
3. For each Zika virus infection case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D);
4. Ensure that one or more specimens from each Zika virus infection case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory; and
5. Provide to the Zika virus infection case or ensure that another person provides to the Zika virus infection case health education that includes measures to:
    a. Avoid mosquito bites,
    b. Reduce mosquito breeding sites, and
    c. Reduce the risk of sexual or congenital transmission of Zika virus.

B. Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each Zika virus infection case or suspect case and implement vector control measures as necessary.

Statutory Authority

9 A.A.C. 6, Article 3. Control Measures for Communicable Diseases and Infestations

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.

BOARD OF BEHAVIORAL HEALTH EXAMINERS
Title 4, Chapter 6

Amend: R4-6-101, R4-6-211, R4-6-212, R4-6-214, R4-6-215, R4-6-216, R4-6-301, Table 1, R4-6-304, R4-6-305, R4-6-306, R4-6-403, R4-6-404, R4-6-1501, R4-6-503, R4-6-601, R4-6-603, R4-6-702, R4-6-703, R4-6-705, R4-6-706, R4-6-801, R4-6-802, R4-6-1101, R4-6-1102, R4-6-1105, R4-6-1106

New Section: R4-6-217

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: August 1, 2023/July 5, 2023

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

FROM: Council Staff

DATE: **June 8, 2023**

SUBJECT: **BOARD OF BEHAVIORAL HEALTH EXAMINERS**
Title 4, Chapter 6

Amend: R4-6-101, R4-6-211, R4-6-212, R4-6-214, R4-6-215, R4-6-216, R4-6-301, Table 1, R4-6-304, R4-6-305, R4-6-306, R4-6-403, R4-6-404, R4-6-1501, R4-6-503, R4-6-601, R4-6-603, R4-6-702, R4-6-703, R4-6-705, R4-6-706, R4-6-801, R4-6-802, R4-6-1101, R4-6-1102, R4-6-1105, R4-6-1106

New Section: R4-6-217

Summary:

This regular rulemaking from the Board of Behavioral Health Examiners (Board) was previously considered at the June 27, 2023 Study Session and tabled at the July 5, 2023 Council Meeting due to the controversy surrounding supervised private practice in Arizona. Since that time supporting documentation for the rulemaking was received from the Department relating to the proposed ratio change in clinical supervision and oversight. The Board has provided responses to the questions asked by the Council at the Study Session as well as letters of support from state and national organizations. This rulemaking seeks to amend twenty-seven (27) rules and add one (1) new section to Title 4, Chapter 6. Under Laws 2021, Chapter 320, the legislature amended the following statutes: A.R.S. § 32-3251 to provide that direct client contact includes providing therapeutic or clinical care by telehealth and A.R.S. § 36-3606 regarding registration of out-of-state providers of telehealth services. Under Laws 2021, Chapter 62, the legislature amended the following statutes: A.R.S. §§ 32-3293 (social work), 32-3301 (counseling), 32-3311 (marriage and family therapy), and 32-3321 (substance abuse counseling) to remove the

requirement that an applicant provide evidence of indirect client hours obtained during training. The Board is also removing provisions regarding supervised private practice from R4-6-211 to R4-6-217, and amending R4-6-306 regarding an application for a temporary license.

In addition to statutory changes, this rulemaking is related to and amending the issues identified in a 5YRR approved by the Council on March 3, 2020.

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

The Board cites both general and specific statutory authority for these rules.

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

The Board indicates that the rulemaking does not contain a fee increase but establishes a new fee to register as an out-of-state health care provider of telehealth services as allowed under A.R.S. § 36-3606(A)(3) and applies an existing fee of $250 to obtaining a license by universal recognition.

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 Board indicates it did not review or rely on any study in conducting this rulemaking.

4. Summary of the agency's economic impact analysis:

The Board believes the rulemaking has minimal economic impact because it makes no substantive changes other than those required to be consistent with statute. Out-of-state providers of telehealth services who choose to register to provide services in Arizona will have to pay a newly established fee.

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 Board has made several changes that reduce regulatory burdens: reducing the time a clinical supervisor must maintain records; clarifying that clinical supervision in a face-to-face setting includes virtual teleconferencing; eliminating a charge for a duplicate license; allowing documentation to be made electronically; and allowing verbal informed consent when providing care by telehealth.

The Board states that there is one provision that will have more than minimal economic impact: the $250 one-time fee charged to register as an out-of-state provider of telehealth in Arizona. The Board determined the fee charged is reasonable compared to work required by the agency and necessary to support the functions of the agency.

6. What are the economic impacts on stakeholders?

The Board currently licenses 6,724 social workers, 6,570 counselors, 1,179 marriage and family therapists, and 1,313 substance abuse counselors.

Licensees who wish to be licensed at a more independent level of practice are required to obtain hours of supervised work experience including hours of clinical supervision.

The Board incurred the cost of completing this rulemaking and will have the benefit of rules that are consistent with statute and agency practice.

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

The Boards indicates that generally, the finals rules are not substantially changed, considered as a whole, from the supplemental proposed rulemaking, but did make the following amendments:

R4-6-305: The Board amended three (3) months to ninety (90) days.

R4-6-101: The Board removed the definition of "indirect client service" to be consistent with statute.

R4-6-215(A)(2) and R4-6-306(A)(1): The Board added the definition of "universal recognition".

R4-6-304(B): amended the rule to be consistent with A.R.S. § 32-4302.

R4-6-403(A), R4-6-503(A), and R4-6-603(A): added clarifying language to the rules.

R4-6-1106(B): the Board amended the subsection to include language from A.R.S. § 32-3271(A)(2) and made grammatical and typographical changes.

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

The Board indicates that the comments on the proposed rules were adequately addressed as identified in the table on subsection 11 of the NFR.

9. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?

The Board does not issue general permits. Rather, the Board issues individual licenses as required by the Board's statutes to each person that is qualified by statute.

10. 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 states that none of the rules is more stringent than federal law. No federal law is directly applicable to the subject of any of the rules in this rulemaking.

11. Conclusion

This regular rulemaking from the Arizona Board of Behavioral Health Examiners seeks to amend twenty-seven rules and add one new section to Title 4, Chapter 6. In addition to statutory changes, this rulemaking is related to the issues identified in a 5YRR approved by the Council on March 3, 2020.

The Department is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A). Council staff recommends approval of this rulemaking.

STATE OF ARIZONA
BOARD OF BEHAVIORAL HEALTH EXAMINERS
1740 WEST ADAMS STREET, SUITE 3600
PHOENIX, AZ 85007
PHONE: 602.542.1882 FAX: 602.364.0890
Board Website: www.azbbhe.us
Email Address: information@azbbhe.us

KATIE HOBBS
Governor

TOBI ZAVALA
Executive Director

May 2, 2023

Ms. Nicole Sornsin, Chair
The Governor's Regulatory Review Council
100 North 15th Avenue, Ste. 305
Phoenix, AZ 85007

Re: A.A.C. Title 4. Professions and Occupations
Chapter 6. Board of Behavioral Health Examiners

Dear Ms. Sornsin:

The attached final rule package is submitted for review and approval by the Council. The following information is provided for Council's use in reviewing the rule package:

A. Close of record date: The rulemaking record was closed on March 21, 2023, following a period for public comment and an oral proceeding. This rule package is being submitted within the 120 days provided by A.R.S. § 41-1024(B).

   An exemption from Executive Order 2022-01 was provided by Tony Hunter, of the Governor's office, in an e-mail dated March 4, 2022. Approval to submit the rulemaking to the Council was provided by Zaida Dedolph, of the Governor's office, in an e-mail dated April 26, 2023.

B. Relation of the rulemaking to a five-year-review report: The rulemaking relates, in part, to a five-year-review report approved by the Council on March 3, 2020.

C. New fee: The rulemaking establishes a new fee that is specifically authorized under A.R.S. § 36-3606(A)(3). It also applies an existing fee to obtaining a license by universal recognition.

D. Fee increase: The rulemaking does not increase an existing fee.

E. Immediate effective date: An immediate effective date is not requested.

F. Certification regarding studies: I certify that the preamble accurately discloses the Board did not review or rely on a study in its evaluation of or justification for any rule in this rulemaking.

G. Certification that the preparer of the EIS notified the JLBC of the number of new full-time employees necessary to implement and enforce the rule: I certify that none of the rules in this rulemaking will require a state agency to employ a new full-time employee. No notification was provided to JLBC.

H. List of documents enclosed:
   1. Cover letter signed by the Executive Director;
   2. Notice of Final Rulemaking including the preamble, table of contents, and rule text;
   3. Economic, Small Business, and Consumer Impact Statement;
   4. Public comments

Sincerely,

Tobi Zavala
Executive Director

NOTICE OF FINAL RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 6. BOARD OF BEHAVIORAL HEALTH EXAMINERS

PREAMBLE

1. Articles, Parts, and Sections Affected	**Rulemaking Action**
R4-6-101	Amend
R4-6-211	Amend
R4-6-212	Amend
R4-6-214	Amend
R4-6-215	Amend
R4-6-216	Amend
R4-6-217	New Section
R4-6-301	Amend
Table 1	Amend
R4-6-304	Amend
R4-6-305	Amend
R4-6-306	Amend
R4-6-403	Amend
R4-6-404	Amend
R4-6-501	Amend
R4-6-503	Amend
R4-6-601	Amend
R4-6-603	Amend
R4-6-702	Amend
R4-6-703	Amend
R4-6-705	Amend
R4-6-706	Amend
R4-6-801	Amend
R4-6-802	Amend
R4-6-1101	Amend
R4-6-1102	Amend
R4-6-1105	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. § 32-3253(A)(1)

Implementing statute: A.R.S. §§ 32-3275, 32-3279, 32-3251, 32-3291, 32-3292, 32-3293, 32-3301, 32-3303, 32-3311, 32-3313, 32-3321, and 36-3606

3. The effective date for the rules:

As specified under A.R.S. § 41-1032(A), the rule will be effective 60 days after the rule package is filed with the Office of the Secretary of State.

a. If the agency selected a date earlier than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable

b. If the agency selected a date later than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable

4. Citation 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 Rulemaking Docket Opening: 28 A.A.R. 1659, July 15, 2022

Notice of Proposed Rulemaking: 28 A.A.R. 1627, July 15, 2022

Notice of Supplemental Proposed Rulemaking: 28 A.A.R. 2009, August 12, 2022

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

Name: Erin Yabu, Deputy Director

Address: 1740 W Adams Street; Suite 3600

Phoenix, AZ 85007

Telephone: 602-542-1882

E-mail: erin.yabu@azbbhe.us

Web site: www.azbbhe.us

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

The Board is amending rules to address issues identified in a 5YRR approved by the Council on March 3, 2020, and to make the rules consistent with statutory changes. Under Laws 2021, Chapter 320, the legislature amended A.R.S. § 32-3251 to provided that direct client contact includes

providing therapeutic or clinical care by telehealth. The legislation also added A.R.S. § 36-3606 regarding registration of out-of-state providers of telehealth services. Under Laws 2021, Chapter 62, the legislature amended A.R.S. §§ 32-3293 (social work), 32-3301 (counseling), 32-3311 (marriage and family therapy), and 32-3321 (substance abuse counseling) to remove the requirement that an applicant provide evidence of indirect client hours obtained during training. The applicant must provide evidence of direct client hours and clinical supervision. The Board is also removing provisions regarding a supervised private practice from R4-6-211 and moving them to a new Section, R4-6-217, and amending R4-6-306 regarding an application for a temporary license. An exemption from Executive Order 2022-01 was provided by Tony Hunter, of the Governor's office, in an e-mail dated March 4, 2022. Approval to submit the rulemaking to the Council was provided by Zaida Dedolph, of the Governor's office, in an e-mail dated April 26, 2023.

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:

The Board did not review or rely on any study in its evaluation of or justification for any rule in 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 Board believes the rulemaking has minimal economic impact because it makes no substantive changes other than those required to be consistent with statute. Out-of-state providers of telehealth services who choose to register to provide services in Arizona will have to pay the newly established fee. The amendment to R4-6-306 clarifies when a temporary license expires.

10. A description of any changes between the proposed rulemaking, including supplemental notices, and the final rulemaking:

Between the Notice of Supplemental Proposed Rulemaking and the final notice, the Board added R4-6-305 to the rulemaking and changed "three months" to "90 days."

The Board removed the definition of "indirect client service" from R4-6-101to be consistent with the statutory changes made under Laws 2021, Chapter 62, and relabeled the remaining definitions.

The Board also added "universal recognition" to R4-6-215(A)(2) and R4-6-306(A)(1); amended R4-6-304(B) to be consistent with A.R.S. § 32-4302; and added clarifying language to R4-6-403(A), R4-6-503(A), and R4-6-603(A).

The Board received numerous comments regarding R4-6-1106(B) that indicated the commenters' concern about the subsection was caused by the commenters not reading or understanding the cross-referenced statute, A.R.S. § 32-3271(A)(2). In response, the Board amended the subsection to include language from the cross-referenced statute.

The Board appreciates the commenters' careful review of the proposed rules and corrected all typographical errors called to the Board's attention. The Board considered the numerous comments regarding word choice and formatting but, except as noted in item 11, did not change the rules in line with the comments. In response to public comments, the Board made non-substantive changes described in item 11.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to comments:

In addition to the numerous comments received regarding R4-6-1106(B), the Board received comments from the following:

- Rachel Bentley, Licensed Marriage and Family Therapist
- Halina Brooke, AZ Sensible Therapy Practices Coalition
- Michele Chinichian, Licensed Clinical Social Worker
- Keith Cross, Licensed Marriage and Family Therapist
- Laura Fontaine, Licensed Independent Substance Abuse/Licensed Professional Counselor
- Courtney Glenny, Licensed Professional Counselor
- Sofia Hassid, Licensed Clinical Social Worker
- Casey Heinsch, AZ Interest Network
- Sheana Kupitz, Licensed Master Social Worker
- Pallavi Lal, Licensed Associate Counselor
- Vic Meadow, Licensed Associate Counselor
- EJ Millston, Licensed Professional Counselor
- Julia Poole, Licensed Master Social Worker
- Joan Rapine, Licensed Professional Counselor
- Erin Stone, Licensed Associate Marriage and Family Therapist
- Troy Stone, Licensed Associate Marriage and Family Therapist

- Shelly Thome, Licensed Professional Counselor
- Dana Vargas, Licensed Professional Counselor

COMMENT	BOARD'S ANALYSIS	BOARD'S RESPONSE
R4-6-101(50): Remove "operates" to align the definition with R4-6-217.	The Board agrees.	Change made
R4-6-211(A): Delete the last five words.	The Board agrees.	Change made
R4-6-211(B)(1): the "and" between 6 and 7 should be "or."	The Board agrees	Change made
R4-6-212: A requirement should be added that the clinical supervision verification form must be completed within 30 days after a clinical supervision contract is terminated. This will ensure accurate and timely verification of supervised hours	The Board considered the comment and decided the change was not needed.	No change
R4-6-212(A)(1)(a): It is overly restrictive to require two years of licensure before being qualified to provide clinical supervision.	The Board agrees.	The rule was changed to require only one year of licensure before being qualified to provide clinical supervision.
R4-6-212(C)(4): A cross reference to the definition of "contemporaneous" is needed.	The Board disagrees that a cross reference to an existing definition is needed.	No change
R4-6-212(C)(6): Provide additional explanation of the term "personal relationship."	The Board considered the suggestion and decided no change was needed.	No change
R4-6-212(D)(1): To be consistent with subsection (E), clarify that clinical supervision	The Board agrees. However, the original subsection (D)(1) was deleted. The issue of virtual	Subsection (D)(1) was deleted.

may be provided face-to-face or by virtual teleconferencing.	teleconferencing is addressed in subsection (E).	
R4-6-214(A)(1)(a)(v): Clarify that the requirement in R4-6-217 deals with supervised private practice.	The Board agrees.	Clarifying language was added.
R4-6-214(A)(1)(a)(vi): The new language needs to be more specific to ensure clarity for all clinical supervisors.	The Board considered the suggestion and decided no change was needed.	No change
R4-6-214(D): The language does not clearly indicate that (A) must be retaken if non-compliant with (B) and (C).	The Board considered the suggestion and decided no change was needed.	No change
R4-6-217: Throughout the Section, change “clinical supervisor” to “supervised-private-practice supervisor” and “licensed supervisee” to “supervised licensee.”	The Board agrees.	The recommended changes were made throughout the Section.
R4-6-217(A)(4): Remove this subsection because all noncompliance is subject to disciplinary action.	The Board believes emphasizing the consequence of noncompliance is justified.	No change
R4-6-217(B)(1)(a): It may not be necessary for the supervisee and supervisor to be in the same discipline.	The Board considered the comment but disagrees.	No change
R4-6-217(B)(1)(c): Suggests this subsection is unnecessary because it is an understood standard.	The Board believes emphasizing that a consent agreement applies to a	No change

	supervised private practice agreement is necessary.	
R4-6-217(B)(2)(a)(i): The change from one hour of supervision for every 20 hours of direct client contact to one hour of supervision for every ten hours of direct client contact is unnecessarily burdensome. It seems designed to prevent clinicians from opening a private practice.	The Board has a statutory responsibility to protect public health and safety. The Board believes the increased amount of supervision is necessary to fulfill this responsibility.	No change
R4-6-217(B)(2)(a)(ii): Consider shifting the supervised private practice site visits from a variable metric (every 60 days) to a fixed, calendar-based metric. Add language specific to telehealth, such as a requirement for a home-based practice.	The Board considered the recommendation but decided a change was not needed. The Board considered the recommendation but decided a change was not needed.	No change No change
R4-6-217(B)(2)(c) and (D)(3): Suggests adding a description of report requirements.	The Board considered the recommendation but decided a change was not needed.	No change
R4-6-217(C)(1): A supervised licensee in private practice should be allowed to employ and provide clinical oversight of other licensees.	The Board considered the recommendation but decided a change was not needed.	No change

R4-6-217(D)(1): It may not be reasonable for a supervisor to be responsible for all aspects of a supervised private practice—such as non-clinical aspects.	The Board disagrees with the comment. The Board believes it is reasonable to expect a supervisor to supervise all aspect of a supervised private practice.	The Board clarified that "all aspects" of a supervised private practice includes both clinical and non-clinical aspects.
R4-6-217(D)(4): It was recommended that requiring the supervisor of a supervised private practice to obtain three CEs related to supervision during each biennial period be deleted because it duplicates the requirement at R4-6-214. Another commenter expressed concern that requiring three CEs regarding supervision of a supervised private practice may be impossible to obtain because no courses are currently offered. Another commenter suggested the supervised private practice CE requirement should be kept separate from other CE requirements and should apply to the supervisee as well as the supervisor.	The Board agrees there is duplication and decided to eliminate the duplicative requirement.	R4-6-217(D)(4) was removed from the rulemaking.
R4-6-304(B): Add that a degree in a behavioral health field from a regionally accredited	The suggestion exceeds the Board's statutory authority.	No change

university is required for licensure by universal recognition.		
R4-6-601(B)(5): Suggests clarifying that the requirements may consist of either three semester or four quarter credit hours.	The Board agrees.	The clarifying language was added.
R4-6-802(C)(1)(c): How does an individual provide evidence of a negative? What evidence does the Board want to show that a licensee does not practice telehealth?	The Board agrees the provision is burdensome and unenforceable.	The requirement to provide evidence of not practicing telehealth was removed.
R4-6-1102(1): Suggested it is more reasonable to require the treatment plan be completed by the fourth visit rather than the third.	The Board agrees.	The requirement was changed as suggested.
R4-6-1106(D)(1): Suggested adding a subsection requiring information regarding local emergency contacts.	The Board agrees.	A new subsection (e) that includes local emergency contacts or services was added.
R4-6-1106(D)(2): Opposes requiring a licensee to obtain contact information regarding a local emergency contact from clients receiving telehealth because of the potential for breach of confidentiality.	The Board believes the change made to subsection (D)(1) adequately addresses the concern.	No change
R4-6-1106(D)(3)(b)(ii): Opposes obtaining the address of a local emergency contact	The Board believes obtaining the address is necessary.	No change

because a telephone number is sufficient. The licensee would not be sending emergency services to the address of the local contact.		

12. All agencies shall list any 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:

None

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 Board does not issue general permits. Rather, the Board issues individual licenses as required by the Board's statutes to each person that is qualified by statute (See A.R.S. §§ 32-3275, 32-3291, 32-3292, 32-3293, 32-3301, 32-3303, 32-3311, 32-3313, and 32-3321) and rule.

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:

None of the rules is more stringent than federal law. No federal law is directly applicable to the subject of any of the rules in this rulemaking.

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:

None of the rules in this rule package was previously made, amended, or repeals as an emergency rule.

15. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 6. BOARD OF BEHAVIORAL HEALTH EXAMINERS

ARTICLE 1. DEFINITIONS

Section

ARTICLE 2. GENERAL PROVISIONS

Section

ARTICLE 3. LICENSURE

Section

ARTICLE 4. SOCIAL WORK

Section

ARTICLE 5. COUNSELING

Section

ARTICLE 6. MARRIAGE AND FAMILY THERAPY

Section

R4-6-601. Curriculum

R4-6-603. Supervised Work Experience for Marriage and Family Therapy Licensure

ARTICLE 7. SUBSTANCE ABUSE COUNSELING

Section

R4-6-702. Licensed Associate Substance Abuse Counselor Curriculum

R4-6-703. Licensed Independent Substance Abuse Counselor Curriculum

R4-6-705. Supervised Work Experience for Substance Abuse Counselor Licensure

R4-6-706. Clinical Supervision for Substance Abuse Counselor Licensure

ARTICLE 8. LICENSE RENEWAL AND CONTINUING EDUCATION

Section

R4-6-801. Renewal of Licensure

R4-6-802. Continuing Education

ARTICLE 11. STANDARDS OF PRACTICE

Section

R4-6-1101. Consent for Treatment

R4-6-1102. Treatment Plan

R4-6-1105. Confidentiality

R4-6-1106. ~~Telepractice~~ Telehealth

ARTICLE 1. DEFINITIONS

R4-6-101. Definitions

A. The definitions at A.R.S. § 32-3251 apply to this Chapter. Additionally, the following definitions apply to this Chapter, unless otherwise specified:

1. "Applicant" means:
   a. An individual requesting a license by examination, endorsement, or universal recognition or a temporary license~~, or a license by endorsement~~ by submitting a completed application packet to the Board; or
   b. A regionally accredited college or university seeking Board approval of an educational program under R4-6-307.
2. "Application packet" means the ~~required~~ documents, forms, fees, and additional information required by the Board of an applicant.
3. "ARC" means an academic review committee established by the Board under A.R.S. § 32-3261(A).
4. "Assessment" means the collection and analysis of information to determine an individual's behavioral health treatment needs.
5. "ASWB" means the Association of Social Work Boards.
6. "Behavioral health entity" means any organization, agency, business, or professional practice, including a for-profit private practice, which provides assessment, diagnosis, and treatment to individuals, groups, or families for behavioral health related issues.
7. "Behavioral health service" means the assessment, diagnosis, or treatment of an individual's behavioral health issue.
8. "CACREP" means the Council for Accreditation of Counseling and Related Educational Programs.
9. "Client record" means collected documentation of the behavioral health services provided to and information gathered regarding a client.
10. "Clinical social work" means social work involving clinical assessment, diagnosis, and treatment of individuals, couples, families, and groups.
11. "Clinical supervision" means direction or oversight provided either face to face or by ~~videoconference~~ virtual teleconference or telephone by an individual qualified to evaluate, guide, and direct all behavioral health services provided by a licensee to assist the licensee to develop and improve the necessary knowledge, skills, techniques, and abilities to allow the licensee to engage in the practice of behavioral health ethically, safely, and competently.
12. "Clinical supervisor" means ~~an~~ a qualified individual who provides clinical supervision.

13. “COAMFTE” means the Commission on Accreditation for Marriage and Family Therapy Education.
14. “Clock hour” means 60 minutes of instruction, not including breaks or meals.
15. “Contemporaneous” means documentation is made within 10 business days after service is provided.
16. “Continuing education” means training that provides an understanding of current developments, skills, procedures, or treatments related to the practice of behavioral health, as determined by the Board.
17. “Co-occurring disorder” means a combination of substance use disorder or addiction and a mental or personality disorder.
18. “CORE” means the Council on Rehabilitation Education.
19. “Counseling related coursework” means education that prepares an individual to provide behavioral health services, as determined by the ARC.
20. “CSWE” means Council on Social Work Education.
21. “Date of service” means the postmark date applied by the U.S. Postal Service to materials addressed to an applicant or licensee at the address the applicant or licensee last placed on file in writing with the Board.
22. “Day” means calendar day.
23. *“Direct client contact” means the performance of therapeutic or clinical functions related to the applicant’s professional practice level of psychotherapy that includes diagnosis, assessment and treatment and that may include psychoeducation for mental, emotional and behavioral disorders based primarily on verbal or nonverbal communications and intervention with, and in the presence of, one or more clients, including through the use of telehealth pursuant to title 36, chapter 36, article 1.* A.R.S. § 32-3251.
24. “Direct supervision” means responsibility and oversight for all services provided by a supervisee as prescribed in R4-6-211.
25. “Disciplinary action” means any action taken by the Board against a licensee, based on a finding that the licensee engaged in unprofessional conduct, including refusing to renew a license ~~and~~ or suspending or revoking a license.
26. “Documentation” means written or electronic ~~supportive~~ evidence.
27. “Educational program” means a degree program in counseling, marriage and family therapy, social work, or substance use or addiction counseling that is:
    a. Offered by a regionally accredited college or university, and
    b. Not accredited by an organization or entity recognized by the Board.

28. "Electronic signature" means an electronic sound, symbol, or process that is attached to or logically associated with a record and that is executed or adopted by an individual with the intent to sign the record.
29. "Family member" means a parent, sibling, half-sibling, child, cousin, aunt, uncle, niece, nephew, grandparent, grandchild, and present and former spouse, in-law, stepchild, stepparent, foster parent, or significant other.
30. "Gross negligence" means careless or reckless disregard of established standards of practice or repeated failure to exercise the care that a reasonable practitioner would exercise within the scope of professional practice.
31. "Inactive status" means the Board has granted a licensee the right to suspend behavioral health practice temporarily by postponing license renewal for a maximum of 48 months.
32. "Independent practice" means engaging in the practice of marriage and family therapy, professional counseling, social work, or substance abuse counseling without direct supervision.
~~33. *"Indirect client service" means training for, and the performance of, functions of an applicant's professional practice level in preparation for or on behalf of a client for whom direct client contact functions are also performed, including case consultation and receipt of clinical supervision. Indirect client service does not include the provision of psychoeducation.* A.R.S. § 32-3251.~~
~~34.~~33. "Individual clinical supervision" means clinical supervision provided by a clinical supervisor to one supervisee.
~~35.~~34. "Informed consent for treatment" means a ~~written~~ document authorizing treatment of a client that~~:~~
   ~~a. Contains~~ meets the requirements of R4-6-1101~~;~~.
   ~~b. Is dated and signed by the client or the client's legal representative, and~~
   ~~c. Beginning on July 1, 2006, is dated and signed by an authorized representative of the behavioral health entity.~~
~~36.~~35. "Legal representative" means an individual authorized by law to act on a client's behalf.
~~37.~~36. "License" means written authorization issued by the Board that allows an individual to engage in the practice of behavioral health in Arizona.
~~38.~~37. "License period" means the two years between the dates on which the Board issues a license and the license expires.
~~39.~~38. "NASAC" means the National Addiction Studies Accreditation Commission.

~~40.~~39. *"Practice of behavioral health" means the practice of marriage and family therapy, professional counseling, social work and substance abuse counseling pursuant to this Chapter.* A.R.S. § 32-3251.

~~41.~~40. *"Practice of marriage and family therapy" means the professional application of family systems theories, principles and techniques to treat interpersonal relationship issues and nervous, mental and emotional disorders that are cognitive, affective or behavioral. The practice of marriage and family therapy includes:*

a. Assessment, appraisal and diagnosis.

b. The use of psychotherapy for the purpose of evaluation, diagnosis and treatment of individuals, couples, families and groups. A.R.S. § 32-3251.

~~42.~~41. *"Practice of professional counseling" means the professional application of mental health, psychological and human development theories, principles and techniques to:*

a. Facilitate human development and adjustment throughout the human life span.

b. Assess and facilitate career development.

c. Treat interpersonal relationship issues and nervous, mental and emotional disorders that are cognitive, affective or behavioral.

d. Manage symptoms of mental illness.

e. Assess, appraise, evaluate, diagnose and treat individuals, couples, families and groups through the use of psychotherapy. A.R.S. § 32-3251.

~~43.~~42. *"Practice of social work" means the professional application of social work theories, principles, methods and techniques to:*

a. Treat mental, behavioral and emotional disorders.

b. Assist individuals, families, groups and communities to enhance or restore the ability to function physically, socially, emotionally, mentally and economically.

c. Assess, appraise, diagnose, evaluate and treat individuals, couples, families and groups through the use of psychotherapy. A.R.S. § 32-3251.

~~44.~~43. *"Practice of substance abuse counseling" means the professional application of general counseling theories, principles and techniques as specifically adapted, based on research and clinical experience, to the specialized needs and characteristics of persons who are experiencing substance abuse, chemical dependency and related problems and to the families of those persons. The practice of substance abuse counseling includes the following as they relate to substance abuse and chemical dependency issues:*

a. Assessment, appraisal, and diagnosis.

b. The use of psychotherapy for the purpose of evaluation, diagnosis and treatment of

individuals, couples, families and groups. A.R.S. § 32-3251.

~~45.~~44. "Progress note" means contemporaneous documentation of a behavioral health service provided to an individual that is dated and signed or electronically acknowledged by the licensee.

~~46.~~45. *"Psychoeducation" means the education of a client as part of a treatment process that provides the client with information regarding mental health, emotional disorders or behavioral health."* A.R.S. § 32-3251.

~~47.~~46. "Quorum" means a majority of the members of the Board or an ARC. Vacant positions do not reduce the quorum requirement.

~~48.~~47. "Regionally accredited college or university" means the institution has been approved by an entity recognized by the Council for Higher Education Accreditation as a regional accrediting organization.

~~49.~~48 "Significant other" means an individual whose participation a client considers to be essential to the effective provision of behavioral health services to the client.

49. "Supervised private practice" means a master's level licensee:

    a. Owns a behavioral health entity,

    b. Is responsible for the behavioral health services provided by the supervised licensee, and

    c. Provides the behavioral health services under direct supervision.

50. "Supervised work experience" means practicing clinical social work, marriage and family therapy, professional counseling, or substance abuse counseling for remuneration or on a voluntary basis under direct supervision and while receiving clinical supervision as prescribed in R4-6-212 and Articles 4 through 7.

~~51. *"Telepractice" means providing behavioral health services through interactive audio, video or electronic communication that occurs between a behavioral health professional and the client, including any electronic communication for evaluation, diagnosis and treatment, including distance counseling, in a secure platform, and that meets the requirements of telemedicine pursuant to A.R.S. § 36-3602.* A.R.S. § 32-3251.~~

~~52.~~51. "Treatment" means the application by a licensee of one or more therapeutic practice methods to improve, eliminate, or manage a client's behavioral health issue.

~~53.~~52. "Treatment goal" means the desired result or outcome of treatment.

~~54.~~53. "Treatment method" means the specific approach a licensee ~~used~~ uses to achieve a treatment goal.

~~55.~~54. "Treatment plan" means a description of the specific behavioral health services that a licensee will provide to a client that is documented in the client record, and meets the requirements found in R4-6-1102.

B. For the purposes of this Chapter, notifications or communications required to be "written" or "in writing" may be transmitted or received by mail, electronic transmission, facsimile transmission or hand delivery and may not be transmitted or received orally. Documents requiring a signature may include a written signature or electronic or digital signature ~~as defined in subsection (A)(28)~~.

ARTICLE 2. GENERAL PROVISIONS

R4-6-211. ~~Direct Supervision:~~ Supervised Work Experience~~: General~~

A. A ~~license~~ licensee subject to practice limitations ~~pursuant to~~ under R4-6-210 shall practice in ~~an~~ a behavioral health entity ~~with responsibility and~~ that is responsible for and provides clinical oversight of the behavioral health services provided by the licensee.

~~**B.** A masters level licensee working under direct supervision who operates or manages their own entity with immediate responsibility for the behavioral health services provided by the licensee shall provide the following to the board for approval prior to providing behavioral health services:~~

~~1. The name of their clinical supervisor who meets the following:~~

~~a. Is independently licensed by the board in the same discipline as the supervisee, and who has practiced as an independently licensed behavioral health professional for a minimum of two years beyond the supervisor's licensure date;~~

~~b. Is in compliance with the clinical supervisor educational requirements specified in R4-6-214;~~

~~c. Is not prohibited from providing clinical supervision by a board consent agreement; and~~

~~2. A copy of the agreement between the clinical supervisor and supervisee demonstrating:~~

~~a. The supervisee and supervisor will meet individually for one hour for every 20 hours of direct client contact provided, to include an onsite meeting every 60 days;~~

~~b. Supervisee's clients will be notified of clinical supervisor's involvement in their treatment and the means to contact the supervisor;~~

~~c. Supervision reports will be submitted to the board every six months;~~

~~d. A 30 day notice is required prior to either party terminating the agreement;~~

~~e. The supervisor and supervisee will notify the board within 10 days of the agreement termination date; and~~

~~f. The supervisee will cease practicing within 60 days of the agreement termination date until such time as a subsequent agreement is provided to the board and approved.~~

~~**C.** A licensee complying with subsection (B) shall not provide clinical oversight and responsibility for the behavioral health services of another licensee subject to the practice limitations pursuant to R4-6-210.~~

~~**D.**~~**B.** To meet the supervised work experience requirements for licensure, an applicant shall ensure the applicant's direct supervision ~~shall~~:

1. ~~Meet~~ Meets the specific supervised work experience requirements contained in Articles 4, 5, 6, ~~and~~ or 7, as applicable;
2. ~~Be acquired after completing the degree required for licensure and receiving certification or licensure from a state regulatory entity;~~
3. ~~2.~~ ~~Be~~ Is acquired before January 1, 2006, if acquired as an unlicensed professional practicing under an exemption provided in A.R.S. § 32-3271;
4. ~~3.~~ ~~Involve~~ Involves the practice of behavioral health; and
5. ~~4.~~ ~~Be for a term of~~ Occurs in no fewer than 24 months.

C. To meet the supervised work experience requirements for licensure, an applicant shall ensure that while working under direct supervision, the applicant:

1. Does not have an ownership interest in, operate, or manage the entity with immediate responsibility for the behavioral health services provided by the applicant unless the Board has approved the applicant for supervised private practice under R4-6-217;
2. Does not receive supervision from:
   a. A family member,
   b. An individual whose objective assessment may be limited by a relationship with the applicant; or
   c. An individual not employed or contracted by the same behavioral health entity as the applicant;
3. Does not engage in the independent practice of behavioral health; and
4. Is not directly compensated by behavioral health clients.

~~**E.**~~**D.** An applicant who acquired supervised work experience outside of Arizona may submit that experience for approval as it relates to the qualifications of the supervisor and the behavioral health entity in which the supervision was acquired. The ~~board~~ Board may accept the supervised work experience as it relates to the supervisor and the behavioral health entity if ~~it~~ the supervised work experience met the requirements of the state in which the supervised work experience occurred. ~~Nothing in this provision shall~~ This subsection does not apply to the supervision requirements ~~set forth~~ in R4-6-403, R4-6-503, R4-6-603 and R4-6-705.

~~**F.**~~**E.** If the Board determines ~~that~~ an applicant engaged in unprofessional conduct related to services ~~rendered~~ provided while acquiring hours ~~under~~ of supervised work experience, including clinical supervision, the Board shall not accept the hours to satisfy the requirements of R4-6-403, R4-6-503, R4-6-603, or R4-6-706. Hours accrued before and after the time during which the conduct that was

the subject of the finding of unprofessional conduct occurred, as determined by the Board, may be used to satisfy the requirements of R4-6-403, R4-6-503, R4-6-603, or R4-6-706 ~~so long as the hours are not the subject of an additional finding of unprofessional conduct~~.

R4-6-212. Clinical Supervision Requirements

A. The Board shall accept hours of clinical supervision submitted by an applicant if the clinical supervision meets the requirements specified in R4-6-404, R4-6-504, R4-6-604, or R4-6-706, as applicable to the license for which application is made, and was provided by one of the following:

1. A clinical social worker, professional counselor, independent marriage and family therapist, or independent substance abuse counselor who:
   a. Holds an active and unrestricted license issued by the Board <u>at least one year before the clinical supervision is provided</u>, and
   b. Has complied with the educational requirements specified in R4-6-214;
2. A mental health professional who holds an active and unrestricted license issued under A.R.S. Title 32, Chapter 19.1 as a psychologist and has complied with the educational requirements specified in R4-6-214; or
3. An individual who:
   a. Holds an active and unrestricted license to practice behavioral health,
   b. Is providing behavioral health services in Arizona:
      i. Under a contract or grant with the federal government under the authority of 25 U.S.C. § 5301 or § 1601-1683, or
      ii. By appointment under 38 U.S.C. § 7402 (8-11), and
   c. Has complied with the educational requirements specified in R4-6-214.

B. Unless an exemption was obtained under R4-6-212.01, the Board shall accept hours of clinical supervision submitted by an applicant if the clinical supervision was provided by an individual who:

1. Was qualified under subsection (A), and
2. Was employed by the behavioral health entity at which the applicant obtained hours of clinical supervision.

C. The Board shall accept hours of clinical supervision submitted by an applicant if the clinical supervision includes all of the following:

1. Reviewing ethical and legal requirements applicable to the supervisee's practice, including unprofessional conduct as defined in A.R.S. § 32-3251;
2. Monitoring the supervisee's activities to verify the supervisee is providing services safely and competently;

3. Verifying in writing that the supervisee provides clients with appropriate written notice of clinical supervision, including the means to obtain the name and telephone number of the supervisee's clinical supervisor;
4. Contemporaneously written documentation by the clinical supervisor of at least the following for each clinical supervision session at each entity:
   a. Date and duration of the clinical supervision session;
   b. A detailed description of topics discussed to include themes and demonstrated skills;
   c. Beginning on July 1, 2006, name and signature of the individual receiving clinical supervision;
   d. Name and signature of the clinical supervisor and the date signed; and
   e. Whether the clinical supervision occurred on a group or individual basis;
5. Maintaining by the clinical supervisor the documentation ~~of clinical supervision~~ required under subsection (C)(4) for ~~at least seven~~ the greater of six years or until the supervisee is independently licensed;
6. Verifying that clinical supervision was not acquired from a family member, as prescribed in R4-6-101(A)(29), or someone with a personal relationship to the supervisee.
7. Conducting on-going compliance review of the supervisee's clinical documentation to ensure the supervisee maintains adequate written documentation;
8. Providing instruction regarding:
   a. Assessment,
   b. Diagnosis,
   c. Treatment plan development, and
   d. Treatment;
9. Rating the supervisee's overall performance as at least satisfactory, using a form approved by the Board; and
10. Complying with the discipline-specific requirements in Articles 4 through 7 regarding clinical supervision.

D. The Board shall accept hours of clinical supervision submitted by an applicant for licensure if:

~~1. At least two hours of the clinical supervision were provided in a face-to-face setting during each six-month period;~~

~~2. No more than 90 hours of the clinical supervision were provided by videoconference and telephone;~~

~~3.~~1. No more than 15 ~~of the 90~~ hours of clinical supervision ~~provided by videoconference and telephone~~ were provided by telephone;

2. The hours of clinical supervision occurred during a month in which the applicant provided direct client contact; and

~~4.~~3. Each clinical supervision session was at least 30 minutes long.

E. Effective July 1, 2006, the Board shall accept hours of clinical supervision submitted by an applicant if at least 10 of the hours involve the clinical supervisor observing the supervisee providing treatment and evaluation services to a client. The clinical supervisor may conduct the observation:

1. In a face-to-face or virtual teleconference setting,
2. By ~~videoconference~~ virtual teleconference,
3. By teleconference, or
4. By review of audio or video recordings.

F. The Board shall accept hours of clinical supervision submitted by an applicant from a maximum of six clinical supervisors.

G. The Board shall accept hours of clinical supervision obtained by an applicant in both individual and group sessions, subject to the following restrictions:

1. At least 25 of the clinical supervision hours involve individual supervision, and
2. Of the minimum 100 hours of clinical supervision required for licensure, the Board may accept:
   a. Up to 75 of the clinical supervision hours involving a group of two supervisees, and
   b. Up to 50 of the clinical supervision hours involving a group of three to six supervisees.

H. If an applicant provides evidence that a catastrophic event prohibits the applicant from obtaining documentation of clinical supervision that meets the standard specified in subsection (C), the Board may consider alternate documentation.

R4-6-214. Clinical Supervisor Educational Requirements

A. The Board shall consider hours of clinical supervision submitted by an applicant only if the individual who provides the clinical supervision is qualified under R4-6-212(A) and complies with the following:

1. Completes one of the following:
   a. At least 12 hours of training, completed within the last three years, ~~that~~ which meets the standard specified in R4-6-802(D), addresses clinical supervision, and includes the following:
      i. Role and responsibilities of a clinical supervisor;
      ii. Skills in providing effective oversight of and guidance to supervisees who diagnose, create treatment plans, and treat clients;
      iii. Supervisory methods and techniques; ~~and~~
      iv. Fair and accurate evaluation of a supervisee's ability to plan and implement clinical assessment and treatment;

v. Knowledge of the provision of supervised private practice as described in R4-6-217; and

vi. Knowledge of statutes and rules of the Arizona Department of Health Services relating to exemptions to licensure.

b. An approved clinical supervisor certification from the National Board for Certified Counselors/Center for Credentialing and Education;

c. A clinical supervisor certification from the International Certification and Reciprocity Consortium; or

d. A clinical member with an approved supervisor designation from the American Association of Marriage and Family Therapy; and

2. Completes the three clock hour Clinical Supervision Tutorial on Arizona Statutes/Regulations.

B. To continue providing clinical supervision, an individual qualified under subsection (A)(1)(a) shall, at least every three years, complete a minimum of nine hours of continuing training that:

1. Meets the standard specified in R4-6-802(D);
2. Concerns clinical supervision;
3. Addresses the topics listed in subsection (A)(1)(a); and
4. Includes the three clock hour Clinical Supervision Tutorial on Arizona Statutes/Regulations.

C. To continue providing clinical supervision, an individual qualified under subsections (A)(1)(b) through (d) shall:

1. Provide documentation that the national certification or designation was renewed before it expired, and
2. Complete the Clinical Supervision Tutorial on Arizona Statutes/Regulations.

D. The Board shall not accept hours of clinical supervision provided by an individual who fails to remain qualified by complying with subsection (B) or (C) until the individual becomes qualified again by complying with subsection (A).

~~**D.**~~**E.** An applicant submitting hours of clinical supervision by an individual qualified by meeting the clinical supervision education requirements in effect before the effective date of this Section shall provide documentation that the clinical supervisor was compliant with the education requirements during the period of supervision.

R4-6-215. Fees and Charges

A. Under the authority provided by A.R.S. § 32-3272, the Board establishes and shall collect the following fees:

1. Application for license by examination: $250;
2. Application for license by endorsement or universal recognition: $250;
3. Application for a temporary license: $50;

4. Application for approval of educational program: $500;
5. Application for approval of an educational program change: $250;
6. Biennial renewal of first area of licensure: $325;
7. Biennial renewal of each additional area of licensure if all licenses are renewed at the same time: $163;
8. Late renewal penalty: $100 in addition to the biennial renewal fee;
9. Inactive status request: $100; and
10. Late inactive status request: $100 in addition to the inactive status request fee.

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: $250.

~~**B.**~~**C.** The Board shall charge the following amounts for the services it provides:

~~1.~~ ~~Issuing a duplicate license: $25;~~

~~2.~~1. Criminal history background check: $40 unless waived under A.R.S. § 32-3280(B);

~~3.~~2. Paper copy of records: $.50 per page after the first four pages;

~~4.~~3. Electronic copy of records: $25;

~~5.~~4. Copy of a Board meeting audio recording: $20;

~~6.~~5. Verification of licensure: $20 per discipline or free if downloaded from the Board's web site;

~~7.~~6. Board's rules and statutes book: $10 or free if downloaded from the Board's web site;

~~8.~~7. Mailing list of licensees: $150, and

~~9.~~8. Returned check due to insufficient funds: $50.

~~**C.**~~**D.** The application fees in subsections (A)(1) and (2) are non-refundable. Other fees established in ~~subsection~~ subsections (A) and (B) are not refundable unless the provisions of A.R.S. § 41-1077 apply.

~~**D.**~~**E.** The Board shall accept payment of fees and charges as follows:

1. For an amount of $40 or less, a personal or business check;
2. For amounts greater than $40, a certified check, cashier's check, or money order; and
3. By proof of online payment by credit card for the following:
   a. All fees in subsection (A);
   b. The charge in subsection ~~(B)(2)~~ (C)(1) for a criminal history background check; and
   c. The charge in subsection ~~(B)(8)~~ (C)(7) for a mailing list of licensees.

R4-6-216. Foreign Equivalency Determination

The Board shall accept as qualification for licensure a degree from an institution of higher education in a foreign country if the degree is substantially equivalent to the educational standards required in this Chapter for professional counseling, marriage and family therapy, and substance abuse counseling

licensure. To enable the Board to determine whether a foreign degree is substantially equivalent to the educational standards required in this Chapter, the applicant shall, at the applicant's expense, have ~~the~~ a course-by-course evaluation of the foreign degree ~~evaluated~~ performed by an evaluation service that is a member of the National Association of Credential Evaluation Services, Inc.

1. Any document that is in a language other than English shall be accompanied by a translation with notarized verification of the translation's accuracy and completeness;
2. The translation shall be completed by an individual, other than the applicant, and demonstrates no conflict of interest; and
3. The individual providing the translation may be college or university language faculty, a translation service, or an American consul.

R4-6-217. Supervised Private Practice

A. General provisions regarding supervised private practice:

1. A supervised private practice, the supervised licensee, and the supervised-private-practice supervisor shall be physically located in Arizona;
2. A supervised licensee shall have only one supervised-private-practice supervisor at any given time;
3. A supervised-private-practice supervisor shall not supervise more than five supervised private practices at any given time; and
4. Failure to comply fully with this Section may result in disciplinary action against both the supervised licensee and the supervised-private-practice supervisor.

B. Before providing behavioral health services in a supervised private practice, as defined at R4-6-101, the supervised licensee shall provide the following to the Board for approval:

1. The name of the supervised licensee's supervised-private-practice supervisor who meets the following:
   a. Is independently licensed by the Board in the same discipline as the supervised licensee and has practiced as an independently licensed behavioral health professional for at least two years after initial licensure;
   b. Is in compliance with the supervised-private-practice supervisor educational requirements specified in R4-6-214;
   c. Is not prohibited from providing clinical supervision by a Board consent agreement; and
2. A copy of the agreement between the supervised-private-practice supervisor and supervised licensee demonstrating:
   a. The supervised licensee and supervised-private-practice supervisor will meet individually:
      i. For one hour for every 10 hours of direct client contact provided, and

ii. At the location of the supervised private practice at least once every 60 calendar days;

b. The supervised licensee will notify clients of the supervised-private-practice supervisor's involvement in the client's treatment and the means to contact the supervised-private-practice supervisor;

c. The supervised-private-practice supervisor will submit supervision reports to the Board every six months;

d. The supervised licensee and supervised-private-practice supervisor will provide 30-days's notice to the other before terminating the agreement;

e. The supervised licensee and supervised-private-practice supervisor will notify the Board within 10 days after terminating the agreement; and

f. The supervised licensee will cease providing behavioral health services within 60 days after termination of the agreement unless another agreement is provided to and approved by the Board.

C. Supervised licensee responsibilities. A supervised licensee providing behavioral health services in a supervised private practice, as defined at R4-6-101, shall:

1. Not employ, contract with, provide clinical oversight of, or have any responsibility for the behavioral health services of another licensee;
2. Before Board approval of the supervised private practice, include notice in all advertising, marketing, and practice materials that clients are not being accepted; and
3. After Board approval of the supervised private practice, include notice in all advertising, marketing, and practice materials of the supervised-private-practice supervisor's involvement in the supervised private practice and the means to contact the supervised-private-practice supervisor.

D. Supervised-private-practice supervisor responsibilities. A supervised-private-practice supervisor of a supervised private practice shall:

1. Supervise all clinical and non-clinical aspects of the supervised private practice;
2. Regularly review the clinical and non-clinical documentation maintained by the licensed supervisee and attest to the Board that the review was thorough and the documentation complete; and
3. Submit all required reports to the Board within two weeks after the reports are due.

ARTICLE 3. LICENSURE

R4-6-301. Application for a License by Examination

An applicant for a license by examination shall submit a completed application packet that contains the following:

1. A statement by the applicant certifying that all information submitted in support of the application is true and correct;
2. Identification of the license for which application is made;
3. The license application fee required under R4-6-215;
4. The applicant's name, date of birth, social security number, and contact information;
5. Each name or alias previously or currently used by the applicant;
6. The name of each college or university the applicant attended and an official transcript for all education used to meet requirements;
7. Verification of current or previous licensure or certification from the licensing or certifying entity as follows:
   a. Any license or certification ever held in the practice of behavioral health; and
   b. Any professional license or certification not identified in subsection (7)(a) held in the last 10 years;
8. Background information to enable the Board to determine whether, as required under A.R.S. § 32-3275(A)(3), the applicant is of good moral character;
9. A list of every entity for which the applicant has worked during the last 7 years;
10. If the relevant licensing examination was previously taken, an official copy of the score the applicant obtained on the examination;
11. A report of the results of a ~~self-query~~ query of the National Practitioner Data Bank;
12. Documentation required under A.R.S. § 41-1080(A) showing that the applicant's presence in the U.S. is authorized under federal law;
13. A completed and legible fingerprint card for a state and federal criminal history background check and payment as prescribed under R4-6-215 if the applicant has not previously submitted a full set of fingerprints to the Board, or verification that the applicant holds a current fingerprint card issued by the Arizona Department of Public Safety; and
14. Other documents or information requested by the Board to determine the applicant's eligibility.

Table 1. Time Frames (in Days)

Type of License	Statutory Authority	Overall Time Frame	Administrative Completeness Time Frame	Substantive Review Time Frame
License by	A.R.S. § 32-3253	270	90	180

Examination	A.R.S. § 32-3275			
Temporary License	A.R.S. § 32-3253 A.R.S. § 32-3279	90	30	60
License by Endorsement; License by Universal Recognition	A.R.S. § 32-3253 A.R.S. § 32-3274 A.R.S. § 32-4302	270	90	180
License Renewal	A.R.S. § 32-3253 A.R.S. § 32-3273	270	90	180
Application for registration as an out-of-state health care provider of telehealth services	A.R.S. § 32-3253 A.R.S. § 36-3606	270	90	180

R4-6-304. Application for a License by Endorsement; Application for a License by Universal Recognition

A. License by endorsement. An applicant who meets the requirements specified under A.R.S. § 32-3274 for a license by endorsement shall submit a completed application packet, as prescribed in R4-6-301, and the following:

1. The name of one or more other jurisdictions where the applicant is certified or licensed as a behavioral health professional by a state or federal regulatory entity, and has been for at least three years;
2. A verification of each certificate or license identified in subsection (1) by the state regulatory entity issuing the certificate or license that includes the following:
   a. The certificate or license number issued to the applicant by the state regulatory entity;
   b. The issue and expiration date of the certificate or license;
   c. Whether the applicant has been the subject of disciplinary proceedings by a state regulatory entity; and
   d. Whether the certificate or license is active and in good standing;
3. If applying at a practice level listed in A.R.S. § 32-3274(B), include:

a. An official transcript as prescribed in R4-6-301(6); and

b. If applicable, a foreign degree evaluation prescribed in R4-6-216 or R4-6-401; and

4. Documentation of completion of the Arizona Statutes/Regulations Tutorial.

B. License by universal recognition. An applicant who meets the requirements specified under A.R.S. § 32-4302 for a license by universal recognition shall submit:

1. An application provided by the Board;
2. A list of all states in which the applicant is currently and has been licensed for at least one year and certification from the licensing states that the applicant's license is in good standing;
3. Proof of Arizona residency;
4. A completed and legible fingerprint card for a state and federal criminal history background check and payment as prescribed under R4-6-215 if the applicant has not previously submitted a full set of fingerprints to the Board, or verification that the applicant holds a current fingerprint card issued by the Arizona Department of Public Safety; and
5. Documentation of completion of the Arizona Statutes/Regulations Tutorial.

R4-6-305. Inactive Status

A. A licensee seeking inactive status shall submit:

1. A written request to the Board before expiration of the current license, and
2. The fee specified in R4-6-215 for inactive status request.

B. To be placed on inactive status after license expiration, a licensee shall, within ~~three months~~ 90 days after the date of license expiration, comply with subsection (A) and submit the fee specified in R4-6-215 for late request for inactive status.

C. The Board shall grant a request for inactive status to a licensee upon receiving a written request for inactive status. The Board shall grant inactive status for a maximum of 24 months.

D. The Board shall not grant a request for inactive status that is received more than ~~three months~~ 90 days after license expiration.

E. Inactive status does not change:

1. The date on which the license of the inactive licensee expires, and
2. The Board's ability to start or continue an investigation against the inactive licensee.

F. To return to active status, a licensee on inactive status shall:

1. Comply with all renewal requirements prescribed under R4-6-801; and
2. Establish to the Board's satisfaction that the licensee is competent to practice safely and competently. To assist with determining the licensee's competence, the Board may order a mental or physical evaluation of the licensee at the licensee's expense.

G. Upon a showing of good cause, the Board shall grant a written request for modification or reduction of the continuing education requirement received from a licensee on inactive status. The Board shall consider the following to show good cause:

1. Illness or disability,
2. Active military service, or
3. Any other circumstance beyond the control of the licensee.

H. The Board may, upon a written request filed before the expiration of the original 24 months of inactive status and for good cause, as described in subsection (G), permit an inactive licensee to remain on inactive status for one additional period not to exceed 24 months. To return to active status after being placed on a 24-month extension of inactive status, a licensee shall, comply with the requirements in subsection (F) and complete an additional 30 hours of continuing education during the 24-month extension.

I. A licensee on inactive status shall not engage in the practice of behavioral health.

R4-6-306. Application for a Temporary License

A. To be eligible for a temporary license, an applicant shall:

1. Have applied under R4-6-301 for a license by examination or R4-6-304 for a license by endorsement or universal recognition,
2. Have submitted an application for a temporary license using a form approved by the Board and paid the fee required under R4-6-215, and
3. Be one of the following:
   a. Applying for a license by endorsement;
   b. Applying for a license by examination, not currently licensed or certified by a state behavioral health regulatory entity, and:
      i. Within 12 months after obtaining a degree from the education program on which the applicant is relying to meet licensing requirements,
      ii. Has completed all licensure requirements except passing the required examination, and
      iii. Has not previously taken the required examination; or
   c. Applying for a license by examination and currently licensed or certified by another state behavioral health regulatory entity.

B. An individual is not eligible for a temporary license if the individual:

1. Is the subject of a complaint pending before any state behavioral health regulatory entity,
2. Has had a license or certificate to practice a health care profession suspended or revoked by any state regulatory entity,

3. Has a criminal history or history of disciplinary action by a state behavioral health regulatory entity unless the Board determines the history is not of sufficient seriousness to merit disciplinary action, or
4. Has been previously denied a license by the Board.

C. A temporary license issued to an applicant expires one year after issuance by the Board.

D. A temporary license issued to an applicant who has not previously passed the required examination for licensure expires immediately if the temporary licensee:

1. Fails to take the required examination by the expiration date of the temporary license; or
2. ~~Takes but fails~~ Fails to pass the required examination by the expiration date of the authorization to test.

E. A temporary licensee shall provide written notice and return the temporary license to the Board if the temporary licensee fails the required examination.

F. An applicant who is issued a temporary license shall practice as a behavioral health professional only under direct supervision. The temporary license may contain restrictions as to time, place, and supervision that the Board deems appropriate.

G. The Board shall issue a temporary license only in the same discipline for which application is made under subsection (A).

H. The Board shall not extend the time of a temporary license or grant an additional temporary license based on the application submitted under subsection (A).

I. A temporary licensee is subject to disciplinary action by the Board under A.R.S. § 32-3281. A temporary license may be summarily revoked without a hearing under A.R.S. § 32-3279(C)(4).

J. If the Board denies a license by examination or endorsement to a temporary licensee, the temporary licensee shall return the temporary license to the Board within five days of receiving the Board's notice of the denial.

K. If a temporary licensee withdraws the license application submitted under R4-6-301 for a license by examination or R4-6-304 for a license by endorsement, the temporary license expires.

ARTICLE 4. SOCIAL WORK

R4-6-403. Supervised Work Experience for Clinical Social Worker Licensure

A. An applicant for licensure as a clinical social worker ~~licensure~~ shall demonstrate completion of at least ~~3200 hours of supervised work experience in the practice of clinical social work in no less than~~ 24 months~~. Supervised work experience in the practice of clinical social work shall include~~ of supervised work experience in the practice of clinical social work that includes:

1. At least 1600 hours of direct client contact involving the use of psychotherapy;

2. No more than 400 of the 1600 hours of direct client contact are in psychoeducation; and
3. At least 100 hours of clinical supervision as prescribed under R4-6-212 and R4-6-404~~; and~~
~~4. For the purpose of licensure, no more than 1600 hours of indirect client contact related to psychotherapy services~~.

B. For any month in which an applicant provides direct client contact, the applicant shall obtain at least one hour of clinical supervision.

C. An applicant may submit more than the required ~~3200~~ hours of supervised work experience for consideration by the Board.

D. During the period of required supervised work experience specified in subsection (A), an applicant for clinical social worker licensure shall practice behavioral health under the limitations specified in R4-6-210.

E. There is no supervised work experience requirement for licensure as a baccalaureate or master social worker.

R4-6-404. Clinical Supervision for Clinical Social Worker Licensure

A. An applicant for clinical social worker licensure shall demonstrate that the applicant received at least 100 hours of clinical supervision that meet the requirements specified in subsection (B) and R4-6-212 during the supervised work experience required under R4-6-403.

B. The Board shall accept hours of clinical supervision for clinical social worker licensure if the hours required under subsection (A) meet the following:
1. At least 50 hours are supervised by a clinical social worker licensed by the Board, and
2. The remaining hours are supervised by an individual qualified under R4-6-212(A), or
3. The hours are supervised by an individual ~~for whom an exemption was obtained under R4-6-212.01~~ who meets the educational requirements under R4-6-214.

C. The Board shall not accept hours of clinical supervision for clinical social worker licensure provided by a substance abuse counselor.

ARTICLE 5. COUNSELING

R4-6-501. Curriculum

A. An applicant for licensure as an associate or professional counselor shall have a master's or higher degree with a major emphasis in counseling from:
1. A program accredited by CACREP or CORE that consists of at least 60 semester or 90 quarter credit hours, including a supervised counseling practicum as prescribed under subsection (E);

2. An educational program previously approved by the Board under A.R.S. § 32-3253(A)(14) that consists of at least 60 semester or 90 quarter credit hours, including a supervised counseling practicum as prescribed under subsection (E); or
3. A program from a regionally accredited college or university that consists of at least 60 semester or 90 quarter credit hours, meets the requirements specified in subsections (C) and (D), and includes a supervised counseling practicum as prescribed under subsection (E).

B. To assist the Board to evaluate a program under subsection (A)(3), an applicant who obtained a degree from a program under subsection (A)(3) shall attach the following to the application required under R4-6-301:

1. Published college or university course descriptions for the year and semester enrolled for each course submitted to meet curriculum requirements,
2. Verification, using a form approved by the Board, of completing the supervised counseling practicum required under subsection (E); and
3. Other documentation requested by the Board.

C. The Board shall accept for licensure the curriculum from a program not accredited by CACREP or CORE if the curriculum includes at least 60 semester or 90 quarter credit hours in counseling-related coursework, of which at least three semester or 4 quarter credit hours are in each of the following eight core content areas:

1. Professional orientation and ethical practice: Studies that provide a broad understanding of professional counseling ethics and legal standards, including but not limited to:
   a. Professional roles, functions, and relationships;
   b. Professional credentialing;
   c. Ethical standards of professional organizations; and
   d. Application of ethical and legal considerations in counseling;
2. Social and cultural diversity: Studies that provide a broad understanding of the cultural context of relationships, issues, and trends in a multicultural society, including but not limited to:
   a. Theories of multicultural counseling, and
   b. Multicultural competencies and strategies;
3. Human growth and development: Studies that provide a broad understanding of the nature and needs of individuals at all developmental stages, including but not limited to:
   a. Theories of individual and family development across the life-span, and
   b. Theories of personality development;
4. Career development: Studies that provide a broad understanding of career development and related life factors, including but not limited to:

a. Career development theories, and
b. Career decision processes;

5. Helping relationship: Studies that provide a broad understanding of counseling processes, including but not limited to:
   a. Counseling theories and models,
   b. Essential interviewing and counseling skills, and
   c. Therapeutic processes;
6. Group work: Studies that provide a broad understanding of group development, dynamics, counseling theories, counseling methods and skills, and other group work approaches, including but not limited to:
   a. Principles of group dynamics,
   b. Group leadership styles and approaches, and
   c. Theories and methods of group counseling;
7. Assessment: Studies that provide a broad understanding of individual and group approaches to assessment and evaluation, including but not limited to:
   a. Diagnostic process including differential diagnosis and use of diagnostic classification systems such as the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases,
   b. Use of assessment for diagnostic and intervention planning purposes, and
   c. Basic concepts of standardized and non-standardized testing; and
8. Research and program evaluation: Studies that provide a broad understanding of recognized research methods and design and basic statistical analysis, including but not limited to:
   a. Qualitative and quantitative research methods, and
   b. Statistical methods used in conducting research and program evaluation.

D. In evaluating the curriculum required under subsection (C), the Board shall assess whether a core content area is embedded or contained in more than one course. The applicant shall provide information the Board requires to determine whether a core content area is embedded in multiple courses. The Board shall not accept a core content area embedded in more than two courses unless the courses are succession courses. The Board shall allow subject matter in a course to qualify in only one core content area.

E. The Board shall accept a supervised counseling practicum <u>and internship</u> that is part of a master's or higher degree program if the supervised counseling practicum <u>and internship</u> meets the following standards:

1. Consists of at least 700 clock hours in a professional counseling setting,

2. Includes at least 240 hours of direct client contact,
3. Provides an opportunity for the supervisee to perform all activities associated with employment as a professional counselor,
4. Oversight of the counseling practicum is provided by a faculty member, and
5. Onsite supervision is provided by an individual approved by the college or university.

F. The Board shall require that an applicant for professional counselor licensure who received a master's or higher degree before July 1, 1989, from a program that did not include a supervised counseling practicum complete three years of post-master's or higher degree work experience in counseling under direct supervision. One year of a doctoral-clinical internship may be substituted for one year of supervised work experience.

G. The Board shall accept for licensure only courses that the applicant completed with a passing grade.

H. The Board shall deem an applicant to meet the curriculum requirements for professional counselor licensure if the applicant:

1. Holds an active and in good standing associate counselor license issued by the Board; and
2. ~~Met the curriculum requirements with~~ Has a master's degree in a behavioral health field from a regionally accredited university ~~when the associate counselor license was issued~~.

R4-6-503. Supervised Work Experience for Professional Counselor Licensure

A. An applicant for licensure as a professional counselor ~~licensure~~ shall demonstrate completion of at least ~~3200 hours of supervised work experience in the practice of professional counseling in no less than~~ 24 months~~. The applicant shall ensure that the~~ of supervised work experience in the practice of professional counseling that includes:

1. At least 1600 hours of direct client contact involving the use of psychotherapy;
2. No more than 400 of the 1600 hours of direct client contact are in psychoeducation; and
3. At least 100 hours of clinical supervision as prescribed under R4-6-212 and R4-6-504~~; and~~
4. ~~For the purpose of licensure, no more than 1600 hours of indirect client contact related to psychotherapy services~~.

B. For any month in which an applicant provides direct client contact, the applicant shall obtain at least one hour of clinical supervision.

C. An applicant may submit more than the required ~~3200~~ hours of supervised work experience for consideration by the Board.

D. During the period of supervised work experience specified in subsection (A), an applicant for professional counselor licensure shall practice behavioral health under the limitations specified in R4-6-210.

E. There is no supervised work experience requirement for licensure as an associate counselor.

ARTICLE 6. MARRIAGE AND FAMILY THERAPY

R4-6-601. Curriculum

A. An applicant for licensure as an associate marriage and family therapist or a marriage and family therapist shall have a master's or higher degree from a regionally accredited college or university in a behavioral health science program that:

1. Is accredited by COAMFTE;
2. Was previously approved by the Board under A.R.S. § 32-3253(A)(14); or
3. Includes at least three semester or four quarter credit hours in each of the ~~number of~~ courses specified in the six core content areas listed in subsection (B).

B. A program under subsection (A)(3) shall include:

1. Marriage and family studies: ~~Three~~ At least nine semester or 12 quarter credit hours in no fewer than three courses from a family systems theory orientation that collectively contain at minimum the following elements:
   a. Introductory family systems theory;
   b. Family development;
   c. Family systems, including marital, sibling, and individual subsystems; and
   d. Gender and cultural issues;
2. Marriage and family therapy: ~~Three~~ At least nine semester or 12 quarter credit hours in no fewer than three courses that collectively contain at minimum the following elements:
   a. Advanced family systems theory and interventions;
   b. Major systemic marriage and family therapy treatment approaches;
   c. Communications; and
   d. Sex therapy;
3. Human development: ~~Three~~ At least nine semester or 12 quarter credit hours in no fewer than three courses that may integrate family systems theory that collectively contain at minimum the following elements:
   a. Normal and abnormal human development;
   b. Human sexuality; and
   c. Psychopathology and abnormal behavior;
4. Professional studies: At least three semester or four quarter credit hours in no fewer than ~~One~~ one course including at minimum:
   a. Professional ethics as a therapist, including legal and ethical responsibilities and liabilities; and

b. Family law;

5. Research: ~~One course~~ At least three semester or four quarter credit hours in no fewer than one course in research design, methodology, and statistics in behavioral health science; and
6. Supervised practicum: Two courses that supplement the practical experience gained under subsection (D).

C. In evaluating the curriculum required under subsection (B), the Board shall assess whether a core content area is embedded or contained in more than one course. The applicant shall provide information the Board requires to determine whether a core content area is embedded in multiple courses. The Board shall not accept a core content area embedded in more than two courses unless the courses are succession courses. The Board shall allow subject matter in a course to qualify in only one core content area.

D. A program's supervised practicum shall meet the following standards:

1. Provides an opportunity for the enrolled student to provide marriage and family therapy services to individuals, couples, and families in an educational or professional setting under the direction of a faculty member or supervisor designated by the college or university;
2. Includes at least 300 client-contact hours provided under direct supervision; and
3. Has supervision provided by a designated licensed marriage and family therapist.

E. An applicant may submit a written request to the ARC for an exemption from the requirement specified in subsection (D)(3). The request shall include the name of the behavioral health professional proposed by the applicant to act as supervisor of the practicum, a copy of the proposed supervisor's transcript and curriculum vitae, and any additional documentation requested by the ARC. The ARC shall grant the exemption if the ARC determines the proposed supervisor is qualified by education, experience, and training to provide supervision.

F. The Board shall deem an applicant to meet the curriculum requirements for marriage and family therapist licensure if the applicant:

1. Holds an active and in good standing associate marriage and family therapist license issued by the Board; and
2. ~~Met the curriculum requirements with~~ Has a master's degree in a behavioral health field from a regionally accredited university ~~when the associate marriage and family therapist license was issued~~.

R4-6-603. Supervised Work Experience for Marriage and Family Therapy Licensure

A. An applicant for licensure as a marriage and family therapist shall demonstrate completion of at least ~~3200 hours of supervised work experience in the practice of marriage and family therapy in no less~~

~~than~~ 24 months~~. The applicant shall ensure that the~~ of supervised work experience in the practice of marriage and family therapy that includes:

1. At least 1600 hours of direct client contact involving the use of psychotherapy:
   a. At least 1000 of the 1600 hours of direct client contact are with couples or families; and
   b. No more than 400 of the 1600 hours of direct client contact are in psychoeducation and at least 60 percent of psychoeducation hours are with couples or families; and
2. At least 100 hours of clinical supervision as prescribed under R4-6-212 and R4-6-604~~; and~~
3. ~~For the purpose of licensure, no more than 1600 hours of indirect client contact related to psychotherapy services~~.

B. For any month in which an applicant provides direct client contact, the applicant shall obtain at least one hour of clinical supervision.

C. An applicant may submit more than the required ~~3200~~ hours of supervised work experience for consideration by the Board.

D. During the period of supervised work experience specified in subsection (A), an applicant for marriage and family therapist licensure shall practice behavioral health under the limitations specified in R4-6-210.

E. There is no supervised work experience requirement for licensure as an associate marriage and family therapist.

ARTICLE 7. SUBSTANCE ABUSE COUNSELING

R4-6-702. Licensed Associate Substance Abuse Counselor Curriculum

A. An applicant for licensure as an associate substance abuse counselor shall have one of the following:

1. A bachelor's degree from a regionally accredited college or university in a program accredited by NASAC and supervised work experience that meets the standards specified in R4-6-705(A);
2. A master's or higher degree from a regionally accredited college or university in a program accredited by NASAC;
3. A bachelor's degree from a regionally accredited college or university in a behavioral health science program that meets the core content standards specified in R4-6-701(B) and supervised work experience that meets the standards specified in R4-6-705(A);
4. A master's or higher degree from a regionally accredited college or university in a behavioral health science program that meets the core content standards specified in R4-6-701(B) and includes at least 300 hours of supervised practicum as prescribed under subsection (C); or

5. A bachelor's degree from a regionally accredited college or university in an educational program previously approved by the Board under A.R.S. § 32-3253(A)(14) and supervised work experience that meets the standards specified in R4-6-705(A); or
6. A master's or higher degree from a regionally accredited college or university in an educational program previously approved by the Board under A.R.S. § 32-3253(A)(14) and includes at least 300 hours of supervised practicum as prescribed under subsection (C).

B. In evaluating the curriculum required under subsection (A)(3) or (4), the Board shall assess whether a core content area is embedded or contained in more than one course. The applicant shall provide information the Board requires to determine whether a core content area is embedded in multiple courses. The Board shall not accept a core content area embedded in more than two courses unless the courses are succession courses. The Board shall allow subject matter in a course to qualify in only one core content area.

C. Supervised practicum. A supervised practicum shall integrate didactic learning related to substance use disorders with face-to-face, direct counseling experience. The counseling experience shall include intake and assessment, treatment planning, discharge planning, documentation, and case management activities.

D. The Board shall deem an applicant to meet the curriculum requirements for associate substance abuse counselor licensure if the applicant:
1. Holds an active and in good standing substance abuse technician license issued by the Board; and
2. ~~Met the curriculum requirements with~~ Has a bachelor's degree ~~when the substance abuse technician license was issued~~ in a behavioral health field from a regionally accredited university.

E. An applicant for licensure as an associate substance abuse counselor who completed the applicant's educational training before the effective date of this Section or no later than October 31, 2017, may request that the Board evaluate the applicant's educational training using the standards in effect before the effective date of this Section.

R4-6-703. Licensed Independent Substance Abuse Counselor Curriculum

A. An applicant for licensure as an independent substance abuse counselor shall have a master's or higher degree from a regionally accredited college or university in one of the following:
1. A program accredited by NASAC;
2. A behavioral health science program that meets the core content standards specified in R4-6-701(B) and includes at least 300 hours of supervised practicum as prescribed under subsection (D); or

3. An educational program previously approved by the Board under A.R.S. § 32-3253(A)(14) that includes at least 300 hours of supervised practicum as prescribed under subsection (D).

B. In addition to the degree requirement under subsection (A), an applicant for licensure as an independent substance abuse counselor shall complete the supervised work experience requirements prescribed under R4-6-705(B).

C. In evaluating the curriculum required under subsection (A)(2), the Board shall assess whether a core content area is embedded or contained in more than one course. The applicant shall provide information the Board requires to determine whether a core content area is embedded in multiple courses. The Board shall not accept a core content area embedded in more than two courses unless the courses are succession courses. The Board shall allow subject matter in a course to qualify in only one core content area.

D. Supervised practicum. A supervised practicum shall integrate didactic learning related to substance use disorders with face-to-face, direct counseling experience. The counseling experience shall include intake and assessment, treatment planning, discharge planning, documentation, and case management activities.

E. The Board shall deem an applicant to meet the curriculum requirements for independent substance abuse counselor licensure if the applicant:

1. Holds an active and in good standing associate substance abuse counselor license issued by the Board; and
2. ~~Met the curriculum requirements with~~ Has a master's degree ~~when the associate substance abuse counselor license was issued~~ in a behavioral health field from a regionally accredited university.

F. An applicant for licensure as an independent substance abuse counselor who completed the applicant's educational training before the effective date of this Section or no later than October 31, 2017, may request that the Board evaluate the applicant's educational training using the standards in effect before the effective date of this Section.

R4-6-705. Supervised Work Experience for Substance Abuse Counselor Licensure

A. An applicant for associate substance abuse counselor licensure who has a bachelor's degree and is required under R4-6-702(A) to participate in a supervised work experience shall complete at least ~~3200 hours of supervised work experience in substance abuse counseling in no less than~~ 24 months~~.~~ ~~The applicant shall ensure that the~~ of supervised work experience that relates to substance use disorder and addiction and meets the following standards:

1. At least 1600 hours of direct client contact involving the use of psychotherapy related to substance use disorder and addiction issues,

2. No more than 400 of the 1600 hours of direct client contact are in psychoeducation,
3. ~~For the purpose of licensure, no more than 1600 hours of indirect client contact related to psychotherapy services,~~
~~4.~~3. At least 100 hours of clinical supervision as prescribed under R4-6-212 and R4-6-706, and
~~5.~~4. At least one hour of clinical supervision in any month in which the applicant provides direct client contact.

B. An applicant for independent substance abuse counselor licensure shall demonstrate completion of at least ~~3200 hours of supervised work experience in substance abuse counseling in no less than~~ 24 months of supervised work experience in substance abuse counseling. The applicant shall ensure that the supervised work experience meets the standards specified in subsection (A).

C. An applicant for substance abuse technician qualifying under R4-6-701(C) shall complete at least 6400 hours of supervised work experience in no less than 48 months. The applicant shall ensure that the supervised work experience includes:
1. At least 3200 hours of direct client contact;
2. Using psychotherapy to assess, diagnose, and treat individuals, couples, families, and groups for issues relating to substance use disorder and addiction; and
3. At least 200 hours of clinical supervision as prescribed under R4-6-212 and R4-6-706.

D. An applicant may submit more than the required number of hours of supervised work experience for consideration by the Board.

E. During the period of required supervised work experience, an applicant for substance abuse licensure shall practice behavioral health under the limitations specified in R4-6-210.

F. There is no supervised work experience requirement for an applicant for licensure as:
1. A substance abuse technician qualifying under R4-6-701(A), or
2. An associate substance abuse counselor qualifying under R4-6-702(A) with a master's or higher degree.

R4-6-706. Clinical Supervision for Substance Abuse Counselor Licensure

A. During the supervised work experience required under R4-6-705, an applicant for substance abuse counselor licensure shall demonstrate that the applicant received, for the level of licensure sought, at least the number of hours of clinical supervision specified in R4-6-705 that meets the requirements in subsection (B) and R4-6-212.

B. The Board shall accept hours of clinical supervision for substance abuse licensure if the focus of the supervised hours relates to substance use disorder and addiction and:
1. At least 50 hours are supervised by:
   a. An independent substance abuse counselor licensed by the Board; or

b. An independently licensed behavioral health professional who:
   i. Provides evidence of knowledge and experience in substance use disorder treatment; and
   ii. Is approved by the ARC or designee, and
2. The remaining hours are supervised by an individual qualified under R4-6-212(A), or
3. The hours are supervised by an individual ~~for whom an exemption was obtained under R4-6-212.01~~ who meets the educational requirements under R4-6-214.

ARTICLE 8. LICENSE RENEWAL AND CONTINUING EDUCATION

R4-6-801. Renewal of Licensure

A. Under A.R.S. § 32-3273, a license issued by the Board under A.R.S. Title 32, Chapter 33 and this Chapter is renewable every two years. A licensee who has more than one license may request in writing that the Board synchronize the expiration dates of the licenses. The licensee shall pay any prorated fees required to accomplish the synchronization.

B. A licensee holding an active license to practice behavioral health in this state shall complete 30 clock hours of continuing education as prescribed under R4-6-802 between the date the Board received the licensee's last renewal application and the next license expiration date. A licensee may not carry excess continuing education hours from one license period to the next.

C. To renew licensure, a licensee shall submit the following to the Board on or before the date of license expiration or as specified in A.R.S. § 32-4301:
1. A renewal application form, approved by the Board. The licensee shall ensure that the renewal form:
   a. Includes a list of 30 clock hours of continuing education that the licensee completed during the license period;
   b. If the documentation previously submitted under R4-6-301(12) was a limited form of work authorization issued by the federal government, includes evidence that the work authorization has not expired; and
   c. Is signed by the licensee attesting that all information submitted is true and correct;
2. Payment of the renewal fee as prescribed in R4-6-215; and
3. Other documents requested by the Board to determine that the licensee continues to meet the requirements under A.R.S. Title 32, Chapter 33 and this Chapter.

D. The Board may audit a licensee to verify compliance with the continuing education requirements under subsection (B). A licensee shall maintain documentation verifying compliance with the continuing education requirements as prescribed under R4-6-803.

E. A licensee whose license expires shall immediately stop the practice of behavioral health. A licensee whose license expires may have the license reinstated by complying with subsection (C) and paying a late renewal penalty within 90 days of the license expiration date. A license reinstated under this subsection is effective with no lapse in licensure. However, a licensee who engages in the practice of behavioral health between the dates of license expiration and license reinstatement may be subject to disciplinary action.

R4-6-802. Continuing Education

A. A licensee who maintains more than one license may apply the same continuing education hours for renewal of each license if the content of the continuing education relates to the scope of practice of each license.

B. For each license period, a licensee may report a maximum of:

1. Ten clock hours of continuing education for first-time presentations by the licensee that deal with current developments, skills, procedures, or treatments related to the practice of behavioral health. The licensee may claim one clock hour for each hour spent preparing, writing, and presenting information;
2. Six clock hours of continuing education for attendance at a Board meeting where the licensee is not:
    a. A member of the Board,
    b. The subject of any matter on the agenda, or
    c. The complainant in any matter that is on the agenda; and
3. Ten clock hours of continuing education for service as a Board or ARC member.

C. For each license period, a licensee shall report:

1. A minimum of three clock hours of continuing education sponsored, approved, or offered by an entity listed in subsection (D) in:
    a. Behavioral health ethics or mental health law~~, and~~ ;
    b. Cultural competency and diversity; and
    c. Telehealth, unless the licensee does not practice behavioral health by telehealth; and
2. Completion of the three clock hour Arizona Statutes/Regulations Tutorial.

D. A licensee shall participate in continuing education that relates to the scope of practice of the license held and to maintaining or improving the skill and competency of the licensee. The Board has determined that in addition to the continuing education listed in subsections (B) and (C), the following continuing education meets this standard:

1. Activities sponsored or approved by national, regional, or state professional associations or organizations in the specialties of marriage and family therapy, professional counseling, social

work, substance abuse counseling, or in the allied professions of psychiatry, psychiatric nursing, psychology, or pastoral counseling;

2. Programs in behavioral health sponsored or approved by a regionally accredited college or university;
3. In-service training, courses, or workshops in behavioral health sponsored by federal, state, or local social service agencies, public school systems, or licensed health facilities or hospitals;
4. Graduate or undergraduate courses in behavioral health offered by a regionally accredited college or university. One semester-credit hour or the hour equivalent of one semester hour equals 15 clock hours of continuing education;
5. Publishing a paper, report, or book that deals with current developments, skills, procedures, or treatments related to the practice of behavioral health. For the license period in which publication occurs, the licensee may claim one clock hour for each hour spent preparing and writing materials; and
6. Programs in behavioral health sponsored by a state superior court, adult probation department, or juvenile probation department.

E. The Board has determined that a substance abuse technician, associate substance abuse counselor, or an independent substance abuse counselor shall ensure that at least 20 of the 30 clock hours of continuing education required under R4-6-801(B) are in the following categories:

1. Pharmacology and psychopharmacology,
2. Addiction processes,
3. Models of substance use disorder and addiction treatment,
4. Relapse prevention,
5. Interdisciplinary approaches and teams in substance use disorder and addiction treatment,
6. Substance use disorder and addiction assessment and diagnostic criteria,
7. Appropriate use of substance use disorder and addiction treatment modalities,
8. Substance use disorder and addiction as it related to diverse populations,
9. Substance use disorder and addiction treatment and prevention,
10. Clinical application of current substance use disorder and addiction research, or
11. Co-occurring disorders.

ARTICLE 11. STANDARDS OF PRACTICE

R4-6-1101. Consent for Treatment

A licensee shall:

1. Provide treatment to a client only in the context of a professional relationship based on informed consent for treatment;
2. Document in writing, including by electronic means, for each client the following elements of informed consent for treatment:
    a. Purpose of treatment;
    b. General procedures to be used in treatment, including benefits, limitations, and potential risks;
    c. The client's right to have the client's records and all information regarding the client kept confidential and an explanation of the limitations on confidentiality;
    d. Notification of the licensee's supervision or involvement with a treatment team of professionals;
    e. Methods for the client to obtain information about the client's records;
    f. The client's right to participate in treatment decisions and in the development and periodic review and revision of the client's treatment plan;
    g. The client's right to refuse any recommended treatment or to withdraw consent to treatment and to be advised of the consequences of refusal or withdrawal; and
    h. The client's right to be informed of all fees that the client is required to pay and the licensee's refund and collection policies and procedures; and
3. ~~Obtain a dated and signed~~ Except as provided in subsection (5), obtain written informed consent for treatment from a client or the client's legal representative before providing treatment to the client and when a change occurs in an element listed in subsection (2) that might affect the client's consent for treatment;
4. ~~Obtain a dated and signed~~ Except as provided in subsection (5), obtain written informed consent for treatment from a client or the client's legal representative before audio or video taping the client or permitting a third party to observe treatment provided to the client; ~~and~~
5. ~~Include a dated signature from an authorized representative of the behavioral health entity~~ If treatment of a client is by telehealth, the informed consent for treatment required under subsections (3) and (4) shall be:
    a. Obtained verbally, and
    b. Contemporaneously documented in the client's record.

R4-6-1102. Treatment Plan

A licensee shall:

1. ~~Work~~ By the fourth session, work jointly with each client or the client's legal representative to prepare an integrated, individualized, written treatment plan, based on the licensee's provisional

or principal diagnosis and assessment of behavior and the treatment needs, abilities, resources, and circumstances of the client, that includes:

a. One or more treatment goals;
b. One or more treatment methods;
c. The date when the client's treatment plan will be reviewed;
d. If a discharge date has been determined, the aftercare needed;
e. The dated signature of the client or the client's legal representative; and
f. The dated signature of the licensee;

2. Review and reassess the treatment plan:
   a. According to the review date specified in the treatment plan as required under subsection (1)(c); and
   b. At least annually with the client or the client's legal representative to ensure the continued viability and effectiveness of the treatment plan and, where appropriate, add a description of the services the client may need after terminating treatment with the licensee;
3. Ensure that all treatment plan revisions include the dated signature of the client or the client's legal representative and the licensee;
4. Upon written request, provide a client or the client's legal representative an explanation of all aspects of the client's condition and treatment; and
5. Ensure that a client's treatment is in accordance with the client's treatment plan.

R4-6-1105. Confidentiality

A. A licensee shall release or disclose client records or any information regarding a client only:
1. In accordance with applicable federal or state law that authorizes release or disclosure; or
2. With written authorization from the client or the client's legal representative.

B. A licensee shall ensure that written authorization for release of client records or any information regarding a client is obtained before a client record or any information regarding a client is released or disclosed unless otherwise allowed by state or federal law.

C. Written authorization includes:
1. The name of the person disclosing the client record or information;
2. The purpose of the disclosure;
3. The individual, agency, or entity requesting or receiving the record or information;
4. A description of the client record or information to be released or disclosed;
5. A statement indicating authorization and understanding that authorization may be revoked at any time;
6. The date or circumstance when the authorization expires, not to exceed 12 months;

7. The date the authorization was signed; and
8. The dated signature of the client or the client's legal representative.

D. A licensee shall ensure that any written authorization to release a client record or any information regarding a client is maintained in the client record.

E. If a licensee provides behavioral health services to multiple members of a family, each legally competent, participating family member shall independently provide written authorization to release client records regarding the family member. Without authorization from a family member, the licensee shall not disclose the family member's client record or any information obtained from the family member unless otherwise allowed by state or federal law.

R4-6-1106. ~~Telepractice~~ Telehealth

A. Except as ~~otherwise~~ provided ~~by statute~~ under A.R.S. § 32-3271(A)(2), an individual who provides counseling, social work, marriage and family therapy, or substance abuse counseling ~~via telepractice~~ by telehealth to a client located in Arizona shall: ~~be~~

1. Be licensed by the Board,
2. Be competent in providing behavioral health services by telehealth, and
3. Ensure that providing behavioral health services by telehealth is appropriate for the client's needs.

B. Under A.R.S. § 32-3271(A)(2), an individual who is licensed in good standing in another state but who is not licensed by the Board shall not provide counseling, social work, marriage and family therapy, or substance abuse counseling by telehealth to a client located in Arizona for more than ninety days. The individual providing behavioral health services under A.R.S. § 32-3271(A)(2) by telehealth to a client in Arizona shall ensure the 90 days are consecutive and occur in one calendar year.

~~B.~~C. Except as otherwise provided by statute, ~~a licensee~~ an individual who provides counseling, social work, marriage and family therapy, or substance abuse counseling ~~via telepractice~~ by telehealth only to a client located outside Arizona shall comply with ~~not only A.R.S. Title 32, Chapter 33, and this Chapter but also~~ the laws and rules of the jurisdiction in which the client is located.

~~C.~~D. An individual who provides counseling, social work, marriage and family therapy, or substance abuse counseling ~~via telepractice~~ by telehealth shall:

1. In addition to complying with the requirements in R4-6-1101, document the limitations and risks associated with ~~telepractice~~ telehealth, including but not limited to the following;
   a. Inherent confidentiality risks of electronic communication,
   b. Potential for technology failure,
   c. Emergency procedures when the licensee is unavailable, ~~and~~
   d. Manner of identifying the client when using electronic communication that does not involve

video; and

e. Local emergency contacts or services;

2. Document the name, address, and telephone number of an individual the client identifies as a local emergency contact; and

~~2.~~3. In addition to complying with the requirements in R4-6-1103, include the following in the progress note required under R4-6-1103(H):

a. Mode of session, whether interactive audio, video, or electronic communication; and

b. Verification of the client's~~:~~

~~i. Physical~~ physical location during the session~~; and~~

~~ii. Local emergency contacts~~.

ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT
TITLE 4. PROFESSIONS AND OCCUPATIONS
CHAPTER 6. BOARD OF BEHAVIORAL HEALTH EXAMINERS

1. Identification of the rulemaking:

   The Board is amending rules to address issues identified in a 5YRR approved by the Council on March 3, 2020, and to make the rules consistent with statutory changes. Under Laws 2021, Chapter 320, the legislature amended A.R.S. § 32-3251 to provided that direct client contact includes providing therapeutic or clinical care by telehealth. The legislation also added A.R.S. § 36-3606 regarding registration of out-of-state providers of telehealth services. Under Laws 2021, Chapter 62, the legislature amended A.R.S. §§ 32-3293 (social work), 32-3301 (counseling), 32-3311 (marriage and family therapy), and 32-3321 (substance abuse counseling) to remove the requirement that an applicant provide evidence of indirect client hours obtained during training. The applicant must provide evidence of direct client hours and clinical supervision. The Board is also removing provisions regarding a supervised private practice from R4-6-211 and moving them to a new Section, R4-6-217, and amending R4-6-306 regarding an application for a temporary license. An exemption from Executive Order 2022-01 was provided by Tony Hunter, of the Governor's office, in an e-mail dated March 4, 2022. Approval to submit the rulemaking to the Council was provided by Zaida Dedolph, of the Governor's office, in an e-mail dated April 26, 2023.

   a. The conduct and its frequency of occurrence that the rule is designed to change:

      Until the rulemaking is completed, the Board's rules will remain inconsistent with recent statutory changes.

   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:

      Failure to comply with statutory changes is not good government practice and creates potential confusion for those who have to comply with the rules.

   c. The estimated change in frequency of the targeted conduct expected from the rule change:

      When the rulemaking is completed, the rules will be consistent with statute and no longer a source of potential confusion or regulatory burden.

2. A brief summary of the information included in the economic, small business, and consumer impact statement:

The Board believes the rulemaking has minimal economic impact because it makes no substantive changes other than those required to be consistent with statute. Out-of-state providers of telehealth services who choose to register to provide services in Arizona will have to pay the newly established fee. The amendment to R4-6-306 clarifies when a temporary license expires.

The Board has made several changes that reduce regulatory burdens: reducing the time a clinical supervisor must maintain records; clarifying that clinical supervision in a face-to-face setting includes virtual teleconferencing; eliminating a charge for a duplicate license; allowing documentation to be made electronically; and allowing verbal informed consent when providing care by telehealth.

The Board also made clarifications to strengthen professional ethics: a licensee may not have an interest in the entity at which the licensee works under direct supervision; direct supervision may not be provided by someone with whom the licensee has a relationship; and an individual may not provide behavioral health services if the individual's license has expired.

3. The person to contact to submit or request additional data on the information included in the economic, small business, and consumer impact statement:

   Name: Erin Yabu, Deputy Director
   Address: 1740 W Adams Street; Suite 3600
   Phoenix, AZ 85007
   Telephone: 602-542-1882
   E-mail: erin.yabu@azbbhe.us
   Web site: www.azbbhe.us

4. Persons who will be directly affected by, bear the costs of, or directly benefit from the rulemaking:

   Licensees, including those who supervise the work of others, applicants, and the Board will be directly affected by, bear the costs of, and directly benefit from this rulemaking.

   The Board currently licenses 6,724 social workers, 6,570 counselors, 1,179 marriage and family therapists, and 1,313 substance abuse counselors. During the last year, the Board received 3,020 applications for licensure. One hundred sixty-eight of these were for licensure by universal recognition and 471 were for a temporary license.

Licensees who wish to be licensed at a more independent level of practice are required to obtain hours of supervised work experience including hours of clinical supervision. During the last year, 1,354 licensees submitted the required evidence of supervised work experience and clinical supervision to qualify for the more independent level of practice.

It is possible for an associate-level licensee to operate a private practice under approved clinical supervision. During the last year, 66 licensees obtained Board approval of a supervised private practice. Independent licensees served as clinical supervisor of a supervised private practice, which required the clinical supervisor to supervise the entire practice.

The Board incurred the cost of completing this rulemaking and will have the benefit of rules that are consistent with statute and agency practice.

5. Cost-benefit analysis:
    a. Costs and benefits to state agencies directly affected by the rulemaking including the number of new full-time employees at the implementing agency required to implement and enforce the proposed rule:
    The Board is the only state agency directly affected by the rulemaking. The Board's costs and benefits are described in item 4. The Board will not require a new full-time employee to implement and enforce the rules.
    b. Costs and benefits to political subdivisions directly affected by the rulemaking:
    No political subdivisions are directly affected by the rulemaking.
    c. Costs and benefits to businesses directly affected by the rulemaking:
    All behavioral health providers are businesses directly affected by the rulemaking. Their costs and benefits are described in item 4. Many behavioral health providers provide services within a business entity. However, the Board does not regulate the business entities.
6. Impact on private and public employment:
    The rulemaking will not have impact on private or public employment.
7. Impact on small businesses[1]:
    a. Identification of the small business subject to the rulemaking:
    Licensees are small businesses subject to the rulemaking.
    b. Administrative and other costs required for compliance with the rulemaking:
    All licensees are required to meet education, examination, and work experience requirements. To work at a more independent level of practice, a licensee is required to obtain additional education and work under clinical supervision. To obtain a license, an applicant is required to submit an application, be fingerprinted and subject to a criminal background check, and pay fees. Licensees are required to renew their licenses biennially, which requires submitting an application, paying a fee, and completing 30 hours of continuing education. Licensees are required to conform to

[1] Small business has the meaning specified in A.R.S. § 41-1001(23).

standards of practice designed to protect the health and safety of those obtaining behavioral health services and are subject to potential disciplinary action for failure to conform.

c. Description of methods that may be used to reduce the impact on small businesses:
Because all licensees are small businesses, it is not possible to reduce the impact on small businesses and achieve the regulatory goal of protecting public health and safety.

8. Cost and benefit to private persons and consumers who are directly affected by the rulemaking:
No private persons or consumers are directly affected by the rulemaking. Consumers of behavioral health services are indirectly affected.

9. Probable effects on state revenues:
A new fee is established for registration as an out-of-state provider of telehealth services. The fee is a one-time charge of $250. Under A.R.S. § 32-3254, 10 percent of the amount collected will be deposited in the state's general fund.

10. Less intrusive or less costly alternative methods considered:
The rulemaking contains one provision the Board believes will have more than minimal economic impact:
    - The $250 one-time fee charged to register as an out-of-state provider of telehealth in Arizona. 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 Board determined the fee charged is reasonable compared to work required by the agency and necessary to support the functions of the agency.

As of May 4, 2023

32-3251. Definitions

In this chapter, unless the context otherwise requires:

1. "Board" means the board of behavioral health examiners.

2. "Client" means a patient who receives behavioral health services from a person licensed pursuant to this chapter.

3. "Direct client contact" means the performance of therapeutic or clinical functions related to the applicant's professional practice level of psychotherapy that includes diagnosis, assessment and treatment and that may include psychoeducation for mental, emotional and behavioral disorders based primarily on verbal or nonverbal communications and intervention with, and in the presence of, one or more clients, including through the use of telehealth pursuant to title 36, chapter 36, article 1.

4. "Equivalent" means comparable in content and quality but not identical.

5. "Indirect client service" means training for, and the performance of, functions of an applicant's professional practice level in preparation for or on behalf of a client for whom direct client contact functions are also performed, including case consultation and receipt of clinical supervision. Indirect client service does not include the provision of psychoeducation.

6. "Letter of concern" means a nondisciplinary written document sent by the board to notify a licensee that, while there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.

7. "Licensee" means a person who is licensed pursuant to this chapter.

8. "Practice of behavioral health" means the practice of marriage and family therapy, professional counseling, social work and substance abuse counseling pursuant to this chapter.

9. "Practice of marriage and family therapy" means the professional application of family systems theories, principles and techniques to treat interpersonal relationship issues and nervous, mental and emotional disorders that are cognitive, affective or behavioral. The practice of marriage and family therapy includes:

(a) Assessment, appraisal and diagnosis.

(b) The use of psychotherapy for the purpose of evaluation, diagnosis and treatment of individuals, couples, families and groups.

10. "Practice of professional counseling" means the professional application of mental health, psychological and human development theories, principles and techniques to:

(a) Facilitate human development and adjustment throughout the human life span.

(b) Assess and facilitate career development.

(c) Treat interpersonal relationship issues and nervous, mental and emotional disorders that are cognitive, affective or behavioral.

(d) Manage symptoms of mental illness.

(e) Assess, appraise, evaluate, diagnose and treat individuals, couples, families and groups through the use of psychotherapy.

11. "Practice of social work" means the professional application of social work theories, principles, methods and techniques to:

(a) Treat mental, behavioral and emotional disorders.

(b) Assist individuals, families, groups and communities to enhance or restore the ability to function physically, socially, emotionally, mentally and economically.

(c) Assess, appraise, diagnose, evaluate and treat individuals, couples, families and groups through the use of psychotherapy.

12. "Practice of substance abuse counseling" means the professional application of general counseling theories, principles and techniques as specifically adapted, based on research and clinical experience, to the specialized needs and characteristics of persons who are experiencing substance abuse, chemical dependency and related problems and to the families of those persons. The practice of substance abuse counseling includes the following as they relate to substance abuse and chemical dependency issues:

(a) Assessment, appraisal and diagnosis.

(b) The use of psychotherapy for the purpose of evaluation, diagnosis and treatment of individuals, couples, families and groups.

13. "Psychoeducation" means the education of a client as part of a treatment process that provides the client with information regarding mental health, emotional disorders or behavioral health.

14. "Psychotherapy" means a variety of treatment methods developing out of generally accepted theories about human behavior and development.

15. "Telehealth" has the same meaning prescribed in section 36-3601.

16. "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere:

(a) Being convicted of a felony. Conviction by a court of competent jurisdiction or a plea of no contest is conclusive evidence of the conviction.

(b) Using fraud or deceit in connection with rendering services as a licensee or in establishing qualifications pursuant to this chapter.

(c) Making any oral or written misrepresentation of a fact:

(i) To secure or attempt to secure the issuance or renewal of a license.

(ii) In any statements provided during an investigation or disciplinary proceeding by the board.

(iii) Regarding the licensee's skills or the value of any treatment provided or to be provided.

(d) Making any false, fraudulent or deceptive statement connected with the practice of behavioral health, including false or misleading advertising by the licensee or the licensee's staff or a representative compensated by the licensee.

(e) Securing or attempting to secure the issuance or renewal of a license by knowingly taking advantage of the mistake of another person or the board.

(f) Engaging in active habitual intemperance in the use of alcohol or active habitual substance abuse.

(g) Using a controlled substance that is not prescribed for use during a prescribed course of treatment.

(h) Obtaining a fee by fraud, deceit or misrepresentation.

(i) Aiding or abetting a person who is not licensed pursuant to this chapter to purport to be a licensed behavioral health professional in this state.

(j) Engaging in conduct that the board determines is gross negligence or repeated negligence in the licensee's profession.

(k) Engaging in any conduct or practice that is contrary to recognized standards of ethics in the behavioral health profession or that constitutes a danger to the health, welfare or safety of a client.

(l) Engaging in any conduct, practice or condition that impairs the ability of the licensee to safely and competently practice the licensee's profession.

(m) Engaging or offering to engage as a licensee in activities that are not congruent with the licensee's professional education, training or experience.

(n) Failing to comply with or violating, attempting to violate or assisting in or abetting the violation of any provision of this chapter, any rule adopted pursuant to this chapter, any lawful order of the board, or any formal order, consent agreement, term of probation or stipulated agreement issued under this chapter.

(o) Failing to furnish information within a specified time to the board or its investigators or representatives if legally requested by the board.

(p) Failing to conform to minimum practice standards as developed by the board.

(q) Failing or refusing to maintain adequate records of behavioral health services provided to a client.

(r) Providing behavioral health services that are clinically unjustified or unsafe or otherwise engaging in activities as a licensee that are unprofessional by current standards of practice.

(s) Terminating behavioral health services to a client without making an appropriate referral for continuation of care for the client if continuing behavioral health services are indicated.

(t) Disclosing a professional confidence or privileged communication except as may otherwise be required by law or permitted by a legally valid written release.

(u) Failing to allow the board or its investigators on demand to examine and have access to documents, reports and records in any format maintained by the licensee that relate to the licensee's practice of behavioral health.

(v) Engaging in any sexual conduct between a licensee and a client or former client.

(w) Providing behavioral health services to any person with whom the licensee has had sexual contact.

(x) Exploiting a client, former client or supervisee. For the purposes of this subdivision, "exploiting" means taking advantage of a professional relationship with a client, former client or supervisee for the benefit or profit of the licensee.

(y) Engaging in a dual relationship with a client that could impair the licensee's objectivity or professional judgment or create a risk of harm to the client. For the purposes of this subdivision, "dual relationship" means a licensee simultaneously engages in both a professional and nonprofessional relationship with a client that is avoidable and not incidental.

(z) Engaging in physical contact between a licensee and a client if there is a reasonable possibility of physical or psychological harm to the client as a result of that contact.

(aa) Sexually harassing a client, former client, research subject, supervisee or coworker. For the purposes of this subdivision, "sexually harassing" includes sexual advances, sexual solicitation, requests for sexual favors, unwelcome comments or gestures or any other verbal or physical conduct of a sexual nature.

(bb) Harassing, exploiting or retaliating against a client, former client, research subject, supervisee, coworker or witness or a complainant in a disciplinary investigation or proceeding involving a licensee.

(cc) Failing to take reasonable steps to inform potential victims and appropriate authorities if the licensee becomes aware during the course of providing or supervising behavioral health services that a client's condition indicates a clear and imminent danger to the client or others.

(dd) Failing to comply with the laws of the appropriate licensing or credentialing authority to provide behavioral health services by electronic means in all governmental jurisdictions where the client receiving these services resides.

(ee) Giving or receiving a payment, kickback, rebate, bonus or other remuneration for a referral.

(ff) Failing to report in writing to the board information that would cause a reasonable licensee to believe that another licensee is guilty of unprofessional conduct or is physically or mentally unable to provide behavioral health services competently or safely. This duty does not extend to information provided by a licensee that is protected by the behavioral health professional-client privilege unless the information indicates a clear and imminent danger to the client or others or is otherwise subject to mandatory reporting requirements pursuant to state or federal law.

(gg) Failing to follow federal and state laws regarding the storage, use and release of confidential information regarding a client's personal identifiable information or care.

(hh) Failing to retain records pursuant to section 12-2297.

(ii) Violating any federal or state law, rule or regulation applicable to the practice of behavioral health.

(jj) Failing to make client records in the licensee's possession available in a timely manner to another health professional or licensee on receipt of proper authorization to do so from the client, a minor client's parent, the client's legal guardian or the client's authorized representative.

(kk) Failing to make client records in the licensee's possession promptly available to the client, a minor client's parent, the client's legal guardian or the client's authorized representative on receipt of proper authorization to do so from the client, a minor client's parent, the client's legal guardian or the client's authorized representative.

(ll) Being the subject of the revocation, suspension, surrender or any other disciplinary sanction of a professional license, certificate or registration or other adverse action related to a professional license, certificate or registration in another jurisdiction or country, including the failure to report the adverse action to the board. The action taken may include refusing, denying, revoking or suspending a license or

certificate, the surrendering of a license or certificate, otherwise limiting, restricting or monitoring a licensee or certificate holder or placing a licensee or certificate holder on probation.

(mm) Engaging in any conduct that results in a sanction imposed by an agency of the federal government that involves restricting, suspending, limiting or removing the licensee's ability to obtain financial remuneration for behavioral health services.

(nn) Violating the security of any licensure examination materials.

(oo) Using fraud or deceit in connection with taking or assisting another person in taking a licensure examination.

32-3252. Board of behavioral health examiners; appointment; qualifications; terms; compensation; immunity; training program

A. The board of behavioral health examiners is established consisting of the following members appointed by the governor:

1. The following professional members:

(a) Two members who are licensed in social work pursuant to this chapter, at least one of whom is a licensed clinical social worker.

(b) Two members who are licensed in counseling pursuant to this chapter, at least one of whom is a licensed professional counselor.

(c) Two members who are licensed in marriage and family therapy pursuant to this chapter, at least one of whom is a licensed marriage and family therapist.

(d) Two members who are licensed in substance abuse counseling pursuant to this chapter, at least one of whom is a licensed independent substance abuse counselor.

2. Four public members.

B. Before appointment by the governor, a prospective member of the board shall submit a full set of fingerprints to the governor 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.

C. Each professional board member shall:

1. Be a resident of this state for not less than one year before appointment.

2. Be an active licensee in good standing.

3. Have at least five years of experience in an area of behavioral health licensed pursuant to this chapter.

D. Each public member shall:

1. Be a resident of this state for not less than one year before appointment.

2. Be at least twenty-one years of age.

3. Not be licensed or eligible for licensure pursuant to this chapter unless the public member has been retired from active practice for at least five years.

4. Not currently have a substantial financial interest in an entity that directly provides behavioral health services.

5. Not have a household member who is licensed or eligible for licensure pursuant to this chapter unless the household member has been retired from active practice for at least five years.

E. The term of office of board members is three years to begin and end on the third Monday in January. A member shall not serve more than two full consecutive terms.

F. The board shall annually elect a chairman and secretary-treasurer from its membership.

G. Board members are eligible to receive compensation of not more than eighty-five dollars for each day actually and necessarily spent in the performance of their duties.

H. Board members and personnel are personally immune from suit with respect to all acts done and actions taken in good faith and in furtherance of the purposes of this chapter.

I. Each board member must complete a twelve-hour training program that emphasizes responsibilities for administrative management, licensure, judicial processes and temperament within one year after appointment to the board.

32-3253. Powers and duties

A. The board shall:

1. Adopt rules consistent with and necessary or proper to carry out the purposes of this chapter.

2. Administer and enforce this chapter, rules adopted pursuant to this chapter and orders of the board.

3. Issue a license by examination, endorsement or temporary recognition to, and renew the license of, each person who is qualified to be licensed pursuant to this chapter. The board must issue or deny a license within one hundred eighty days after the applicant submits a completed application.

4. Establish fees by rule, except that the board is exempt from the rulemaking requirements of title 41, chapter 6 for the purposes of reducing or eliminating fees.

5. Collect fees and spend monies.

6. Keep a record of all persons who are licensed pursuant to this chapter, actions taken on all applications for licensure, actions involving renewal, suspension, revocation or denial of a license or probation of licensees and the receipt and disbursal of monies.

7. Adopt an official seal for attestation of licensure and other official papers and documents.

8. Conduct investigations and determine on its own motion whether a licensee or an applicant has engaged in unprofessional conduct, is incompetent or is mentally or physically unable to engage in the practice of behavioral health.

9. Conduct disciplinary actions pursuant to this chapter and board rules.

10. Establish and enforce standards or criteria of programs or other mechanisms to ensure the continuing competence of licensees.

11. Establish and enforce compliance with professional standards and rules of conduct for licensees.

12. Engage in a full exchange of information with the licensing and disciplinary boards and professional associations for behavioral health professionals in this state and other jurisdictions.

13. Subject to section 35-149, accept, expend and account for gifts, grants, devises and other contributions, money or property from any public or private source, including the federal government. Monies received under this paragraph shall be deposited, pursuant to sections 35-146 and 35-147, in special funds for the purpose specified, which are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

14. Adopt rules regarding the application for and approval of educational curricula of regionally accredited colleges or universities with a program not otherwise accredited by an organization or entity recognized by the board that are consistent with the requirements of this chapter and maintain a list of those programs. Approvals are valid for a period of five years if no changes of curricula are made that are inconsistent with the requirements of this chapter or board rule.

15. Maintain a registry of licensees who have met the educational requirements to provide supervision as required pursuant to this chapter to applicants in the same profession.

16. Adopt rules to allow approval of persons who wish to provide supervision pursuant to this chapter and who are not licensed by the board and who are licensed in a profession other than the profession in which the applicant is seeking licensure.

17. Recognize not more than four hundred hours of psychoeducation for work experience required pursuant to sections 32-3293, 32-3301, 32-3311 and 32-3321.

18. Adopt rules regarding the use of telepractice.

19. If an applicant is required to pass an examination for licensure, allow the applicant to take the examination three times during a twelve-month period.

B. The board may join professional organizations and associations organized exclusively to promote the improvement of the standards of the practice of behavioral health, protect the health and welfare of the public or assist and facilitate the work of the board.

C. The board may enter into stipulated agreements with a licensee for the confidential treatment, rehabilitation and monitoring of chemical dependency or psychiatric, psychological or behavioral health disorders in a program provided pursuant to subsection D of this section. A licensee who materially fails to comply with a program shall be terminated from the confidential program. Any records of the licensee who is terminated from a confidential program are no longer confidential or exempt from the public records law, notwithstanding any law to the contrary. Stipulated agreements are not public records if the following conditions are met:

1. The licensee voluntarily agrees to participate in the confidential program.

2. The licensee complies with all treatment requirements or recommendations, including participation in approved programs.

3. The licensee refrains from professional practice until the return to practice has been approved by the treatment program and the board.

4. The licensee complies with all monitoring requirements of the stipulated agreement, including random bodily fluid testing.

5. The licensee's professional employer is notified of the licensee's chemical dependency or medical, psychiatric, psychological or behavioral health disorders and participation in the confidential program and is provided a copy of the stipulated agreement.

D. The board shall establish a confidential program for the monitoring of licensees who are chemically dependent or who have psychiatric, psychological or behavioral health disorders that may impact their ability to safely practice and who enroll in a rehabilitation program that meets the criteria prescribed by the board. The licensee is responsible for the costs associated with rehabilitative services and monitoring. The board may take further action if a licensee refuses to enter into a stipulated agreement or fails to comply with the terms of a stipulated agreement. In order to protect the public health and safety, the confidentiality requirements of this subsection do not apply if a licensee does not comply with the stipulated agreement.

E. The board shall audio record all meetings and maintain all audio and video recordings or stenographic records of interviews and meetings for a period of three years from when the record was created.

32-3254. Board of behavioral health examiners fund

A. A board of behavioral health examiners fund is established. Pursuant to sections 35-146 and 35-147, the board shall deposit ten per cent of all monies received by the board in the state general fund and deposit the remaining ninety per cent in the board of behavioral health examiners fund.

B. All monies deposited in the board of behavioral health examiners fund are subject to section 35-143.01.

32-3255. Executive director; compensation; duties

A. On or after January 31, 2014 and subject to title 41, chapter 4, article 4, the board shall appoint an executive director who shall serve at the pleasure of the board. The executive director is eligible to receive compensation set by the board within the range determined under section 38-611.

B. The executive director shall:

1. Perform the administrative duties of the board.

2. Subject to title 41, chapter 4, article 4, employ personnel as the executive director deems necessary, including professional consultants and agents necessary to conduct investigations. An investigator must complete a nationally recognized investigator training program within one year after the date of hire. Until the investigator completes this training program, the investigator must work under the supervision of an investigator who has completed a training program.

32-3256. Executive director; complaints; dismissal; review

A. If delegated by the board, the executive director may dismiss a complaint if the investigative staff's review indicates that the complaint is without merit and that dismissal is appropriate.

B. At each regularly scheduled board meeting, the executive director shall provide to the board a list of each complaint the executive director dismissed pursuant to subsection A of this section since the last board meeting.

C. A person who is aggrieved by an action taken by the executive director pursuant to subsection A of this section may file a written request that the board review that action. The request must be filed within thirty-five days after that person is provided written notification of the executive director's action. At the

next regular board meeting, the board shall review the executive director's action and, on review, shall approve, modify or reject the executive director's action.

32-3257. Written notifications and communications; methods of transmission

For the purposes of this chapter, notifications or communications required to be written or in writing may be transmitted or received by mail, electronic transmission, facsimile transmission or hand delivery and shall not be transmitted or received orally.

32-3261. Academic review committees; members; appointment; qualifications; terms; compensation; immunity; training

A. The board shall establish an academic review committee for each professional area licensed pursuant to this chapter to do the following:

1. Review applications referred to the committee by the board or the executive director to determine whether an applicant, whose curriculum has not been approved pursuant to section 32-3253, subsection A, paragraph 14 or whose program is not accredited by an organization or entity approved by the board, has met the educational requirements of this chapter or board rules.

2. On referral by the executive director, make recommendations to the board regarding whether an applicant has met the requirements of supervised work experience required for licensure pursuant to this chapter or board rules.

3. Make specific findings concerning an application's deficiencies.

4. Review applications and make recommendations to the board for curriculum approval applications made pursuant to section 32-3253, subsection A, paragraph 14.

5. At the request of the board, make recommendations regarding examinations required pursuant to this chapter.

6. Review applications for and make determinations regarding exemptions related to clinical supervision requirements.

B. If an application is referred to an academic review committee for review and the academic review committee finds that additional information is needed from the applicant, the academic review committee shall provide a comprehensive written request for additional information to the applicant.

C. An academic review committee shall be composed of three members who have been residents of this state for at least one year before appointment, at least one of whom is licensed in the professional area pursuant to this chapter and have five years of experience in the applicable profession. At least one member must have served within the previous ten years as core or full-time faculty at a regionally accredited college or university in a program related to the applicable profession and have experience in the design and development of the curriculum of a related program. If qualified, a faculty member may serve on more than one academic review committee. A board member may not be appointed to serve on an academic review committee.

D. Committee members shall initially be appointed by the board. From and after January 1, 2016, the governor shall appoint the committee members. A committee member who is initially appointed by the board may be reappointed by the governor. A committee member who is initially appointed by the board shall continue to serve until appointed or replaced by the governor.

E. Committee members serve at the pleasure of the governor for terms of three years. A member shall not serve more than two full consecutive terms.

F. Committee members are eligible to receive compensation of not more than eighty-five dollars for each day actually and necessarily spent in the performance of their duties.

G. An academic review committee shall annually elect a chairman and secretary from its membership.

H. Committee members are personally immune from suit with respect to all acts done and actions taken in good faith and in furtherance of the purposes of this chapter.

I. Committee members shall receive at least five hours of training as prescribed by the board within one year after the member is initially appointed and that includes instruction in ethics and open meeting requirements.

32-3271. Exceptions to licensure; jurisdiction

A. This chapter does not apply to:

1. A person who is currently licensed, certified or regulated pursuant to another chapter of this title and who provides services within the person's scope of practice if the person does not claim to be licensed pursuant to this chapter.

2. A person who is not a resident of this state if the person:

(a) Performs behavioral health services in this state for not more than ninety days in any one calendar year as prescribed by board rule.

(b) Is authorized to perform these services pursuant to the laws of the state or country in which the person resides or pursuant to the laws of a federally recognized tribe.

(c) Informs the client of the limited nature of these services and that the person is not licensed in this state.

3. A rabbi, priest, minister or member of the clergy of any religious denomination or sect if the activities and services that person performs are within the scope of the performance of the regular or specialized ministerial duties of an established and legally recognizable church, denomination or sect and the person performing the services remains accountable to the established authority of the church, denomination or sect.

4. A member run self-help or self-growth group if no member of the group receives direct or indirect financial compensation.

5. A behavioral health technician or behavioral health paraprofessional who is employed by an agency licensed by the department of health services.

6. A person contracting with the supreme court or a person employed by or contracting with an agency under contract with the supreme court who is otherwise ineligible to be licensed or who is in the process of applying to be licensed under this chapter as long as that person is in compliance with the supreme court contract conditions regarding professional counseling services and practices only under supervision.

7. A person who is employed by the department of economic security or the department of child safety and who practices social work, marriage and family therapy, substance abuse counseling, counseling and case management within the scope of the person's job duties and under direct supervision by the employer department.

8. A student, intern or trainee who is pursuing a course of study in social work, counseling, marriage and family therapy, substance abuse counseling or case management in a regionally accredited institution of higher education or training institution if the person's activities are performed under qualified supervision and are part of the person's supervised course of study.

9. A person who is practicing social work, counseling and case management and who is employed by an agency licensed by the department of economic security or the department of child safety.

10. A paraprofessional employed by the department of economic security or by an agency licensed by the department of economic security.

11. A Christian Science practitioner if all of the following are true:

(a) The person is not providing psychotherapy.

(b) The activities and services the person performs are within the scope of the performance of the regular or specialized duties of a Christian Science practitioner.

(c) The person remains accountable to the established authority of the practitioner's church.

12. A person who is not providing psychotherapy.

B. A person who provides services pursuant to subsection A, paragraph 2 is deemed to have agreed to the jurisdiction of the board and to be bound by the laws of this state.

32-3272. Fees

A. For issuance of a license pursuant to this chapter, including application fees, the board shall establish and charge reasonable fees not to exceed five hundred dollars.

B. For renewal of a license pursuant to this chapter, the board shall establish and charge reasonable fees not to exceed five hundred dollars. The board shall not increase fees pursuant to this subsection more than twenty-five dollars each year.

C. The board by rule may adopt a fee for applications for approval of educational curricula pursuant to section 32-3253, subsection A, paragraph 14.

D. The board shall establish fees to produce monies that approximate the cost of maintaining the board.

E. The board shall waive the application fee for an independent level license if an applicant has paid the fee for an initial or renewal associate level license in this state and within ninety days after payment of the fee the applicant applies for an independent level license.

32-3273. License renewal; continuing education

A. Except as provided in section 32-4301, a license issued pursuant to this chapter is renewable every two years by paying the renewal fee prescribed by the board and submitting documentation prescribed by the board by rule of completion of relevant continuing education experience as determined by the board during the previous twenty-four-month period.

B. The board shall send notice in writing of required relevant continuing education experience to each licensee at least ninety days before the renewal date.

C. A licensee must satisfy the continuing education requirements that are prescribed by the board by rule and that are designed to provide the necessary understanding of ethics, cultural competency, current developments, skills, procedures and treatments related to behavioral health and to ensure the continuing competence of licensees. The board shall adopt rules to prescribe the manner of documenting compliance with this subsection.

D. At the request of a licensee who has been issued two or more licenses, the board shall establish the same renewal dates for those licenses. The board may prorate any fees due as necessary to synchronize the dates.

32-3274. Licensure by endorsement

A. The board may issue a license by endorsement to a person in that person's behavioral health discipline if the person is licensed or certified by the regulatory agency of one or more other states or federal jurisdictions at a substantially equivalent or higher practice level as determined by the board, pays the fee prescribed by the board and meets all of the following requirements:

1. The person is currently licensed or certified in behavioral health by the regulatory agency of one or more other states or federal jurisdictions and each license or certification is current and in good standing.

2. The person has been licensed or certified for at least three years in one or more jurisdictions in the discipline and practice level for which an application is submitted. The practice level of the jurisdictions must be substantially equivalent, as determined by the board, to the practice level for which the application is submitted.

3. The person meets the basic requirements for licensure prescribed by section 32-3275.

4. The person submits to the board all of the following:

(a) A listing of every jurisdiction in the United States in which the person has been licensed or certified in the practice of behavioral health and any disciplinary action taken by any regulatory agency or any instance in which a license has been surrendered in lieu of discipline.

(b) Verification of licensure or certification from every jurisdiction in which the person is licensed or certified for the discipline and practice level for which the person applies.

(c) Any other procedural application requirements adopted by the board in rule.

B. In addition to the requirements of subsection A of this section, a person seeking license by endorsement for the following practice levels must have earned a master's or higher degree in the applicable field of practice granted by a regionally accredited college or university:

1. Licensed clinical social worker.

2. Licensed professional counselor.

3. Licensed marriage and family therapist.

4. Licensed independent substance abuse counselor.

C. Except for licenses by endorsement issued in the practice levels prescribed in subsection B of this section, a person issued a license pursuant to this section shall practice behavioral health only under the direct supervision of a licensee.

D. The board by rule may prescribe a procedure to issue licenses pursuant to this section.

32-3275. Requirements for licensure; withdrawal of application

A. An applicant for licensure must meet all of the following requirements:

1. Submit an application as prescribed by the board.

2. Be at least twenty-one years of age.

3. Pay all applicable fees prescribed by the board.

4. Have the physical and mental capability to safely and competently engage in the practice of behavioral health.

5. Not have committed any act or engaged in any conduct that would constitute grounds for disciplinary action against a licensee pursuant to this chapter.

6. Not have had a professional license or certificate refused, revoked, suspended or restricted by this state or any other regulatory jurisdiction in the United States or any other country for reasons that relate to unprofessional conduct.

7. Not have voluntarily surrendered a professional license or certificate in this state or another regulatory jurisdiction in the United States or any other country while under investigation for conduct that relates to unprofessional conduct.

8. Not have a complaint, allegation or investigation pending before the board or another regulatory jurisdiction in the United States or another country that relates to unprofessional conduct. If an applicant has any such complaint, allegation or investigation pending, the board shall suspend the application process and may not issue or deny a license to the applicant until the complaint, allegation or investigation is resolved.

B. Before the board considers denial of a license based on a deficiency pursuant to subsection A, paragraph 4, 5, 6 or 7 of this section, the applicant shall be given thirty-five days' notice of the time and place of a meeting at which the applicant may provide in person, by counsel or in written form information and evidence related to any deficiency relating to subsection A, paragraph 4, 5, 6 or 7 of this section, including any evidence that the deficiency has been corrected or monitored or that a mitigating circumstance exists. In any notice of denial, the board shall provide notice of the applicant's right to a hearing pursuant to title 41, chapter 6, article 10.

C. If the board finds that an applicant is subject to subsection A, paragraphs 4, 5, 6 or 7 of this section, the board may determine to its satisfaction that the conduct or condition has been corrected, monitored and resolved and may issue a license. If the conduct or condition has not been resolved, the board may determine to its satisfaction that mitigating circumstances exist that prevent its resolution and may issue a license.

D. An applicant for licensure may withdraw the application unless the board has sent to the applicant notification that the board has initiated an investigation concerning professional misconduct. Following that notification, the applicant may request that the board review the applicant's request to withdraw the application. In considering the request the board shall determine whether it is probable that the investigation would result in an adverse action against the applicant.

E. After a final board order of denial has been issued, the board shall report the denial if required by the health care quality improvement act of 1986 (42 United States Code chapter 117). For the purposes of this subsection and except as required by federal law, "final board order" means:

1. For an applicant who seeks a hearing pursuant to title 41, chapter 6, article 10, when a final administrative decision has been made.

2. For an applicant who does not timely file a notice of appeal, after the time for the filing expires pursuant to section 41-1092.03.

32-3276. Notice of address and telephone number changes; penalties

A. A licensee must provide the board with the licensee's current home address and telephone number and office address and telephone number and promptly and in writing inform the board of any change in this information.

B. The board may assess the costs it incurs in locating a licensee and impose a penalty of not to exceed one hundred dollars against a licensee who does not notify the board pursuant to subsection A of this section within thirty days after the change of address or telephone number.

32-3277. Expired licenses; reinstatement

A. A person who does not renew a license is ineligible to practice pursuant to this chapter.

B. The board may reinstate an expired license if the person submits an application for reinstatement within ninety days after the expiration of the license. The application must document to the board's satisfaction that the applicant has met the renewal requirements prescribed by this chapter and include a late renewal penalty prescribed by the board by rule.

32-3278. Inactive license

A. The board by rule may establish procedures for a licensee to delay renewal of the license for good cause and to place the licensee on inactive status. A person on inactive status shall not practice behavioral health or claim to be a licensee.

B. A licensee on inactive status may request reinstatement of the license to active status by submitting a license renewal application.

32-3279. Probationary and temporary licenses

A. If an applicant does not meet the basic requirements for licensure prescribed in section 32-3275, the board may issue a probationary license that is subject to any of the following:

1. A requirement that the licensee's practice be supervised.

2. A restriction on the licensee's practice.

3. A requirement that the licensee begin or continue medical or psychiatric treatment.

4. A requirement that the licensee participate in a specified rehabilitation program.

5. A requirement that the licensee abstain from alcohol and other drugs.

B. If the board offers a probationary license, the board shall notify the applicant in writing of the:

1. Applicant's specific deficiencies.

2. Probationary period.

3. Applicant's right to reject the terms of probation.

4. Applicant's right to a hearing on the board's denial of the application.

C. The board by rule may prescribe a procedure to issue temporary licenses. At a minimum, these rules must include the following provisions:

1. A person issued a temporary license may practice behavioral health only under the direct supervision of a licensee.

2. A temporary license expires on the date specified by the board and not more than one year after the date of issuance.

3. A temporary license may contain restrictions as to time, place and supervision that the board deems appropriate.

4. The board may summarily revoke a temporary license without a hearing.

5. The board's denial of a licensure application terminates a temporary license.

32-3280. Fingerprinting

A. An applicant for licensure under this article other than for a temporary license must submit a full set of fingerprints to the board, at the applicant's own expense, 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.

B. The board shall waive the records check required in subsection A of this section for an applicant who provides evidence acceptable to the board that the applicant holds a valid fingerprint clearance card issued by the department of public safety.

32-3281. Disciplinary action; investigations; hearings; civil penalty; timely complaints; burden of proof

A. The board, on its own motion or on a complaint, may investigate any evidence that appears to show that a licensee is or may be incompetent, is or may be guilty of unprofessional conduct or is or may be mentally or physically unable to safely engage in the practice of behavioral health. A motion by the board to initiate an investigation shall be made at an open and properly noticed board meeting and shall include the basis on which the investigation is being initiated and the name of the board member making the motion. The board's vote on the motion to initiate an investigation shall be recorded. As part of its investigation, the board may hold an investigational meeting pursuant to this chapter. Any person may, and a licensee and any entity licensed by the department of health services shall, report to the board any information that would cause a reasonable licensee to believe that another licensee is guilty of unprofessional conduct or is physically or mentally unable to provide behavioral health services competently or safely. Any person or entity that reports or provides information to the board in good faith is not subject to an action for civil damages. It is an act of unprofessional conduct for any licensee to fail to report as required by this section. The board shall report to the department of health services any entity licensed by the department of health services that fails to report as required by this section. For complaints related to conduct that is inconsistent with professional standards or ethics, scope of practice or standard of care, the board may consult with one or more licensed or retired behavioral health

professionals of the same profession as the licensee to review complaints and make recommendations to the board.

B. On determination of reasonable cause, the board shall require, at the licensee's own expense, any combination of mental, physical or psychological examinations, assessments or skills evaluations necessary to determine the licensee's competence or ability to safely engage in the practice of behavioral health and conduct necessary investigations, including investigational interviews between representatives of the board and the licensee, to fully inform the board with respect to any information filed with the board under subsection A of this section. These examinations may include biological fluid testing. The board may require the licensee, at the licensee's expense, to undergo assessment by a rehabilitative, retraining or assessment program approved by the board.

C. If the board finds, based on the information received pursuant to subsection A or B of this section, that the public health, safety or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, the board may restrict, limit or order a summary suspension of a license pending proceedings for revocation or other action. If the board takes action pursuant to this subsection, it must also serve the licensee with a written notice that states the charges and that the licensee is entitled to a formal hearing before the board or an administrative law judge within sixty days.

D. If after completing an investigation the board finds that the information provided is not of sufficient seriousness to merit disciplinary action against the licensee, the board shall either:

1. Dismiss the complaint if, in the opinion of the board, the complaint is without merit.

2. File a letter of concern and dismiss the complaint. The licensee may file a written response with the board within thirty days after the licensee receives the letter of concern.

3. Issue a nondisciplinary order requiring the licensee to complete a prescribed number of hours of continuing education in an area or areas prescribed by the board to provide the licensee with the necessary understanding of current developments, skills, procedures or treatment.

E. A complaint dismissed by the board pursuant to subsection D, paragraph 1 of this section is not a complaint of unprofessional conduct and shall not be disclosed by the board as a complaint on the licensee's complaint history.

F. If after completing its investigation the board believes that the information is or may be true, the board may enter into a consent agreement with the licensee to limit or restrict the licensee's practice or to rehabilitate the licensee, protect the public and ensure the licensee's ability to safely engage in the practice of behavioral health. A consent agreement may also require the licensee to successfully complete a board approved rehabilitative, retraining or assessment program.

G. If the board finds that the information provided pursuant to subsection A of this section is or may be true, the board may request a formal interview with the licensee. If the licensee refuses the invitation for a formal interview or accepts and the results indicate that grounds may exist for revocation or suspension of the licensee's license for more than twelve months, the board shall issue a formal complaint and order that a hearing be held pursuant to title 41, chapter 6, article 10. If after completing a formal interview the board finds that the protection of the public requires emergency action, the board may order a summary suspension of the licensee's license pending formal revocation proceedings or other action authorized by this section.

H. If after completing the formal interview the board finds the information provided is not of sufficient seriousness to merit suspension for more than twelve months or revocation of the license, the board may take the following actions:

1. Dismiss if, in the opinion of the board, the information is without merit.

2. File a letter of concern and dismiss the complaint. The licensee may file a written response with the board within thirty days after the licensee receives the letter of concern.

3. Issue a decree of censure. A decree of censure is an official action against the licensee's license and may include a requirement for restitution of fees to a client resulting from violations of this chapter or rules adopted pursuant to this chapter.

4. Fix a period and terms of probation best adapted to protect the public health and safety and rehabilitate or educate the licensee concerned. Probation may include temporary suspension not to exceed twelve months, restriction of the licensee's license to practice behavioral health, a requirement for restitution of fees to a client or education or rehabilitation at the licensee's own expense. If a licensee fails to comply with the terms of probation, the board shall serve the licensee with a written notice that states that the licensee is subject to a formal hearing based on the information considered by the board at the formal interview and any other acts or conduct alleged to be in violation of this chapter or rules adopted by the board pursuant to this chapter, including noncompliance with the terms of probation or a consent agreement.

5. Issue a nondisciplinary order requiring the licensee to complete a prescribed number of hours of continuing education in an area or areas prescribed by the board to provide the licensee with the necessary understanding of current developments, skills, procedures or treatment.

I. If the board finds that the information provided in subsection A or G of this section warrants suspension or revocation of a license issued under this chapter, the board shall initiate formal proceedings pursuant to title 41, chapter 6, article 10.

J. In a formal interview pursuant to subsection G of this section or in a hearing pursuant to subsection I of this section, the board in addition to any other action may impose a civil penalty not to exceed one thousand dollars for each violation of this chapter or a rule adopted under this chapter.

K. A letter of concern is a public document.

L. A licensee who after a formal hearing is found by the board to be guilty of unprofessional conduct, to be mentally or physically unable to safely engage in the practice of behavioral health or to be professionally incompetent is subject to censure, probation as provided in this section, suspension of license or revocation of license or any combination of these, including a stay of action, and for a period of time or permanently and under conditions as the board deems appropriate for the protection of the public health and safety and just in the circumstance. The board may charge all costs incurred in the course of the investigation and formal hearing to the licensee it finds is in violation of this chapter. The board shall deposit, pursuant to sections 35-146 and 35-147, monies collected pursuant to this subsection in the board of behavioral health examiners fund established by section 32-3254.

M. If the board during the course of any investigation determines that a criminal violation may have occurred involving the delivery of behavioral health services, the board shall make the evidence of violations available to the appropriate criminal justice agency for its consideration.

N. The board shall deposit, pursuant to sections 35-146 and 35-147, all monies collected from civil penalties paid pursuant to this chapter in the state general fund.

O. Notice of a complaint and hearing is effective by a true copy of the notice being sent by certified mail to the licensee's last known address of record in the board's files. Notice of the complaint and hearing is complete on the date of its deposit in the mail.

P. In determining the appropriate disciplinary action under this section, the board shall consider all previous nondisciplinary and disciplinary actions against a licensee.

Q. The board may defer action with regard to an impaired licensee who voluntarily signs an agreement, in a form satisfactory to the board, agreeing to practice restrictions and treatment and monitoring programs deemed necessary by the board to protect the public health and safety. A licensee who is impaired and who does not agree to enter into an agreement with the board is subject to other action as provided pursuant to this chapter.

R. Subject to an order duly entered by the board, a person whose license to practice behavioral health has been suspended or restricted pursuant to this chapter, whether voluntarily or by action of the board, may at reasonable intervals apply to the board for reinstatement of the license. The person shall submit the application in writing and in the form prescribed by the board. After conducting an investigation and hearing, the board may grant or deny the application or modify the original finding to reflect any circumstances that have changed sufficiently to warrant modification. The board may require the applicant to pass an examination or complete board imposed continuing education requirements or may impose any other sanctions the board deems appropriate for reentry into the practice of behavioral health.

S. A person whose license is revoked, suspended or not renewed must return the license to the offices of the board within ten days after notice of that action.

T. The board may enforce a civil penalty imposed pursuant to this section in the superior court in Maricopa county.

U. For complaints being brought before the full board, the information released to the public regarding an ongoing investigation must clearly indicate that the investigation is a pending complaint and must include the following statement:

Pending complaints represent unproven allegations. On investigation, many complaints are found to be without merit or not of sufficient seriousness to merit disciplinary action against the licensee and are dismissed.

V. The board shall not act on its own motion or on any complaint received by the board in which an allegation of unprofessional conduct or any other violation of this chapter against a professional who holds an Arizona license occurred more than four years before the complaint is received by the board. The time limitation does not apply to:

1. Malpractice settlements or judgments, allegations of sexual misconduct or an incident or occurrence that involved a felony, diversion of a controlled substance or impairment while practicing by the licensee.

2. The board's consideration of the specific unprofessional conduct related to the licensee's failure to disclose conduct or a violation as required by law.

W. The board shall not open an investigation if identifying information regarding the complainant is not provided.

X. Except for disciplinary matters prescribed by section 32-3251, paragraph 16, subdivision (v), the board has the burden of proof by clear and convincing evidence for disciplinary matters brought pursuant to this chapter.

32-3282. Right to examine and copy evidence; summoning witnesses and documents; taking testimony; right to counsel; confidentiality

A. In connection with information received pursuant to section 32-3281, subsection A, the board or the board's authorized agents or employees at all reasonable times have access to, for the purpose of examination, and the right to copy any psychotherapy notes, documents, reports, records or other physical evidence of any person being investigated, or the reports, records and any other documents maintained by and in possession of any hospital, clinic, physician's office, laboratory, pharmacy or health care institution as defined in section 36-401 or any other public or private agency, if the psychotherapy notes, documents, reports, records or evidence relate to the specific complaint.

B. For the purpose of all investigations and proceedings conducted by the board:

1. The board on its own initiative may issue subpoenas compelling the attendance and testimony of witnesses or demanding the production for examination or copying of documents or any other physical evidence if the evidence relates to the unauthorized practice of behavioral health or to the competence, unprofessional conduct or mental or physical ability of a licensee to safely practice. Within five days after the service of a subpoena on any person requiring the production of any evidence in that person's possession or under that person's control, the person may petition the board to revoke, limit or modify the subpoena. The board shall revoke, limit or modify a subpoena if in its opinion the evidence required does not relate to unlawful practices covered by this chapter or is not relevant to the charge that is the subject matter of the hearing or investigation or the subpoena does not describe with sufficient particularity the physical evidence required to be produced. Any member of the board and any agent designated by the board may administer oaths, examine witnesses and receive evidence.

2. Any person appearing before the board may be represented by counsel.

3. The board shall make available to the licensee who is the subject of the investigation, or the licensee's designated representative, for inspection at the board's office the investigative file at least five business days before a board meeting at which the board considers the complaint. The board may redact any confidential information before releasing the file to the licensee.

4. The superior court, on application by the board or by the person subpoenaed, has jurisdiction to issue an order either:

(a) Requiring the person to appear before the board or the board's authorized agent to produce evidence relating to the matter under investigation.

(b) Revoking, limiting or modifying the subpoena if in the court's opinion the evidence demanded does not relate to unlawful practices covered by this chapter or is not relevant to grounds for disciplinary action that are the subject matter of the hearing or investigation or the subpoena does not describe with sufficient particularity the physical evidence required to be produced. Any failure to obey an order of the court may be punished by the court as contempt.

C. Records, including clinical records, reports, files or other reports or oral statements relating to examinations, findings or treatments of clients, any information from which a client or the client's family might be identified or information received and records kept by the board as a result of the investigation procedure prescribed by this chapter are not available to the public.

D. This section and any other law that makes communications between a licensee and the licensee's client a privileged communication do not apply to investigations or proceedings conducted pursuant to this chapter. The board and and the board's employees, agents and representatives shall keep in confidence the names of any clients whose records are reviewed during the course of investigations and proceedings pursuant to this chapter.

32-3283. Confidential relationship; privileged communications; clients with legal guardians; treatment decisions

A. The confidential relationship between a client and a licensee, including a temporary licensee, is the same as between an attorney and a client. Unless a client waives this privilege in writing or in court testimony, a licensee shall not voluntarily or involuntarily divulge information that is received by reason of the confidential nature of the behavioral health professional-client relationship.

B. A licensee shall divulge to the board information the board requires in connection with any investigation, public hearing or other proceeding.

C. The behavioral health professional-client privilege does not extend to cases in which the behavioral health professional has a duty to:

1. Inform victims and appropriate authorities that a client's condition indicates a clear and imminent danger to the client or others pursuant to this chapter.

2. Report information as required by law.

D. A client's legal guardian may make treatment decisions on behalf of the client, except that the client receiving services is the decision maker for issues:

1. That directly affect the client's physical or emotional safety, such as sexual or other exploitative relationships.

2. That the guardian agrees to specifically reserve to the client.

3. Where the right to seek behavioral health services without parental or guardian consent is established by state or federal law.

32-3284. Cease and desist orders; injunctions

A. The board may issue a cease and desist order or request that an injunction be issued by the superior court to stop a person from engaging in the unauthorized practice of behavioral health or from violating or threatening to violate a statute, rule or order that the board has issued or is empowered to enforce. If the board seeks an injunction to stop the unauthorized practice of behavioral health, it is sufficient to charge that the respondent on a day certain in a named county engaged in the practice of behavioral health without a license and without being exempt from the licensure requirements of this chapter. It is not necessary to show specific damages or injury. The cease and desist order must state the reason for its issuance and give notice of the person's right to request a hearing under applicable procedures prescribed in title 41, chapter 6, article 10.

B. Violation of an injunction shall be punished as for contempt of court.

32-3285. Judicial review

Except as provided in section 41-1092.08, subsection H, final decisions of the board are subject to judicial review pursuant to title 12, chapter 7, article 6.

32-3286. Unlawful practice; unlawful use of title; violations; classification; civil penalty; exception

A. Except as prescribed in section 32-3271, a person who is not licensed pursuant to this chapter shall not engage in the practice of behavioral health.

B. A person who is not licensed pursuant to this chapter shall not use any of the following designations or any other designation that indicates licensure status, including abbreviations, or claim to be licensed pursuant to this chapter:

1. Licensed professional counselor.

2. Licensed associate counselor.

3. Licensed marriage and family therapist.

4. Licensed associate marriage and family therapist.

5. Licensed clinical social worker.

6. Licensed master social worker.

7. Licensed baccalaureate social worker.

8. Licensed independent substance abuse counselor.

9. Licensed associate substance abuse counselor.

10. Licensed substance abuse technician.

C. A person who is not licensed pursuant to this chapter and who practices or attempts to practice or who holds himself out as being trained and authorized to practice behavioral health, including diagnosing or treating any mental ailment, disease or disorder or other mental condition of any person, without being authorized by law to perform the act is engaging in the unauthorized practice of behavioral health, is in violation of this chapter, is guilty of a class 6 felony and is subject to a civil penalty of not more than $500 for each offense.

D. A person who conspires with or aids and abets another to commit any act described in subsection C of this section is guilty of a class 6 felony and is subject to a civil penalty of not more than $500 for each offense.

E. The board shall notify the department of health services if a licensed health care institution employs or contracts with a person who is investigated pursuant to this section.

F. Each day that a violation is committed constitutes a separate offense.

G. All fees received for services described in this section shall be refunded by the person found guilty pursuant to this section.

H. Notwithstanding subsection A of this section and based on circumstances presented to the board, the board may sanction a person's failure to timely renew a license while continuing to engage in the practice of behavioral health as an administrative violation rather than as a violation of this section or grounds for unprofessional conduct and may impose a civil penalty of not more than $500. The board shall deposit, pursuant to sections 35-146 and 35-147, monies collected pursuant to this subsection in the state general fund.

32-3291. Licensed baccalaureate social worker; licensure; qualifications; supervision

A. A person who wishes to be licensed by the board to engage in the practice of social work as a licensed baccalaureate social worker shall:

1. Furnish documentation as prescribed by the board by rule that the person has earned a baccalaureate degree in social work from a regionally accredited college or university in a program accredited by the council on social work education or a degree from a foreign school based on a program of study that the board determines is substantially equivalent.

2. Pass an examination approved by the board.

B. A licensed baccalaureate social worker shall only engage in clinical practice under direct supervision as prescribed by the board.

32-3292. Licensed master social worker; licensure; qualifications; supervision

A. A person who wishes to be licensed by the board to engage in the practice of social work as a licensed master social worker shall:

1. Furnish documentation satisfactory to the board that the person has earned a master's or higher degree in social work from a regionally accredited college or university in a program accredited by the council on social work education or a degree from a foreign school based on a program of study that the board determines is substantially equivalent.

2. Pass an examination approved by the board.

B. A licensed master social worker shall only engage in clinical practice under direct supervision as prescribed by the board.

32-3293. Licensed clinical social worker; licensure; qualifications

A person who wishes to be licensed by the board to engage in the practice of social work as a licensed clinical social worker shall:

1. Furnish documentation as prescribed by the board by rule that the person has:

(a) Earned a master's or higher degree in social work from a regionally accredited college or university in a program accredited by the council on social work education or a degree from a foreign school based on a program of study that the board determines is substantially equivalent.

(b) Received at least twenty-four months of post-master's degree experience in the practice of clinical social work under supervision that includes at least one thousand six hundred hours of direct client contact that meets the requirements prescribed by the board by rule. For clinical supervision, at least one hundred hours of experience must be as prescribed by the board by rule. For direct client contact hours, not more than four hundred hours may be in psychoeducation.

2. Provide documentation on a board-approved form completed by the person's supervisor attesting that the person both:

(a) Was observed during supervised hours to have demonstrated satisfactory competency in clinical documentation, consultation, collaboration and coordination of care related to clients to whom the person provided direct care.

(b) Has a rating of at least satisfactory in overall performance.

3. Pass an examination approved by the board.

32-3301. Licensed professional counselor; licensure; requirements

A. A person who wishes to be licensed by the board to engage in the practice of professional counseling as a licensed professional counselor shall:

1. Meet the education requirements of subsection B of this section and the work experience requirements of subsection F of this section.

2. Pass an examination approved by the board.

B. An applicant for licensure shall furnish documentation as prescribed by the board by rule that the person has received a master's or higher degree with a major emphasis in counseling from a regionally accredited college or university in a program of study that includes at least sixty semester credit hours or ninety quarter credit hours at one of the following:

1. A program accredited by the council for the accreditation of counseling and related educational programs or the national council on rehabilitation education.

2. A program with a curriculum that has been approved by the board pursuant to section 32-3253.

3. A program with a curriculum meeting requirements as prescribed by the board by rule.

C. A program that is not accredited by the council for the accreditation of counseling and related educations programs or the national council on rehabilitation education must require seven hundred hours of supervised clinical hours and twenty-four semester hours or thirty-two quarter hours in courses in the following eight core content areas as prescribed by the board by rule:

1. Professional orientation and ethical practice.

2. Social and cultural diversity.

3. Human growth and development.

4. Career development.

5. Helping relationships.

6. Group work.

7. Assessment.

8. Research and program evaluation.

D. Credit hours offered above those prescribed pursuant to subsection C of this section must be in studies that provide a broad understanding in counseling related subjects as prescribed by the board by rule.

E. The board may accept equivalent coursework in which core content area subject matter is embedded or contained within another course, including another subject matter.

F. An applicant for licensure shall furnish documentation as prescribed by the board by rule that the applicant has received at least twenty-four months in post-master's degree work experience in the practice of professional counseling under supervision that includes at least one thousand six hundred hours of direct client contact and that meets the requirements prescribed by the board by rule. An applicant may use a doctoral-clinical internship to satisfy the requirement for one year of work experience under supervision.

G. In addition to the requirements of subsection F of this section, the applicant must have at least one hundred hours of clinical supervision as prescribed by the board by rule. For the direct client contact hours, not more than four hundred hours may be in psychoeducation.

H. The applicant's supervisor shall attest on a board-approved form that the applicant both:

1. Was observed during supervised hours to have demonstrated satisfactory competency in clinical documentation, consultation, collaboration and coordination of care related to clients to whom the applicant provided direct care.

2. Has a rating of at least satisfactory in overall performance.

I. An applicant who is deficient in hours required pursuant to subsection B of this section may satisfy those requirements by successfully completing post-master's degree coursework.

J. An applicant who completed a degree before July 1, 1989 and whose course of study did not include a practicum may substitute a one-year doctoral-clinical internship or an additional year of documented post-master's degree work experience in order to satisfy the requirements of subsection B of this section.

32-3303. Licensed associate counselor; licensure; requirements; supervision

A. A person who wishes to be licensed by the board to engage in the practice of professional counseling as a licensed associate counselor shall satisfy the requirements of section 32-3301, subsections B, H and I and pass an examination approved by the board.

B. A licensed associate counselor shall only practice under direct supervision as prescribed by the board.

32-3311. Licensed marriage and family therapist; licensure; qualifications

A. A person who wishes to be licensed by the board to engage in the practice of marriage and family therapy as a licensed marriage and family therapist shall furnish documentation as prescribed by the board by rule that the person has:

1. Earned a master's or doctoral degree in behavioral science, including, but not limited to, marriage and family therapy, psychology, sociology, counseling and social work, granted by a regionally accredited college or university in a program accredited by the commission on accreditation for marriage and family therapy education or a degree based on a program of study that the board determines is substantially equivalent.

2. Completed one thousand six hundred hours of post-master's degree experience in at least twenty-four months in the practice of marriage and family therapy under supervision that meets the requirements prescribed by the board by rule. For the direct client contact hours, not more than four hundred hours may be in psychoeducation. The one thousand six hundred hours must consist of direct client contact and include at least one thousand hours of clinical experience with couples and families and at least one hundred hours of clinical supervision as prescribed by the board by rule.

3. Passed an examination approved by the board.

4. Provided an attestation from the person's supervisor on a board-approved form that the person both:

(a) Was observed during supervised hours to have demonstrated satisfactory competency in clinical documentation, consultation, collaboration and coordination of care related to clients to whom the person provided direct care.

(b) Has a rating of at least satisfactory in overall performance.

B. The curriculum for the master's or doctoral degree in behavioral science accepted by the board pursuant to subsection A, paragraph 1 of this section shall include a specified number of graduate courses as prescribed by the board by rule and shall be consistent with national standards of marriage and family therapy. Part of this course of study may be taken in a post-master's degree program as approved by the board.

C. The one thousand hours of clinical experience required by subsection A, paragraph 2 of this section may include one year in an approved marriage and family doctoral internship program.

32-3313. Licensed associate marriage and family therapist; licensure; requirements; supervision

A. A person who wishes to be licensed by the board to engage in the practice of marriage and family therapy as a licensed associate marriage and family therapist shall satisfy the requirements of section 32-3311, subsection A, paragraphs 1 and 3 and subsection B.

B. A licensed associate marriage and family therapist shall only practice under direct supervision as prescribed by the board.

32-3321. Licensed substance abuse technician; licensed associate substance abuse counselor; licensed independent substance abuse counselor; qualifications; supervision

A. A person who wishes to be licensed by the board to engage in the practice of substance abuse counseling as a licensed substance abuse technician shall present documentation as prescribed by the board by rule that the person has:

1. Received one of the following:

(a) An associate degree in chemical dependency or substance abuse with an emphasis on counseling that meets the requirements as prescribed by the board by rule from a regionally accredited college or university.

(b) A bachelor's degree in a behavioral science with an emphasis on counseling that meets the requirements as prescribed by the board by rule from a regionally accredited college or university.

2. Passed an examination approved by the board.

B. A licensed substance abuse technician shall only practice under direct supervision as prescribed by the board.

C. The board may waive the education requirement for an applicant requesting licensure as a substance abuse technician if the applicant provides services pursuant to contracts or grants with the federal government under the authority of Public Law 93-638 (25 United States Code section 5301) or Public Law 94-437 (25 United States Code sections 1601 through 1683). A person who becomes licensed as a substance abuse technician pursuant to this subsection shall only provide substance abuse services to those persons who are eligible for services pursuant to Public Law 93-638 (25 United States Code section 5301) or Public Law 94-437 (25 United States Code sections 1601 through 1683).

D. A person who wishes to be licensed by the board to engage in the practice of substance abuse counseling as a licensed associate substance abuse counselor shall present evidence as prescribed by the board by rule that the person has:

1. Received one of the following:

(a) A bachelor's degree in a behavioral science with an emphasis on counseling that meets the requirements as prescribed by the board by rule from a regionally accredited college or university and present documentation as prescribed by the board by rule that the applicant has received at least one thousand six hundred hours of direct client contact work experience in at least twenty-four months in substance abuse counseling under supervision that meets the requirements prescribed by the board by rule. For the direct client contact hours, not more than four hundred hours may be in psychoeducation.

(b) A master's or higher degree in a behavioral science with an emphasis on counseling as prescribed by the board by rule from a regionally accredited college or university.

2. Passed an examination approved by the board.

3. Provided an attestation from the person's supervisor on a board-approved form that the person both:

(a) Was observed during supervised hours to have demonstrated satisfactory competency in clinical documentation, consultation, collaboration and coordination of care related to clients to whom the person provided direct care.

(b) Has a rating of at least satisfactory in overall performance.

E. A licensed associate substance abuse counselor shall only practice under direct supervision as prescribed by the board.

F. A person who wishes to be licensed by the board to engage in the practice of substance abuse counseling as a licensed independent substance abuse counselor shall:

1. Have received a master's or higher degree in a behavioral science with an emphasis on counseling, in a program that is approved by the board pursuant to section 32-3253 or that meets the requirements as prescribed by the board by rule, from a regionally accredited college or university.

2. Present documentation as prescribed by the board by rule that the applicant has received at least one thousand six hundred hours of work experience in at least twenty-four months in substance abuse counseling with direct client contact under supervision that meets the requirements as prescribed by the board by rule. For the direct client contact hours, not more than four hundred hours may be in psychoeducation.

3. Pass an examination approved by the board.

4. Provide an attestation from the person's supervisor on a board-approved form that the person both:

(a) Was observed during supervised hours to have demonstrated satisfactory competency in clinical documentation, consultation, collaboration and coordination of care related to clients to whom the person provided direct care.

(b) Has a rating of at least satisfactory in overall performance.

STATE OF ARIZONA
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PHOENIX, AZ 85007
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KATIE M. HOBBS
Governor

TOBI ZAVALA
Executive Director

July 14, 2023

To the Members and Staff of the Governor's Regulatory Review Rule Council:

Thank you for allowing me the opportunity to provide additional information in regards to A.A.C. R4-6-217 B. 2 A. i. proposing the ratio change from 1:20 to 1:10 based on our Board's concern regarding clinical supervision and oversight. I have gathered some information that I believe will be helpful and I would also like to note that in all 5 letters of support the common theme is oversight and supervision. There were a lot of questions and I will attempt to answer in the best of my ability and succinctly as possible.

Before getting to your questions and concerns, I would like put a few things into perspective. Our Board regulates the practice of over 16,000 licensed behavioral health professionals in the fields of counseling, marriage and family therapy, social work and substance abuse counseling. Individuals who are eligible for SPP has a minimum of a master's degree. The population that is served would be considered the most vulnerable in the state of Arizona.

Our two-tier licensure is modeled after national associations as well as almost all other jurisdictions. You receive your license by using your credentials (master's degree) and then you receive your 2nd level licensure after receiving clinical oversight for the pyschotherapy services being provided. Each and every states requirement for supervision and oversight is different. You will see that Arizona is aligned with the majority. **Attachment 1**

I have included letters of support of the rule change from:

- Association of Social Work Boards (ASWB) **Attachment 2**
- National Board of Certified Counselors (NBCC) **Attachment 3**
- Az Chapter of Social Workers (AzNASW) **Attachment 4**

I have also included an email from American Counseling Association supporting the importance of clinical supervision and oversight. **Attachment 5**

The purpose of clinical supervision for the lower level license to state it simply if for the safety of the client. Clinical supervision supports trainee mental health professionals by offering oversight and support from a more experienced provider. To become licensed to practice, all mental health providers must complete a minimum number of therapy hours under clinical supervision. The specific requirements vary depending on the license a therapist seeks and the state in which they practice. During clinical supervision, a trainee provider meets with a more experienced provider to discuss cases, treatment

strategies, and other important topics. Daily work with distraught people can be inherently distressing, so a key aspect of clinical supervision is often helping therapists learn to compartmentalize their own emotions and practice better self-care.

Comparison to an associate level who is not in SPP compared to one in SPP:

Associate Level: 1600 hours of direct client contact, 100 hours of clinical supervision in no less than 24 months (most receive 1 hour a week)

Associate Level: 1600 hour of direct client contact, 100 hours of clinical supervision in no less than 24 months (current 1 hour per 20 hours of direct client contact, proposed 1 hour per 10 hours)

NOTE: less than 1% of our associates participate in this volunteer and temporary program and additionally out of that only 30% do this full time; therefore the financial burden affects about 50 licensees.

Your Questions:

1. Why were there changes and what occurred in 2019 to allow SPP?

In 04/26/2017, pursuant to ARS §41-1093.02 (A) a petition to a rule was submitted. Based on that petition by Annette Stanley, the Board worked together with Goldwater Institute, stakeholders and the Governors' office to implement changes to promote equity and to remain a state that national organizations continue to model after. The allowance of SPP was well receptive amongst most as long as safety stipulations were put in place. Ms. Stanley has submitted a letter of support for the proposed changes. (**Attachment 6**)

2. How the complaints are tracked and the breakdown between the complaints as well as the types/number of complaints between SPP practitioners and non SPP practitioners?

All complaints are tracked through the Board's database. What is not currently tracked are those 150 licensees that participate in SPP. Therefore, it has made it very difficult to come up with stats. Additionally many of the concerns in regards to not following the rules have been difficult for staff to memorialize. Board staff brought to the members attention in May 2023 many concerns in regards to SPP participants not following the rules. (**Attachment 7**) Non-disciplinary matters are not posted under Board Actions; however, all disciplinary actions are displayed under Board's actions are on our website by year such as; https://www.azbbhe.us/node/1003. I would like to bring your attention to some case examples of consistent issues that have come before our Board.

Case examples:

https://www.azbbhe.us/pdfs/BoardOrder/2022-0039.pdf
https://www.azbbhe.us/pdfs/BoardOrder/2021-0159.pdf
https://www.azbbhe.us/pdfs/BoardOrder/2021-0173.pdf
https://www.azbbhe.us/pdfs/BoardOrder/2021-0174.pdf
https://www.azbbhe.us/pdfs/BoardOrder/2022-0025.pdf
https://www.azbbhe.us/pdfs/BoardOrder/2021-0170.pdf

Lindsay Love letter of concern:
(https://www.azbbhe.us/sites/default/files/agendas/August%2013%2C%202021%20Minutes.pdf
https://www.azbbhe.us/pdfs/BoardOrder/2022-0031.pdf
https://www.azbbhe.us/pdfs/BoardOrder/2021-0158.pdf
https://www.azbbhe.us/pdfs/BoardOrder/2022-0105.pdf

On February 17th 2023-0005, DeAnna Perry presented before the Board. The Board is in settlement with her but the facts are public. Her clinical supervisor was deceased and she was filling out paperwork and emailing Board staff as if she was the supervisor.

Additionally, we have 3 cases going to our July 21st Board meeting that all involve SPP. They are not public yet; however, when we meet on July 25th I will be able to divulge the misconduct.

3. What are the differences in the types of supervision and the number of hours of supervision between the different states?

I have requested information from both the national counseling and social work associations that represent more than 84% of our licensees and this is not data that they have collected since few states allow it. I did a list serve request and received information back from New Jersey, Wisconsin, Nebraska, California and West Virginia that they do not allow it. Comparisons of apples to apples are next to impossible as you can see by Annette Stanley in Kansas. Kansas ratio is 1:15; however, they are required 1/3 more clinical supervision hours.

Please consider what was stated in the NBCC letter of support as Arizona is a strong state that other states and organizations look up to. “Arizona has long been a model for other states in terms of clarity of requirements and efficiency of operations. The Arizona State Board of Behavioral Health Examiners staff provides necessary information to pre-service training programs for counselors to help counselors transition as quickly as possible from student to professional. Other state boards regularly reach out to NBCC to ask for guidance on increasing the efficiency of transitioning students into the workforce and we often call on the AZ Board Executive Director, Tobi Zavala, to share lessons learned and innovations implemented in your state.”

4. Is there any training for the management of a business and record/data keeping not only required by provided by the Board.

There is not required training in business in Arizona or any other state that I am aware of; however, the intent to have a seasoned independent licensee provide oversight to all business practices and clinical supervision would assist with this.

5. Information/data demonstrating the increase in supervision will decrease complaints/concerns and/or increase quality of services.

This is not tangible information, with that being said, based on the support of the national organization for counselors and social workers that represent more than 84% of our licensee they concur that clinical supervision is a must for the protection of vulnerable clients.

6. More information on what supervision entails, including anything specified for SPPs to cove in supervision.

Please see the requirements the link for supervised private practice.
https://www.azbbhe.us/node/773

Application:
https://www.azbbhe.us/pdfs/Supervised%20Private%20Practice%20Application%20-%20FINAL%20fillable%20011023.pdf

Additionally, it was mentioned by public comment and some Council Members that the Board may not have been transparent with this rule change. I disagree, as it was in the initial request to the Governor's Office and part of the rule package. Public comment was also accepted for almost six months from June 30, 2022 through January 13, 2023, which included two public meetings and an assigned email to collect feedback. Not only were these located on our Board's website, but shared verbally during various presentations by Board staff. As for the Arizona Sensible Therapy Practice Coalition, I personally have been engaged exhaustively since November 2022, particularly, with Ms. Halina Brooke. It is always a privilege to work with stakeholders, and our Board is known to be transparent and fair. It is concerning this Coalition stated both in writing and verbally that they were unaware of ethical complaints outside of independent level licensees, as this has generally been the issue all along. It was always stated that Patricia Dobratz was the only clinical supervisor for supervised private practice and that is also simply not true. Additionally, it was stated that our Board likes to vote unanimously and, again, this is false. Lastly, it was stated that they never received the May minutes even though the information was requested, which, again, is incorrect. I reviewed the numerous emails from Ms. Brooke and that was not ever quantified as a request. It is true that data was requested, which was not provided as the Board is not required to furnish information that has not already been gathered. I think it is very important to note, that due to this Coalition, I requested from the Board Chair that we allow this Coalition to have a voice at a Board meeting prior to the vote of this proposed rule. This is not standard in our process, but I felt as a Board Administrator that it was my responsibility to err on the side of caution, ensuring that the Coalition had a chance to present, as well as provide the members an opportunity to ask questions. It has been a long time since any rule has been contested, and I felt this was an important exercise to ensure all aspects of this issue were discussed and considered so the Board could make a fair decision.

Again, I appreciate the opportunity to gather additional information to help the review process of this proposed rule that our Board believes supports the mission to protect the people of Arizona.

Sincerely,

Tobi Zavala
Executive Director

ATTACHMENT

(1)

Jurisdiction	Supervised Experience Required	Minimum Time to Accrue Time	Minimum Direct Client Hours Required	Minimum Direct Supervisor Contact Hours Required	Minimum Frequency of Supervision
Alabama	3,000 hours	2 years		96 hours	4 hours per month
Alaska	3000 hours	2 years		100 hours	
Arizona	1600	24 months	1600 hours	100 hours	
Arkansas	4000 hours	24 months	Not specified	100 hours	1 hour per week
California	3000 hours	2 years	750 hours	104 hours	1 hour per week
Colorado	3360 hours	2 years	1680 hours	96 hours	1 hour per week
Connecticut	3000 hours			100 hours	
Delaware	3200 hours	2 years		100 hours	1 hour per week
District of Columbia	3000 hours	2 years		100 hours	1 hour supervision per 32 practice hours
Florida	1500 hours	No less than 100 weeks	1500 hours	100 hours	1 hour per 15 hours of practice
Georgia	3000 hours	36 months		120 hours	
Guam	3000 hours	2 years	800 hours	100 hours	
Hawaii	3000 hours	2 years	2000 hours	100 hours	
Idaho	3000 hours	2 years	1750 hours	100 hours	Regular and ongoing
Illinois	3000 hours				4 hours per month
Illinois	2000 hours			Not specified	4 hours per month
Indiana	24 months required, number of hours not specified	2 years		96 hours	4 hours per month
Iowa	3000 hours	2 years	2000 hours	110 hours	1 hour for every 40 practice hours
Kansas	3000 hours	2 years	1500 hours	100 hours	1 hour for every 20 practice hours
Kentucky	3600 hours	2 years	At least 60% supervision experience; no specific hourly requirement	200 hours	2 hours for every 2 weeks of practice
Louisiana	3,000 hours			96 hours	2 hours for every 80 practice hours
Maine	3200 hours	2 years		96 hours	1 hour per week / 4 hours per month
Maine	6400 hours	2 years		192 hours	1 hour per week / 4 hours per month
Maryland	3000 hours	2 years	1500 hours	100 hours	3 hours per month
Massachusetts	3500 hours	2 years		100 hours	
Michigan	4000 hours			96 hours	4 hours per month
Minnesota	4000 hours			100 hours	4 hours for every 160 practice hours
Mississippi	24 months, number of hours not specified	24 months	1000 hours	100 hours	1 hour per week
Missouri	3000 hours	24 months		100 hours	2 hours for every 2 weeks of practice
Montana	3000 hours	2 years	1500 hours	100 hours	2 hours for every 160 practice hours
Nebraska	3000 hours		1500 hours		
Nebraska	3000 hours		1500 hours	300 hours	1 hour per week
Nevada	3000 hours	2 years	2000 hours	104 hours	1 hour per week

Jurisdiction	Supervised Experience Required	Minimum Time to Accrue Time	Minimum Direct Client Hours Required	Minimum Direct Supervisor Contact Hours Required	Minimum Frequency of Supervision
New Hampshire	3000 hours	2 years		100 hours	1 hour per week
New Jersey	3000 hours	2 years	1920 hours	96 hours	1 hour per week
New Mexico	3600 hours	2 years		90 hours	1 hour for every 40 practice hours
New York	2000 hours	36 months	2000 hours	100 hours	No less than 2 hours per month
North Carolina	3000 hours	2 years	Experience must include direct client content; no specific hourly requirement	100 hours	1 hour for every 30 practice hours
North Dakota	3000 hours			150 hours	Weekly
Northern Mariana Islands	Two years required, number of hours not specified	2 years			
Ohio	3000 hours	2 years		150 hours	1 hour for every 20 practice hours
Oklahoma	4000 hours	2 years	3000 hours	100 hours	1 hour per week
Oregon	3500 hours	2 years	2000 hours	100 hours	1 hour at least 2 times per month
Pennsylvania	3000 hours	2 years	1500 hours	150 hours	2 hours for every 40 practice hours
Rhode Island	3000 hours	2 years	1500 hours	150 hours	2 hours for every 2 weeks of practice
South Carolina	3000 hours	2 years		100 hours	
South Dakota	Two years required, number of hours not specified	2 years			4 hours per month
Tennessee	3000 hours	2 years		100 hours	1 hour for every 30 practice hours
Texas	3000 hours	24 months		100 hours	1 hour for every 40 practice hours
Utah	3000 hours	2 years		100 hours	
Vermont	3000 hours	2 years	2000 hours	75 hours	1 hour for every 40 practice hours
Virgin Islands	Two years				
Virginia	3000 hours	2 years	1380 hours	100 hours	1 hour for every 40 practice hours
Washington	4000 hours	3 years	1000 hours	130 hours	
West Virginia	4000 hours	2 years		100 hours	
Wisconsin	3000 hours		1000 hours	104 hours	1 hour per week
Wyoming	3000 hours	18 months	1200 hours	100 hours	1 hour for every 20 practice hours

ATTACHMENT

(2)

ASWB
Association of Social Work Boards

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Culpeper, VA 22701

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aswb.org

June 30, 2023

Sent electronically via email

Tobi Zavala
Executive Director, Arizona Board of Behavioral Health Examiners
1740 West Adams St. #3600
Phoenix, AZ 85007

Re. request for information on private practice by an LMSW / clinical associate licensees

Dear Tobi,

This letter follows up on your request for information regarding private practice by a licensed masters social worker (LMSW) / clinical associate licensee as you work to amend clinical supervision regulations.

As you know, ASWB is the nonprofit professional regulatory association whose members are comprised of the 64 social work regulatory authorities in the United States, Canada, and north American territories, including the Arizona Board of Behavioral Health Examiners. ASWB provides programs and services to regulatory boards in promoting uniformity and lessening burdens on state governments. Among its services, ASWB oversees the Model Social Work Practice Act (model law) reflecting best practice guidance for regulators and legislators and facilitating greater regulatory uniformity. First adopted in 1997, the model law is periodically reviewed and affirmed by ASWB member jurisdictions during its annual business meeting. ASWB also maintains a laws and regulations database on state and provinical social work regulatory requirements and policies in service to the regulatory community and the public. This information is compiled from research of jurisdiction statutes, regulations, and policies and from correspondence with regulatory entitites. In consulting both these resources, ASWB staff find that private practice by a clinical associate licensee is not suggesed under the ASWB model law. Relevant portions of the model law follow on the next page, and information compiled from a review of state statues, regulations and policies is included in the Excel file shared with this letter.

ASWB Model Social Work Practice Act

A definition for private practice is provided in Section 109 of the model law. Private practice is exlicitly referenced in clinical scope of practice as defined in Section 106. By its very definition in the model law, private practice is restricted to licensed clinical social workers.

ASWB Model Social Work Practice Act

Section 109. Definitions.
(w) Private Practice means the provision of Clinical Social Work services ***by a licensed Clinical Social Worker*** *who assumes responsibility and accountability for the nature and quality of the services provided to the Client in exchange for direct payment or third-party reimbursement.*

Accountabiility
Section 106. Practice of Clinical Social Work.
The practice of Clinical Social Work is a specialty within the practice of Master's Social Work and requires the application of social work theory, knowledge, methods, ethics, and the professional use of self to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals, couples, families, groups, organizations and communities. The practice of Clinical Social Work requires the application of ***specialized clinical knowledge and advanced clinical skills*** *in the areas of assessment, diagnosis and treatment of mental, emotional, and behavioral disorders, conditions and addictions. Treatment methods include the provision of individual, marital, couple, family and group Counseling and Psychotherapy. The practice of Clinical Social Work may include Private Practice and the provision of Clinical Supervision.*

Research

ASWB staff periodically reviews all state and provincial jurisdiction statutes, regulations, and policies for topical areas maintained in the association's laws and regulations database. A comprehensive review for the regulation of scope of practice including private practice restrictions found that four of the 54 U.S. member jurisdictions permit private practice by a licensed masters social worker. This includes Colorado, Kansas, New York, and Ohio. However, in New York, the LMSW cannot perform activities restricted to the clinical scope of practice i.e., they cannot perform supervised clinical practice in a private practice setting. The states and the relevant provisions are included in the Excel file shared with this letter in a separate attachment.

I hope this information is helpful in your efforts to amend the clinical supervision regulations.

Sincerely,

Stacy D. Haney Chandler, PhD, JD, LCSW

Chief Executive Officer
Association of Social Work Boards

ATTACHMENT

(3)

nbcc
NATIONAL BOARD FOR CERTIFIED COUNSELORS® AND AFFILIATES
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Greensboro, North Carolina
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TEL: 336-547-0607
FAX: 336-547-0017
WEB: nbcc.org

July 6, 2023

National Board for Certified Counselors
3 Terrace Way
Greensboro, NC 27403

To Whom it May Concern:

Our organization, the National Board for Certified Counselors (NBCC), is the largest certification organization for counselors in the United States. Counselors who become nationally certified have met appropriate standards of practice necessary for the protection of the public through education, examination, supervision, experience, and ethical guidelines. As a voluntary credential, national certification serves to solidify a cohesive model for the professional recognition of counselors and we work hand-in-hand with state and jurisdictional regulatory boards to increase public awareness, credential counselors, and expand access to essential mental health resources.

Today, there are over 74,000 National Certified Counselors (NCCs) and more than 200,000 licensed professional counselors nationwide. NBCC's national examinations are utilized by all states and jurisdictions that license counselors for professional practice in the United States and we are committed to the efficient matriculation of counselors from training into practice. We believe increasing access to mental health services is necessary for a robust, healthy, engaged workforce and society.

Key to sustaining a productive, prepared body of professional counselors in each state or jurisdiction are clearly articulated licensure eligibility requirements. Arizona has long been a model for other states in terms of clarity of requirements and efficiency of operations. The Arizona State Board of Behavioral Health Examiners staff provides necessary information to pre-service training programs for counselors to help counselors transistion as quickly as possible from student to professional. Other state boards regularly reach out to NBCC to ask for guidance on increasing the efficiency of transitioning students into the workforce and we often call on the AZ Board Executive Director, Tobi Zavala, to share lessons learned and innovations implemented in your state.

The Licensed Associate Counselor serves to move counseling graduates quickly into professional practice, increasing access to mental health resources for citizens and reducing the time needed for graduates to evidence a return on the investment they have made in their education/professional training. The tiered licensure approach utilized by Arizona is comparable to the model for licensure in many other states and jurisdictions in the United States and is a strong model. As governing bodies have realized the vast need for mental health services and sought to increase the number of professionals in the field serving citizens, many legislatures have modified their professional counselor licensure laws to implement tiered licensure models

to move new professionals into practice swiftly, while providing supervision to help novice counselors navigate challenging situations that might impact the protection of the public.

The integration of opportunities for associate level licensees to operate an official, recognized Supervised Private Practice is an innovation that many states do not currently provide. This innovation may provide increased access to mental health services in rural communities that have not traditionally had active mental health agencies and the inclusion of the clear requirements for supervision ensures that this innovation is provided in ways that appropriately protect the public.

As with any effective regulation, we understand that, at times, to meet the necessary public protection intention, the regulation must be modified. In the case of *A.A.C. R4-6-217 B. 2 A. i.*, it is our understanding that a modification of the supervision requirement has been proposed, transitioning from 1 hour of supervision for every 20 hours of direct client contact to 1 hour of supervision for every 10 hours of direct client contact. The National Board for Certified Counselors supports this proposal.

Supervision for associate level private practice owners will help to prevent costly malpractice issues, billing problems, and compliance concerns and reduce the overall risk to the public. The proposed levels of supervision will ensure that the novice counselor has an experienced source of information and direction readily accessible, as they encounter complex, challenging client and business issues. It will also reassure the public that they are getting an appropriate, informed level of care, even though the counselor has limited professional experience as a newly licensed professional. Though, the opportunity for Associate level counselors to operate a Private Practice may not be typical for counseling, we do believe that with the revision of the requirement to be 1 hour of supervision for every 10 hours of direct client contact, associate level counselors will be able to operate safely and effectively.

We appreciate the opportunity for public comment on this proposed revision and we thank you for taking the time to consider the information we offered in this response. We know that the Council will carefully consider the proposed revision and we are hopeful that this needed modification of the requirements will be approved. If further information would be helpful or if I can be of assistance in any manner, please feel free to contact me at dotson-blake@nbcc.org.

Sincerely,

Kylie P. Dotson-Blake, PhD, NCC, LCMHC
President and CEO
NBCC, Inc. and Affiliates

ATTACHMENT

(4)

77 E. Columbus Avenue, Suite 202, Phoenix, AZ 85012
480.968.4595 » naswaz.com

NASW | ARIZONA CHAPTER
National Association of Social Workers

Tobi Zavala
Executive Director, Arizona Board of Behavioral Health Examiners
1740 W. Adams, Ste. 3600
Phoenix, AZ 85007

Dear Ms. Zavala:

Thank you for the opportunity to provide feedback regarding the proposed changes to supervision of candidates for associate level licensees in Arizona. The NASW Arizona chapter submits this letter to express its strong support for this proposed regulatory change by the Arizona Board of Behavioral Health Examiners, which we believe will protect the quality of care provided to Arizonans and strengthen the integrity of mental health professions. As you know from data provided by the Association of Social Work Boards' and the National Board for Certified Counselors (NBCC), a very select few states currently allow for supervised private practice at the associate level due to the elevated risk it poses to the public. We believe that the supervision requirements from 1 hour of supervision for every 20 hours of direct client contact to 1 hour of supervision for every 10 hours of direct client contact will strengthen our mental health workforce while also protect our most vulnerable populations.

The National Association of Social Workers (NASW) represents the largest group of professional social workers in the world. As the largest growing profession in our country with over 720,000 social workers nationwide, nearly 500,000 of those are clinical social workers. Arizona's social workers provide essential psychosocial services to individuals and families from all walks of life. Importantly, due to their education and training in psychotherapy based on the Person in the Environment (PIE) model, they are also uniquely qualified to provide mental health services to the most vulnerable.

Supervision is a crucial element in preparing mental health professionals, including social workers, for clinical practice. That is why all states require supervision and have numerous stipulations about the supervisor's qualifications, their setting, and the supervisory focus. Supervisors play a key role in ensuring that licensure candidates are developing the complex set of skills and competencies that independent, unsupervised practice requires. To be effective supervisors of social work licensure candidates, supervisors must possess first-hand experience – and ideally extensive experience – in the competencies which they are overseeing.

The NASW and the ASWB *Model Social Work Practice Act* states that "a specialty within the practice of Master's Level Social Work and requires the application of social work theory, knowledge, methods, ethics, and the professional use of self to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals, couples, families, groups, organizations and communities. The practice of Clinical Social Work requires the application of **specialized clinical knowledge and advanced clinical skills** in the areas of assessment, diagnosis and treatment of mental, emotional, and behavioral disorders, conditions, and addictions. Treatment methods include the provision of individual, marital, couple, family and group Counseling and Psychotherapy. The practice of Clinical Social Work may include Private Practice and the provision of Clinical Supervision." Given that those currently practicing privately at the associate level do not have the furthered specialize clinical knowledge and advanced clinical skills gained at that master level, we believe this rule change will help prevent costly malpractice disputes, compliance issues, billing and insurance fraud, but most importantly, it will reduce the overall risk to the clients these individuals serve.

This additional supervision enhances the social workers clinical resources, ensures accessible support from a trained expert, and will reassure the public that the level of care they are receiving is ethical, appropriate, and consistent with mental health best practices even though these social workers have limited professional experience as newly licensed professionals. As associate level private practice licensure is not typically best practice standards for social work, as evidenced by how few states currently have this model, we do believe that the requirement of 1 hour of supervision for every 10 hours of direct client contact, will ensure ethical social work practice with clients.

As always, we are committed to working constructively with the AZBBHE around the development and implementation of effective licensing policy for social work. Please let me know if you need further information.

Brandie Reiner

Brandie Reiner, MSW
Executive Director, NASW Arizona

ATTACHMENT

(5)

---------- Forwarded message ---------
From: **Lynn Linde** <llinde@counseling.org>
Date: Wed, Jul 5, 2023 at 2:34 PM
Subject: independent practice
To: Tobi Zavala <tobi.zavala@azbbhe.us>

Tobi,

Thank you for your question regarding the policies around independent practice. While I have not reviewed the regulations for all state/jurisdiction licensing boards, staff at the American Counseling Association is unaware of any state that allows counselors who have not completed two years of supervised experience to practice independently or own their own practice apart from Arizona. I also asked Jamie Doming, who is the chair of the Compact Commission and the board administrator in Louisiana if she had any knowledge of states that permit this type of practice, and she does not.

The prevailing thinking in the profession is that new counselors need two years of supervised experience, or the requisite number of hours, to gain the experience they need. Working in a group practice or with another counselor provides safeguards and accountability that is necessary for professional growth and protecting clients. Those safeguards are missing when the supervisor is not physically present or part of the practice.

The Advisory Group for the Counseling Compact reviewed current state statutes and research regarding licensure and concluded that only counselors who are licensed at the highest level and can practice independently should be allowed to be granted a privilege to practice under the Compact. These experts felt it was necessary to restrict the privilege to this group, and that counselors with less experience should not practice independently.

Experts in the field argue against allowing counselors with provisional licenses from setting up their own practice, despite supervision requirements. However, we recognize the right of Arizona to make its own decision.

Sincerely,

Lynn E. Linde

Dr. Lynn E. Linde | *Chief of Professional Practice*

American Counseling Association

Ph/Fx 703-212-22421 800-347-6647 x324

Facebook | Twitter | Linkedin | Instagram

ATTACHMENT

(6)

Renew
COUNSELING CENTER

July 14, 2023

To Whom It May Concern,

My name is Annette Stanley, and I am writing as the past petitioner before the AZBBHE in 2017 regarding licensure portability and supervised hours from the state of Kansas. In the process, I requested a change to the board rule concerning supervised private practice as at the time supervised private practice was disallowed in Arizona which prevented me from importing my supervised hours from Kansas. I am writing to show my support for the modification of the rules proposed for those working under supervision in a private practice setting. The primary issue for me was about portability when moving in from another state and following the rules for that state. I am aware of the ratios set forth in the proposed rule before the Board. I believe the ratios set forth in the initial rule making do not provide for adequate oversight to the Supervisee. It is very important that every newly licensed counselor on the heels of graduate school recognize and understand the need for continued learning and supervision. The practice of counseling in a private office setting (as opposed to an agency setting) has additional considerations for process and procedures to manage when a newly licensed counselor is still in the struggle to bring together all the learning from graduate school, internship experiences, and apply theory and skills into practice. There are a lot of business considerations and ethical responsibilities that can be a distraction from the counselor focusing on professional development and ethical caregiving leading to a need for additional oversight.

When I began supervised private practice in Kansas following graduation and initial licensure, the rules required me to have a Board approved supervision training plan and close monitoring of all activities undertaken as both a business owner and counselor. Two supervision meetings were required monthly with one of those required to be in an individual format. We were also required to maintain a minimum ratio of 1 supervision hour per 15 client hours, and our total hours of clinical supervision equaled 150, a third more hours than are presently required in Arizona. This represents a significant and valuable oversight of the counselor's development, and specifically in the private practice setting. Sure, acquiring supervision in this manner is costly, but supervision is an invaluable piece that should never be taken lightly as it also fosters learning for best practices and safety with the vulnerable populations we serve. In short, it seems very reasonable to me, in light of the lower number of currently required overall supervision hours prior to independent licensure approval that a Licensed Associate Counselor should be supervised more closely in private practice with smaller ratios than what the initial rule making sets forth.

Sincerely,

Annette E. Stanley MA, LPC

Annette E. Stanley, MA LPC
Owner/Clinical Supervisor

FAITH-INTEGRATED
COUNSELING
SERVICES

18185 N. 83RD AVE.
SUITE 209
GLENDALE, AZ 85308
(602) 633-4032

RESTORING THE BROKEN
REFRESHING THE HEART
RENEWING JOY

ATTACHMENT

(7)

STATE OF ARIZONA
BOARD OF BEHAVIORAL HEALTH EXAMINERS
1740 WEST ADAMS STREET, SUITE 3600
PHOENIX, AZ 85007
PHONE: 602.542.1882 FAX: 602.364.0890
Board Website: www.azbbhe.us
Email Address: information@azbbhe.us

DOUGLAS A. DUCEY
Governor

TOBI ZAVALA
Executive Director

BOARD OF BEHAVIORAL HEALTH EXAMINERS
MEETING MINUTES
May 13, 2022

Members Present: Kimberly Bailey, Robert Charles, Mary Coonrod, Cedric Davis, Patricia Dobratz, Leanette Henagan (out at 11:46 a.m., in at 1:44 p.m.), Polly Knape, Adalesa Meek, Diane Palacios, Antwan Trotter

Members Absent: Meaghan Kramer, Kasondra Parr

Staff Present: Mona Baskin, A.A.G., Tobi Zavala, Executive Director; Erin Yabu, Deputy Director; Jarett Carver, Investigations Manager

1. Call to Order
A meeting of the Arizona Board of Behavioral Health Examiners was called to order on May 13, 2022 at 9:04 a.m. with Ms. Dobratz presiding.

2. Roll Call
See above.

3. Minutes: review, consideration and action
A. March 11, 2022, general meeting minutes
Board members were replaced since the March 11, 2022 Board meeting; therefore, a quorum could not be reached to approve the minutes. The March 11, 2022 general meeting minutes were reviewed and considered by the Board and will be maintained as draft minutes.

4. Consent Agenda: review, consideration and action
A. Cases recommended for dismissal

1. *2022-0017, John Clarizio, LMSW-19527*
2. *2021-0178, Karen-Michelle Morrow, LPC-19637*

Following discussion, Mr. Davis moved, seconded by Ms. Bailey, to approve the consent agenda item 4(A). The motion passed unanimously.

B. Cases recommended for dismissal with a letter of concern.

1. *2021-0163, Jordan Helms, LCSW-19963*

Following discussion, Mr. Davis moved, seconded by Ms. Henagan, to approve the consent agenda item 4(B). The motion passed unanimously.

C. Cases recommended for release from consent agreements.

1. *2020-0111, Marian Eberly, LCSW-4127 active-restricted*
2. *2021-0013, Carol Farmer, LPC-18275 active-restricted*
3. *2019-0070, Rocio Fonseca, LPC-20071 active-restricted*

4. *2021-0051, Irene Jacobs, LPC-13643*
5. *2021-0146, Joshua Reish, LMFT-15553*
6. *2022-0003, Vincent Ruzzo, LPC-18481, LISAC-15112*
7. *2021-0038, Nancy Skocy, LPC-1851 active-restricted*

Following discussion, Mr. Davis moved, seconded by Mr. Trotter, to approve the consent agenda item 4(C). The motion passed unanimously.

D. Cases recommended for opening a complaint and acceptance of a proposed signed non-disciplinary consent agreement.

1. *Molly Badilla, LMSW Applicant*
2. *Sydney Gonzales, LMSW Applicant*
3. *Tessa Grooms, LBSW Applicant*
4. *Irvin Nunez, LAC Applicant*

Following discussion, Mr. Davis moved, seconded by Ms. Bailey, to approve the consent agenda item 4(D). The motion passed unanimously.

E. Cases recommended for opening a complaint and acceptance of a proposed signed disciplinary consent agreement.
N/A

F. Cases recommended for opening a complaint and dismissing with a letter of concern.
N/A

G. Cases recommended for acceptance of a proposed signed non-disciplinary consent agreement.

1. *2021-0180, Tanja Haaland, LPC-17307*
2. *2022-0022, Tanja Haaland, LPC-17307*
3. *2022-0071, 2022-0092, Derek Reece, LCSW-19743*

Following discussion, Mr. Davis moved, seconded by Mr. Trotter, to approve the consent agenda item 4(G). The motion passed unanimously.

H. Cases recommended for acceptance of a proposed signed disciplinary consent agreement. The Board will review, discuss, and may vote to take action on the following case(s).

1. *2022-0088, Basil Argento, LAC-20036*

Following discussion, Mr. Davis moved, seconded by Ms. Meek, to approve the consent agenda item 4(H). The motion passed unanimously.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X			X	X	X
NAY												
Absent								X	X			

5. **Administrative Hearings**
Administrative Hearing Pursuant to A.R.S. §§ 32-3281 and 41-1092.07, the Board will conduct administrative hearings or consider related procedural issues in the following matter(s). During the administrative hearing, the Board may go into executive session to discuss confidential records pursuant to A.R.S. § 38-431.03(A)(2) or to obtain legal advice pursuant to A.R.S. § 38- 431.03(A)(3).
N/A

6. **Formal Interviews**
N/A

7. **Complaints and other disciplinary matters: review, consideration and action**

A. 2022-0116, Daed Ayala Penaloza, LCSW-17129

Ms. Zavala summarized the Board's investigation.

The complainant was properly noticed, but failed to appear.

The professional appeared and addressed the Board.

Following review and discussion by members, Ms. Henagan moved, seconded by Ms. Bailey, to find the following violation:

- A.R.S. § 32-3251(16)(ii), violating any federal or state law, rule or regulation applicable to the practice of behavioral health, as it relates to
    - A.R.S. § 32-517.02, Duty to Warn

The motion passed unanimously. Ms. Meek recused.

Following further review, Ms. Henagan moved, seconded by Ms. Bailey, to offer a consent agreement that stipulates the following:

- The professional shall be placed on probation for 12 months
- The professional shall complete 6 clock hours each of pre-approved continuing education in:
    - NASW Staying Out of Trouble course or its pre-approved equivalent
    - Duty to warn and mandated reporting
    - Behavioral health ethics
- The professional shall receive clinical supervision monthly from a pre-approved independently licensed behavioral health professional
- Clinical supervision shall focus on duty to report, mandated reporting, and Arizona Statutes/Rules

and if not signed, to invite the professional to participate in a formal interview and, if not accepted, to remand the matter to a formal hearing. The motion passed unanimously. Ms. Meek recused.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X				X	X
NAY												
Absent								X	X	recused		

B. Santos Gonzales, LCSW-19185

Ms. Zavala summarized the background information.

The professional and her attorney, Joey Hamby, appeared and addressed the Board.

Following review and discussion by members, Ms. Henagan moved, seconded by Ms. Bailey, to open a complaint. The motion passed unanimously.

Following further review, Ms. Henagan moved, seconded by Ms. Bailey, to offer an interim consent agreement not to practice and if not signed, to remand the matter to a formal hearing. The motion passed unanimously.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X			X	X	X
NAY												
Absent								X	X			

C. 2022-0124, 2022-0125, Bethany Grismore, LAC-19211

Ms. Zavala summarized the signed proposed interim consent agreement.

The complainants were properly noticed, but failed to appear.

The professional was properly noticed, but failed to appear.

Following review and discussion by members, Mr. Trotter moved, seconded by Ms. Bailey, to accept the signed proposed interim consent agreement as presented. The motion passed unanimously.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X			X	X	X
NAY												
Absent								X	X			

D. 2022-0004, Cynthia Heath, LMFT-10073
Ms. Zavala summarized the signed proposed consent agreement.

The complainant appeared and addressed the Board.

The professional's attorney, Charles Hover, appeared telephonically and addressed the Board.

Following review and discussion by members, Mr. Charles moved, seconded by Ms. Bailey, to accept the signed proposed consent agreement as presented. The motion passed unanimously.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X			X	X	X
NAY												
Absent								X	X			

The Board took a break at 10:19 a.m., reconvening its public meeting at 10:32 a.m.

E. 2022-0013, Samuel Jean-Baptiste, LMSW-18185
Mr. Carver summarized the Board's investigation.

The complainant was properly noticed, but failed to appear.

The professional appeared and addressed the Board.

Following review and discussion, Ms. Bailey moved, seconded by Ms. Meek, to offer the professional a non-disciplinary consent agreement for completion of 6 clock hours each of pre-approved continuing education in:

- Behavioral health ethics and boundaries
- Sexual harassment
- Social media/technology
- Culture diversity
- Child and family systems

and if not signed, to invite the professional to participate in a formal interview and, if not accepted to remand the matter to a formal hearing. The motion carried with Mr. Davis and Mr. Trotter opposed. Ms. Henagan abstained.

F. 2021-0154, Har Khalsa, LCSW-11307
Ms. Zavala summarized the signed proposed consent agreement.

The complainant and his attorney, Andrew Rahtz, appeared and addressed the Board.

The professional's attorney, Charles Hover, appeared telephonically and addressed the Board.

Following review and discussion by members, Ms. Coonrod moved, seconded by Mr. Trotter, to accept the signed

proposed consent agreement as presented. The motion passed unanimously.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X			X	X	X
NAY												
Absent								X	X			

G. Jacquelyn Montrie, LMFT Applicant
Ms. Zavala summarized the background information.

The applicant appeared telephonically and addressed the Board.

Following review and discussion, Ms. Bailey moved, seconded by Mr. Davis, to deny the request to withdraw the application.

Following further review, Ms. Bailey moved, seconded by Ms. Henagan, to open a complaint. The motion passed unanimously.

Following discussion by members, Ms. Bailey moved, seconded by Mr. Davis, to find the following violations:

- A.R.S. § 32-3251(16)(l), engaging in any conduct, practice or condition that impairs the ability of the licensee to safely and competently practice the licensee's profession
- A.R.S. § 32-3251(16)(k), engaging in any conduct or practice that is contrary to recognized standards of ethics in the behavioral health profession or that constitutes a danger to the health, welfare or safety of a client as it relates to the following section of the AAMFT Code of Ethics:
    - 1.5 Sexual Intimacy with Former Clients and Others

Following further discussion, Ms. Bailey moved, seconded by Ms. Henagan, to deny the application based on a finding of unprofessional conduct pursuant to A.R.S. 32-3275(6). The motion passed unanimously.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X			X	X	X
NAY												
Absent								X	X			

H. 2022-0094, Pamela Opper, LCSW-12398
Ms. Zavala summarized the Board's investigation.

The complainant was properly noticed, but failed to appear.

The attorney was properly noticed, but failed to appear.

Following review and discussion by members, Ms. Henagan moved, seconded by Ms. Bailey, to dismiss the complaint. The motion passed unanimously.

Following further review, Ms. Henagan moved, seconded by Ms. Bailey, to open a complaint for the professional's supervisor, Susie Hallowell, for further investigation. The motion passed unanimously.

I. Debbie Ritterbush, LPC-14266
Ms. Zavala summarized the background information.

The professional appeared and addressed the Board.

Following review and discussion by members, Ms. Bailey moved, seconded by Ms. Coonrod, to open a complaint for further investigation. The motion passed unanimously.

J. 2021-0143, Patricia Turner, LMSW-18235
Ms. Zavala summarized the Board's investigation.

The complainant was properly noticed, but failed to appear.

The professional and her attorney, Sara Stark, appeared and addressed the Board.

Ms. Bailey moved, seconded by Mr. Trotter to go into Executive Session pursuant to A.R.S. § 38-431.03(A)(2) to review records exempt from public inspection. The motion passed unanimously and the Board went into executive session at 9:50 am, reconvening its public meeting at 10:03 am.

Following review and discussion, Ms. Bailey moved, seconded by Ms. Coonrod, to offer the professional a non-disciplinary consent agreement for completion of 6 clock hours of pre-approved continuing education in burnout, selfcare, and stress management, and if not signed, to invite the professional to participate in a formal interview and, if not accepted to remand the matter to a formal hearing. The motion passed unanimously.

K. 2021-0150, Tamera Van Berkel, LPC-18663
Mr. Carver summarized the Board's investigation.

The complainant appeared and addressed the Board.

The professional appeared telephonically and addressed the Board.

Following review and discussion by members, Mr. Davis moved, seconded by Ms. Bailey, to find the following violation:

- A.R.S. § 32-3251(16)(k), engaging in any conduct or practice that is contrary to recognized standards of ethics in the behavioral health profession or that constitutes a danger to the health, welfare or safety of a client as it relates to the following section of the ACA Code of Ethics:
    - D.1.G Employer Policies

The motion passed unanimously.

Following review and discussion by members, Mr. Davis moved, seconded by Ms. Henagan, to order the professional to get a comprehensive psychological evaluation with a pre-approved licensed Psychologist within 60 days, and if not completed, to remand the matter back to the Board. The motion passed unanimously.

L. 2022-0140, Kristen Vasosaust, LPC-20627
Ms. Zavala summarized the signed proposed consent agreement.

The complainant appeared and addressed the Board.

The professional was properly noticed, but failed to appear.

Following review and discussion by members, Ms. Bailey moved, seconded by Mr. Trotter, to accept the signed proposed consent agreement as presented. The motion passed unanimously.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X			X	X	X
NAY												
Absent								X	X			

M. 2022-0156, Jolene Wallace, LMSW-17318
Ms. Zavala summarized the signed proposed interim consent agreement.

The complainant was properly noticed, but failed to appear.

The professional appeared and addressed the Board.

Ms. Dobratz moved, seconded by Mr. Trotter to go into Executive Session pursuant to A.R.S. § 38-431.03(A)(3) to obtain legal advice. The motion passed unanimously and the Board went into executive session at 11:29 am, reconvening its public meeting at 11:48 am.

Following review and discussion by members, Ms. Bailey moved, seconded by Ms. Coonrod, to accept the signed proposed interim consent agreement. The motion carried with Ms. Trotter opposed. Ms. Henagan abstained.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X		X			X	X	
NAY												X
Absent						abstained		X	X			

The Board took a break at 11:51 a.m., reconvening its public meeting at 12:39 p.m.

8. Assistant Attorney General's Report: Mona Baskin, A.A.G.

N/A

9. Temporary licenses: review, consideration and action

N/A

10. Applications for licensure and educational programs: review, consideration and action

A. Review, consideration, and possible action regarding applications for licensure

Counseling

Ms. Dobratz moved, seconded by Ms. Coonrod to deny 6 applications based on a failure to pass the required examination, 6 applications based on a failure to take the required examination, 2 applications based on a failure to meet the minimum requirements, and 1 application based on a finding of unprofessional conduct. The motion passed unanimously.

Marriage and Family Therapy

Ms. Bailey moved, seconded by Ms. Henagan to deny 3 applications based on a failure to pass the required examination, 2 applications based on a failure to take the required examination, and 3 applications based on a failure to meet the minimum requirements. The motion passed unanimously.

Social Work

Ms. Henagan moved, seconded by Mr. Trotter, to deny 29 applications based on a failure to pass the required examination, 9 applications based on a failure to take the required examination, and 1 application based on a finding of unprofessional conduct. The motion passed unanimously.

Substance Abuse

Ms. Henagan moved, seconded by Ms. Bailey, to deny 1 application based on a failure to take the required examination and 1 application based on a failure to meet the minimum requirements. The motion passed unanimously.

B. Review, consideration, and possible action regarding applications for educational programs

N/A

11. Report from Chair

A. Summary of current events

No report.

12. Report from the Treasurer

A. Review, consideration, and possible action regarding February financial report

B. Review, consideration, and possible action regarding March financial report

C. Review, consideration, and possible action regarding April financial report

Following review and discussion by members, Mr. Davis moved, seconded by Mr. Trotter, to accept the February, March, and April financial reports as presented. The motion passed unanimously.

The Board took a break at 2:44 p.m., reconvening its public meeting at 2:50 p.m.

13. Report from the Executive Director and/or staff

A. Update on Board member status

Ms. Zavala welcomed new Board members, Ms. Palacios, Ms. Meek, and Ms. Knape, who provided introductions to the members.

B. Review, consideration, and possible action regarding August meeting date change

Following review and discussion by members, Mr. Trotter moved, seconded by Ms. Bailey, to change the date of the August Board meeting from the 12th to the 19th. The motion passed unanimously.

C. Discussion regarding quarterly newsletter

Ms. Zavala shared with members that beginning on July 1st, Board staff will be introducing a quarterly newsletter. It will include important updates, reminders, and other informational items that will be emailed to all licensees and posted on the website.

D. Update regarding the Association of Social Work Board's Board member training

Ms. Zavala, Mr. Trotter, and Ms. Henagan shared their experience at the training to be beneficial.

E. Update regarding the Association of Social Work Board's Educational Conference

Ms. Dobratz and Ms. Zavala shared their experience at the conference to be beneficial.

F. Review, consideration, and possible action regarding Board members' participation in the Center for Credentialing and Education conference

Following review and discussion by members, Mr. Trotter moved, seconded by Ms. Bailey, to approve Ms. Dobratz, Ms. Zavala, and Ms. Kramer's participation in the Center for Credentialing and Education conference. The motion passed unanimously.

G. *Update regarding Petition filed for rule R4-6-1106(B) pursuant to A.R.S. Section 41-1033(G)*

Ms. Zavala shared that the Petition filed for rule R4-6-1106(B) pursuant to A.R.S. Section 41-1033(G) was rejected by the Governor's Regulatory Review Council.

H. Discussion regarding Board elections

Ms. Zavala announced that the annual election of Board Officers, Chairperson and Secretary Treasurer, will take place in June. It was requested that questions regarding the roles and time commitments be directed through Ms. Zavala.

I. Discussion regarding supervised private practice and possible rule modifications

A discussion regarding supervised private practice took place, and the members determined that policy and rules need to reflect the following:

- Supervised private practices shall only be located in Arizona.
- Supervisee must be physically in Arizona providing services.
- Clinical supervisor shall:
    - Oversee entire practice.
    - Be physically located in Arizona while providing supervision.
    - Attest to each review that thorough and regular reviews of documentation are completed.
- Only one clinical supervisor shall be approved for each supervised private practice at any given time.
- One clinical supervisor shall not be approved for more than five supervised private practices at any given time.
- Onsite clinical supervision requirement:
    - No exemptions.
    - Physically, in-person at the supervised private practice location.
- Verification of Supervision report:
    - After two non-compliant reports, both the supervisor and supervisee shall be brought to the Board.
    - Reports shall be submitted within 2 weeks from the due date.
- Advertising, marketing, and practice materials:
    - Prior to approval, shall indicate that clients are not being accepted.
    - Upon approval, shall include supervised private practice notice and clinical supervisor information.

- Supervised private practice owner shall be sole owner and not hire others to work in practice.
- For future rule modification proposal:
    - 3 supervised private practice continuing education units shall be required.
    - Clinical supervisor shall acquire two-year independent licensure minimum in Arizona.
    - Supervisee and supervisor shall meet individually for one hour for every 10 hours of direct client contact provided.

A comprehensive memo summarizing the discussion will be sent to all supervised private practice participants and posted on the website.

J. *Discussion regarding Boardroom update*
Ms. Yabu provided an update regarding the pending project to upgrade the audio and video equipment in Boardroom C. Due to global supply chain delays, new equipment is on backorder until 2023.

K. Update on the Board's new database
Ms. Yabu provided an update regarding the new database. Work is currently underway with the contractor to build individual web portals for applicants, licensees, and requests from the public.

14. Request for extension of inactive status: review, consideration and action

A. Lisa Gielow, LMSW-17160 (inactive)
Following review and discussion by members, Mr. Trotter moved, seconded by Mr. Davis, to grant the request for extension of inactive status. The motion passed unanimously.

B. Joan Lisa, LAC-13962 (inactive)
Following review and discussion by members, Mr. Davis moved, seconded by Mr. Trotter, to grant the request for extension of inactive status. The motion passed unanimously.

15. Future agenda items
None.

16. Call for public comment
No one was present to respond to the call for public comment.

17. Establishment of future meeting date(s)
The next regular meeting is scheduled for Friday, June 10, 2022 at 9:00 a.m., at 1740 W. Adams St., Board Room C.

18. Adjournment
Mr. Trotter moved, seconded by Ms. Coonrod, to adjourn. The motion passed unanimously and the meeting was adjourned at 3:45 p.m.

Dr Cedric E Davis LCSW
Dr Cedric E Davis LCSW (Jun 18, 2022 11:14 PDT)
Cedric Davis
Secretary/Treasurer

Jun 18, 2022
Date

Gmail

Patricia Grant <patricia.grant@azdoa.gov>

Rulemaking for Title 4, Chapter 6

Tobi Zavala <tobi.zavala@azbbhe.us> Thu, Jun 29, 2023 at 2:15 PM
To: Patricia Grant <patricia.grant@azdoa.gov>
Cc: Erin Yabu <erin.yabu@azbbhe.us>

The data has not been collected which I confirmed with the national associations of both counseling and social work today. We would need to hire someone to gather the information or collect the data ourselves. With that being said, I would ask that you go ahead and send to the members without. Both national associations have indicated that they will be providing me with a letter stating that associate level licensees should not own and operate their own practice based on the limited oversight they would receive.

Additionally, the national association of social work practice act says that associate (LMSW) level licensees should not be in private practice.

Page 29, Section 306 https://www.aswb.org/wp-content/uploads/2020/12/Model-law-for-web.pdf

Tobi Zavala, Executive Director

she | *her* | *hers*

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ARIZONA BOARD OF BEHAVIORAL HEALTH EXAMINERS
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Patricia Grant <patricia.grant@azdoa.gov>

Rulemaking for Title 4, Chapter 6

Tobi Zavala <tobi.zavala@azbbhe.us> Wed, Jun 28, 2023 at 7:34 AM
To: Patricia Grant <patricia.grant@azdoa.gov>
Cc: Erin Yabu <erin.yabu@azbbhe.us>

Good morning,

I have prepared a historical glimpse on licensure as well as a response to the committee members request for statistics. Please let me know if I can further assist in this process. Additionally, Council Member Lashgari has requested a follow-up meeting. Is this permissible, and if so, may I reach out to other Council Members?

History

In 2004, the Arizona Board of Behavioral Health Examiners ("Board") was established. The Board has a two-tiered licensing process. The first tier requires supervision for an associate-level licensee. The purpose of the supervision is to not only protect the public but to support the associate's growth and development. Once supervision and direct client hours are acquired, a licensee can then apply for an independent-level license, allowing independent practice. This process can be compared to a medical doctor who graduates from medical school and has a residency prior to operating independently.

In 2019, the Board afforded the opportunity for independent practice at the associate level, allowing a licensee to own a private practice (supervised private practice or "SPP"). To ensure client's safety, stipulations included approved supervision over the SPP. Since 2019, the Board has been presented with a number of issues regarding those approved for SPP, specifically lending to the oversight under the current supervision requirements. In the consideration of the time a clinical supervisor needs to adequately review a SPP, which includes review of client documents and client modalities, it appears that more supervision is needed. This is the Board's attempt to continue to protect client safety.

On average, the Board has approximately 150 associate-level licensees in SPP out of over 16,000 licensees. This change would only impact approximately 1% of licensees. The Board recognizes this could be a significant increase in supervision costs; however, it is a significant risk to the clients of the state of Arizona without this added protection. Considering the extra cost, the Board has agreed to "legacy" the existing SPP participants so that they would not have the additional cost and their current business plans could remain intact. Additionally, SPP individuals are only in SPP on a temporary basis while they are acquiring hours to become independently licensed. It appears that the individuals who have concern with this change are current participants in SPP.

It is difficult to compare to other states, as they do not have the same SPP structure. There are other states that have this opportunity for associate-level licensees, and there are many states that do not allow this at all.

Request by Committee Members

During the Study Session, disciplinary action statistical data was requested, along with what was clinical in nature as opposed to documentation concerns. This Board's database system does not have the capability of pulling statistics with an SPP associate licenses distinction. Additionally, this Board typically does not take disciplinary action solely on documentation issues. Therefore, one can concur that any formal complaint was clinically related. Since the enactment of SPP, the Board has consistently seen an increase in concern with individuals at the associate level with regard to client care. Based on that, when staff engaged in rulemaking for other modifications, it was requested by Board members that the SPP issues be addressed.

I have attached the 2022 May Board Meeting Minutes as SPP was thoroughly discussed by the members, see agenda item #13 (I). This proactive change was made solely for the protection of the vulnerable population that our licensees serve. It was represented by Halina Brooke that there is a gap in this state for certain types of modality and populations served. I would agree that there are gaps in the mental health services in Arizona; however, I would solely disagree that the brand-new graduates, such as participants in SPP, are filling this gap. These services often come from veteran service providers who not only have the education, but the crucial experience.

I would also note that many insurance companies recognize the limitations in associate-level practice, and do not allow billing. This means that many SPP cannot bill through insurance and only accept out-of-pocket payment, excluding many of the most vulnerable who do not have insurance.

In addition to complaints, there has been ongoing correspondence that cannot be memorialized with statistics. It is our job to survey the current behavioral health environment and react accordingly to ensure that the public is properly protected. These are issues that do not rise to the level of formal discipline; however, they clearly demonstrate the need for change or the potential for risk. As a reminder, this impacts less than 1% of licensees on a temporary basis who choose this opportunity before independent licensure.

Tobi Zavala, Executive Director

she | *her* | *hers*

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May 13, 2022 Minutes.pdf
383K

Colorado	Licensed Social Worker	Colorado Revised Statutes 2020 Title 12 Professions and Occupations Article 245: Metal Health 12-245-213. Professional service corporations for the practice of psychology, social work, marriage and family therapy, professional counseling, and addiction counseling - definitions. (1) Licensees, registrants, or certificate holders may, but are not required to, form professional service corporations for the practice of psychology, social work, marriage and family therapy, professional counseling, psychotherapy, or addiction counseling under the "Colorado Business Corporation Act", articles 101 to 117 of title 7, if the corporations are organized and operated in accordance with this section. The articles of incorporation of a professional service corporation formed pursuant to this section must contain provisions complying with the following requirements: (a) The name of the corporation shall contain the words "professional company" or "professional corporation" or abbreviations thereof. (b) The corporation must be organized by licensees, registrants, or certificate holders for the purpose of conducting the practice of psychology, social work, marriage and family therapy, professional counseling, psychotherapy, or addiction counseling by the respective licensees, registrants, or certificate holders of those practices. The corporation may be organized with any other person, and any person may own shares in the corporation, if the following conditions are met: (II) The practice of social work, as defined in section 12-245-403, by the professional service corporation is performed by a licensed social worker acting independently or under the supervision of a person licensed pursuant to this article 245 or a licensed social worker. Any licensed social worker member of the professional service corporation remains individually responsible for his or her professional acts and conduct as provided elsewhere in this article 245.
Kansas	Licensed Master Social Worker	On-going supervision requirements: Post licensure supervision is required if in private practice or involved in the diagnosis and treatment of mental health disorders. KSBSRB Regulations 102-2-8. Supervision. (d) Supervision of persons engaged in private practice or persons seeking licensure as a specialist clinical social worker. (1) A licensed specialist clinical social worker shall supervise the practice or delivery of social work services by the following persons: (A) Any licensee who is attaining the two years of supervised experience required for licensure as a specialist clinical social worker; and (B) any licensee who is not a licensed specialist clinical social worker and who is engaged in private practice. KSBSRB Regulations 102-2-1a. Definitions. (v) Private, independent practice of social work means the unsupervised provision of social work services as a self-employed person, a member of a partnership, a member of a professional corporation, or a member of a group, and not as a salaried employee of a person or a public or private agency, organization, institution, or other entity. (aa) Social work supervision means a formal professional relationship between the supervisor and supervisee that promotes the development of responsibility, skill, knowledge, attitudes, and ethical standards in the practice of social work. (cc)(1) Under the direction means the formal relationship between the individual providing direction and the licensee in which both of the following conditions are met: (A) The directing individual provides the licensee, commensurate with the welfare of the client and the education, training, and experience of the licensee with the following: (i) Professional monitoring and oversight of the social work services provided by the licensee; (ii) regular and periodic evaluation of treatment provided to clients by the licensee; and (iii) verification that direction was provided to the licensee. (B) The licensee receiving direction provides the following to the board, with each license renewal: (i) The name, identifying information, and type of licensee of the directing individual;
New York	Licensed Master Social Worker	An LMSW may own and operate a practice where they provide services in the LMSW scope; it may not include clinical practice. New York policy statement (#6) http://www.op.nysed.gov/prof/sw/swpracfaqs.htm An LMSW who is registered to practice may form any legal business entity, including a private practice. The LMSW may provide any services defined as within the scope of practice of Licensed Master Social Work, so long as the licensee is competent. However, Education Law Section 7701 restricts Licensed Master Social Workers from providing clinical services in settings other than "facility settings or other supervised settings approved by the Department under supervision in accordance with the Commissioners Regulations." Accordingly, New York law does not allow an LMSW to establish a private practice or professional entity (e.g., professional corporation or professional limited liability partnership) for the purpose of providing "clinical social work services" since that is outside the LMSW scope of practice/authorization. An LMSW may establish a professional service corporation, professional limited liability corporation or professional limited liability partnership, subject to the requirements of the Education and the Business Corporation laws. Licensees should consult with an attorney or accountant to determine if the creation of a professional entity is appropriate. In most cases, the attorney will file an application with the Department of State and the Education Department must consent to the title and purpose of a professional entity. More information about establishing professional corporations is available on the Board's website.
Ohio	Licensed Social Worker	ORC 4757-21-02 Scope of practice for a social worker. Using the definition of social work as defined in division (C) of section 4757.01 of the Revised Code, the board adopts the following scope of practice for a social worker. Each social worker has a personal competency within the license's scope of practice, which is determined by their education, training and practice as defined within the board's ethics rules in paragraph (A) of rule 4757-5-02 of the Administrative Code. (A) A social worker may perform for a fee, salary, or other consideration, counseling and psychosocial interventions without supervision; and social psychotherapy under the supervision of an independent social worker, a professional clinical counselor, a psychologist, a psychiatrist, or a registered nurse with a master's degree in psychiatric nursing. (B) When practicing as an employee of a private individual, partnership, or group practice, a social worker may perform for a fee, salary, or other consideration, counseling, psychological interventions, and social psychotherapy only if supervised by an independent social worker, a clinical counselor, a psychologist, a psychiatrist or a registered nurse with a master's degree in psychiatric nursing. (C) A social worker may practice as an independent contractor. (D) The scope of practice for a social worker may include the following range of psychosocial duties: (1) Intervention planning; (2) Psychosocial intervention; (3) Counseling; (4) Social psychotherapy under supervision; and (5) Evaluation.

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DOUGLAS A. DUCEY
Governor

TOBI ZAVALA
Executive Director

BOARD OF BEHAVIORAL HEALTH EXAMINERS
MEETING MINUTES
May 13, 2022

Members Present: Kimberly Bailey, Robert Charles, Mary Coonrod, Cedric Davis, Patricia Dobratz, Leanette Henagan (out at 11:46 a.m., in at 1:44 p.m.), Polly Knape, Adalesa Meek, Diane Palacios, Antwan Trotter

Members Absent: Meaghan Kramer, Kasondra Parr

Staff Present: Mona Baskin, A.A.G., Tobi Zavala, Executive Director; Erin Yabu, Deputy Director; Jarett Carver, Investigations Manager

1. Call to Order

A meeting of the Arizona Board of Behavioral Health Examiners was called to order on May 13, 2022 at 9:04 a.m. with Ms. Dobratz presiding.

2. Roll Call

See above.

3. Minutes: review, consideration and action

A. March 11, 2022, general meeting minutes

Board members were replaced since the March 11, 2022 Board meeting; therefore, a quorum could not be reached to approve the minutes. The March 11, 2022 general meeting minutes were reviewed and considered by the Board and will be maintained as draft minutes.

4. Consent Agenda: review, consideration and action

A. Cases recommended for dismissal

1. 2022-0017, John Clarizio, LMSW-19527
2. 2021-0178, Karen-Michelle Morrow, LPC-19637

Following discussion, Mr. Davis moved, seconded by Ms. Bailey, to approve the consent agenda item 4(A). The motion passed unanimously.

B. Cases recommended for dismissal with a letter of concern.

1. 2021-0163, Jordan Helms, LCSW-19963

Following discussion, Mr. Davis moved, seconded by Ms. Henagan, to approve the consent agenda item 4(B). The motion passed unanimously.

C. Cases recommended for release from consent agreements.

1. 2020-0111, Marian Eberly, LCSW-4127 active-restricted
2. 2021-0013, Carol Farmer, LPC-18275 active-restricted
3. 2019-0070, Rocio Fonseca, LPC-20071 active-restricted

4. *2021-0051, Irene Jacobs, LPC-13643*
5. *2021-0146, Joshua Reish, LMFT-15553*
6. *2022-0003, Vincent Ruzzo, LPC-18481, LISAC-15112*
7. *2021-0038, Nancy Skocy, LPC-1851 active-restricted*

Following discussion, Mr. Davis moved, seconded by Mr. Trotter, to approve the consent agenda item 4(C). The motion passed unanimously.

D. Cases recommended for opening a complaint and acceptance of a proposed signed non-disciplinary consent agreement.

1. *Molly Badilla, LMSW Applicant*
2. *Sydney Gonzales, LMSW Applicant*
3. *Tessa Grooms, LBSW Applicant*
4. *Irvin Nunez, LAC Applicant*

Following discussion, Mr. Davis moved, seconded by Ms. Bailey, to approve the consent agenda item 4(D). The motion passed unanimously.

E. Cases recommended for opening a complaint and acceptance of a proposed signed disciplinary consent agreement.
N/A

F. Cases recommended for opening a complaint and dismissing with a letter of concern.
N/A

G. Cases recommended for acceptance of a proposed signed non-disciplinary consent agreement.

1. *2021-0180, Tanja Haaland, LPC-17307*
2. *2022-0022, Tanja Haaland, LPC-17307*
3. *2022-0071, 2022-0092, Derek Reece, LCSW-19743*

Following discussion, Mr. Davis moved, seconded by Mr. Trotter, to approve the consent agenda item 4(G). The motion passed unanimously.

H. Cases recommended for acceptance of a proposed signed disciplinary consent agreement. The Board will review, discuss, and may vote to take action on the following case(s).

1. *2022-0088, Basil Argento, LAC-20036*

Following discussion, Mr. Davis moved, seconded by Ms. Meek, to approve the consent agenda item 4(H). The motion passed unanimously.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X			X	X	X
NAY												
Absent								X	X			

5. <u>Administrative Hearings</u>

Administrative Hearing Pursuant to A.R.S. §§ 32-3281 and 41-1092.07, the Board will conduct administrative hearings or consider related procedural issues in the following matter(s). During the administrative hearing, the Board may go into executive session to discuss confidential records pursuant to A.R.S. § 38-431.03(A)(2) or to obtain legal advice pursuant to A.R.S. § 38- 431.03(A)(3).
N/A

6. <u>Formal Interviews</u>
N/A

7. Complaints and other disciplinary matters: review, consideration and action

A. 2022-0116, Daed Ayala Penaloza, LCSW-17129

Ms. Zavala summarized the Board's investigation.

The complainant was properly noticed, but failed to appear.

The professional appeared and addressed the Board.

Following review and discussion by members, Ms. Henagan moved, seconded by Ms. Bailey, to find the following violation:

- A.R.S. § 32-3251(16)(ii), violating any federal or state law, rule or regulation applicable to the practice of behavioral health, as it relates to
    - A.R.S. § 32-517.02, Duty to Warn

The motion passed unanimously. Ms. Meek recused.

Following further review, Ms. Henagan moved, seconded by Ms. Bailey, to offer a consent agreement that stipulates the following:

- The professional shall be placed on probation for 12 months
- The professional shall complete 6 clock hours each of pre-approved continuing education in:
    - NASW Staying Out of Trouble course or its pre-approved equivalent
    - Duty to warn and mandated reporting
    - Behavioral health ethics
- The professional shall receive clinical supervision monthly from a pre-approved independently licensed behavioral health professional
- Clinical supervision shall focus on duty to report, mandated reporting, and Arizona Statutes/Rules

and if not signed, to invite the professional to participate in a formal interview and, if not accepted, to remand the matter to a formal hearing. The motion passed unanimously. Ms. Meek recused.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X				X	X
NAY												
Absent								X	X	recused		

B. Santos Gonzales, LCSW-19185

Ms. Zavala summarized the background information.

The professional and her attorney, Joey Hamby, appeared and addressed the Board.

Following review and discussion by members, Ms. Henagan moved, seconded by Ms. Bailey, to open a complaint. The motion passed unanimously.

Following further review, Ms. Henagan moved, seconded by Ms. Bailey, to offer an interim consent agreement not to practice and if not signed, to remand the matter to a formal hearing. The motion passed unanimously.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X			X	X	X
NAY												
Absent								X	X			

C. 2022-0124, 2022-0125, Bethany Grismore, LAC-19211

Ms. Zavala summarized the signed proposed interim consent agreement.

The complainants were properly noticed, but failed to appear.

The professional was properly noticed, but failed to appear.

Following review and discussion by members, Mr. Trotter moved, seconded by Ms. Bailey, to accept the signed proposed interim consent agreement as presented. The motion passed unanimously.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X			X	X	X
NAY												
Absent								X	X			

D. 2022-0004, Cynthia Heath, LMFT-10073
Ms. Zavala summarized the signed proposed consent agreement.

The complainant appeared and addressed the Board.

The professional's attorney, Charles Hover, appeared telephonically and addressed the Board.

Following review and discussion by members, Mr. Charles moved, seconded by Ms. Bailey, to accept the signed proposed consent agreement as presented. The motion passed unanimously.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X			X	X	X
NAY												
Absent								X	X			

The Board took a break at 10:19 a.m., reconvening its public meeting at 10:32 a.m.

E. 2022-0013, Samuel Jean-Baptiste, LMSW-18185
Mr. Carver summarized the Board's investigation.

The complainant was properly noticed, but failed to appear.

The professional appeared and addressed the Board.

Following review and discussion, Ms. Bailey moved, seconded by Ms. Meek, to offer the professional a non-disciplinary consent agreement for completion of 6 clock hours each of pre-approved continuing education in:

- Behavioral health ethics and boundaries
- Sexual harassment
- Social media/technology
- Culture diversity
- Child and family systems

and if not signed, to invite the professional to participate in a formal interview and, if not accepted to remand the matter to a formal hearing. The motion carried with Mr. Davis and Mr. Trotter opposed. Ms. Henagan abstained.

F. 2021-0154, Har Khalsa, LCSW-11307
Ms. Zavala summarized the signed proposed consent agreement.

The complainant and his attorney, Andrew Rahtz, appeared and addressed the Board.

The professional's attorney, Charles Hover, appeared telephonically and addressed the Board.

Following review and discussion by members, Ms. Coonrod moved, seconded by Mr. Trotter, to accept the signed

proposed consent agreement as presented. The motion passed unanimously.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X			X	X	X
NAY												
Absent								X	X			

G. Jacquelyn Montrie, LMFT Applicant
Ms. Zavala summarized the background information.

The applicant appeared telephonically and addressed the Board.

Following review and discussion, Ms. Bailey moved, seconded by Mr. Davis, to deny the request to withdraw the application.

Following further review, Ms. Bailey moved, seconded by Ms. Henagan, to open a complaint. The motion passed unanimously.

Following discussion by members, Ms. Bailey moved, seconded by Mr. Davis, to find the following violations:

- A.R.S. § 32-3251(16)(l), engaging in any conduct, practice or condition that impairs the ability of the licensee to safely and competently practice the licensee's profession
- A.R.S. § 32-3251(16)(k), engaging in any conduct or practice that is contrary to recognized standards of ethics in the behavioral health profession or that constitutes a danger to the health, welfare or safety of a client as it relates to the following section of the AAMFT Code of Ethics:
    - 1.5 Sexual Intimacy with Former Clients and Others

Following further discussion, Ms. Bailey moved, seconded by Ms. Henagan, to deny the application based on a finding of unprofessional conduct pursuant to A.R.S. 32-3275(6). The motion passed unanimously.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X			X	X	X
NAY												
Absent								X	X			

H. 2022-0094, Pamela Opper, LCSW-12398
Ms. Zavala summarized the Board's investigation.

The complainant was properly noticed, but failed to appear.

The attorney was properly noticed, but failed to appear.

Following review and discussion by members, Ms. Henagan moved, seconded by Ms. Bailey, to dismiss the complaint. The motion passed unanimously.

Following further review, Ms. Henagan moved, seconded by Ms. Bailey, to open a complaint for the professional's supervisor, Susie Hallowell, for further investigation. The motion passed unanimously.

I. Debbie Ritterbush, LPC-14266
Ms. Zavala summarized the background information.

The professional appeared and addressed the Board.

Following review and discussion by members, Ms. Bailey moved, seconded by Ms. Coonrod, to open a complaint for further investigation. The motion passed unanimously.

J. 2021-0143, Patricia Turner, LMSW-18235
Ms. Zavala summarized the Board's investigation.

The complainant was properly noticed, but failed to appear.

The professional and her attorney, Sara Stark, appeared and addressed the Board.

Ms. Bailey moved, seconded by Mr. Trotter to go into Executive Session pursuant to A.R.S. § 38-431.03(A)(2) to review records exempt from public inspection. The motion passed unanimously and the Board went into executive session at 9:50 am, reconvening its public meeting at 10:03 am.

Following review and discussion, Ms. Bailey moved, seconded by Ms. Coonrod, to offer the professional a non-disciplinary consent agreement for completion of 6 clock hours of pre-approved continuing education in burnout, selfcare, and stress management, and if not signed, to invite the professional to participate in a formal interview and, if not accepted to remand the matter to a formal hearing. The motion passed unanimously.

K. 2021-0150, Tamera Van Berkel, LPC-18663
Mr. Carver summarized the Board's investigation.

The complainant appeared and addressed the Board.

The professional appeared telephonically and addressed the Board.

Following review and discussion by members, Mr. Davis moved, seconded by Ms. Bailey, to find the following violation:

- A.R.S. § 32-3251(16)(k), engaging in any conduct or practice that is contrary to recognized standards of ethics in the behavioral health profession or that constitutes a danger to the health, welfare or safety of a client as it relates to the following section of the ACA Code of Ethics:
    - D.1.G Employer Policies

The motion passed unanimously.

Following review and discussion by members, Mr. Davis moved, seconded by Ms. Henagan, to order the professional to get a comprehensive psychological evaluation with a pre-approved licensed Psychologist within 60 days, and if not completed, to remand the matter back to the Board. The motion passed unanimously.

L. 2022-0140, Kristen Vasosaust, LPC-20627
Ms. Zavala summarized the signed proposed consent agreement.

The complainant appeared and addressed the Board.

The professional was properly noticed, but failed to appear.

Following review and discussion by members, Ms. Bailey moved, seconded by Mr. Trotter, to accept the signed proposed consent agreement as presented. The motion passed unanimously.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X	X	X			X	X	X
NAY												
Absent								X	X			

M. 2022-0156, Jolene Wallace, LMSW-17318
Ms. Zavala summarized the signed proposed interim consent agreement.

The complainant was properly noticed, but failed to appear.

The professional appeared and addressed the Board.

Ms. Dobratz moved, seconded by Mr. Trotter to go into Executive Session pursuant to A.R.S. § 38-431.03(A)(3) to obtain legal advice. The motion passed unanimously and the Board went into executive session at 11:29 am, reconvening its public meeting at 11:48 am.

Following review and discussion by members, Ms. Bailey moved, seconded by Ms. Coonrod, to accept the signed proposed interim consent agreement. The motion carried with Ms. Trotter opposed. Ms. Henagan abstained.

	Kimberly Bailey	Robert Charles	Mary Coonrod	Cedric Davis	Patricia Dobratz	Leanette Henagan	Polly Knape	Meaghan Kramer	Kasondra Parr	Adalesa Meek	Diane Palacios	Antwan Trotter
AYE	X	X	X	X	X		X			X	X	
NAY												X
Absent						abstained		X	X			

The Board took a break at 11:51 a.m., reconvening its public meeting at 12:39 p.m.

8. Assistant Attorney General's Report: Mona Baskin, A.A.G.

N/A

9. Temporary licenses: review, consideration and action

N/A

10. Applications for licensure and educational programs: review, consideration and action

A. Review, consideration, and possible action regarding applications for licensure

Counseling

Ms. Dobratz moved, seconded by Ms. Coonrod to deny 6 applications based on a failure to pass the required examination, 6 applications based on a failure to take the required examination, 2 applications based on a failure to meet the minimum requirements, and 1 application based on a finding of unprofessional conduct. The motion passed unanimously.

Marriage and Family Therapy

Ms. Bailey moved, seconded by Ms. Henagan to deny 3 applications based on a failure to pass the required examination, 2 applications based on a failure to take the required examination, and 3 applications based on a failure to meet the minimum requirements. The motion passed unanimously.

Social Work

Ms. Henagan moved, seconded by Mr. Trotter, to deny 29 applications based on a failure to pass the required examination, 9 applications based on a failure to take the required examination, and 1 application based on a finding of unprofessional conduct. The motion passed unanimously.

Substance Abuse

Ms. Henagan moved, seconded by Ms. Bailey, to deny 1 application based on a failure to take the required examination and 1 application based on a failure to meet the minimum requirements. The motion passed unanimously.

B. Review, consideration, and possible action regarding applications for educational programs

N/A

11. Report from Chair

A. Summary of current events

No report.

12. Report from the Treasurer

A. Review, consideration, and possible action regarding February financial report

B. Review, consideration, and possible action regarding March financial report

C. Review, consideration, and possible action regarding April financial report

Following review and discussion by members, Mr. Davis moved, seconded by Mr. Trotter, to accept the February, March, and April financial reports as presented. The motion passed unanimously.

The Board took a break at 2:44 p.m., reconvening its public meeting at 2:50 p.m.

13. <u>Report from the Executive Director and/or staff</u>

A. Update on Board member status

Ms. Zavala welcomed new Board members, Ms. Palacios, Ms. Meek, and Ms. Knape, who provided introductions to the members.

B. Review, consideration, and possible action regarding August meeting date change

Following review and discussion by members, Mr. Trotter moved, seconded by Ms. Bailey, to change the date of the August Board meeting from the 12th to the 19th. The motion passed unanimously.

C. Discussion regarding quarterly newsletter

Ms. Zavala shared with members that beginning on July 1st, Board staff will be introducing a quarterly newsletter. It will include important updates, reminders, and other informational items that will be emailed to all licensees and posted on the website.

D. Update regarding the Association of Social Work Board's Board member training

Ms. Zavala, Mr. Trotter, and Ms. Henagan shared their experience at the training to be beneficial.

E. Update regarding the Association of Social Work Board's Educational Conference

Ms. Dobratz and Ms. Zavala shared their experience at the conference to be beneficial.

F. Review, consideration, and possible action regarding Board members' participation in the Center for Credentialing and Education conference

Following review and discussion by members, Mr. Trotter moved, seconded by Ms. Bailey, to approve Ms. Dobratz, Ms. Zavala, and Ms. Kramer's participation in the Center for Credentialing and Education conference. The motion passed unanimously.

G. *Update regarding Petition filed for rule R4-6-1106(B) pursuant to A.R.S. Section 41-1033(G)*

Ms. Zavala shared that the Petition filed for rule R4-6-1106(B) pursuant to A.R.S. Section 41-1033(G) was rejected by the Governor's Regulatory Review Council.

H. Discussion regarding Board elections

Ms. Zavala announced that the annual election of Board Officers, Chairperson and Secretary Treasurer, will take place in June. It was requested that questions regarding the roles and time commitments be directed through Ms. Zavala.

I. Discussion regarding supervised private practice and possible rule modifications

A discussion regarding supervised private practice took place, and the members determined that policy and rules need to reflect the following:

- Supervised private practices shall only be located in Arizona.
- Supervisee must be physically in Arizona providing services.
- Clinical supervisor shall:
    - Oversee entire practice.
    - Be physically located in Arizona while providing supervision.
    - Attest to each review that thorough and regular reviews of documentation are completed.
- Only one clinical supervisor shall be approved for each supervised private practice at any given time.
- One clinical supervisor shall not be approved for more than five supervised private practices at any given time.
- Onsite clinical supervision requirement:
    - No exemptions.
    - Physically, in-person at the supervised private practice location.
- Verification of Supervision report:
    - After two non-compliant reports, both the supervisor and supervisee shall be brought to the Board.
    - Reports shall be submitted within 2 weeks from the due date.
- Advertising, marketing, and practice materials:
    - Prior to approval, shall indicate that clients are not being accepted.
    - Upon approval, shall include supervised private practice notice and clinical supervisor information.

- Supervised private practice owner shall be sole owner and not hire others to work in practice.
- For future rule modification proposal:
    - 3 supervised private practice continuing education units shall be required.
    - Clinical supervisor shall acquire two-year independent licensure minimum in Arizona.
    - Supervisee and supervisor shall meet individually for one hour for every 10 hours of direct client contact provided.

A comprehensive memo summarizing the discussion will be sent to all supervised private practice participants and posted on the website.

J. *Discussion regarding Boardroom update*
Ms. Yabu provided an update regarding the pending project to upgrade the audio and video equipment in Boardroom C. Due to global supply chain delays, new equipment is on backorder until 2023.

K. Update on the Board's new database
Ms. Yabu provided an update regarding the new database. Work is currently underway with the contractor to build individual web portals for applicants, licensees, and requests from the public.

14. Request for extension of inactive status: review, consideration and action

A. Lisa Gielow, LMSW-17160 (inactive)
Following review and discussion by members, Mr. Trotter moved, seconded by Mr. Davis, to grant the request for extension of inactive status. The motion passed unanimously.

B. Joan Lisa, LAC-13962 (inactive)
Following review and discussion by members, Mr. Davis moved, seconded by Mr. Trotter, to grant the request for extension of inactive status. The motion passed unanimously.

15. Future agenda items
None.

16. Call for public comment
No one was present to respond to the call for public comment.

17. Establishment of future meeting date(s)
The next regular meeting is scheduled for Friday, June 10, 2022 at 9:00 a.m., at 1740 W. Adams St., Board Room C.

18. Adjournment
Mr. Trotter moved, seconded by Ms. Coonrod, to adjourn. The motion passed unanimously and the meeting was adjourned at 3:45 p.m.

Dr Cedric E Davis LCSW
Dr Cedric E Davis LCSW (Jun 18, 2022 11:14 PDT)

Cedric Davis
Secretary/Treasurer

Jun 18, 2022
Date

June 30, 2023

Sent electronically via email

Tobi Zavala
Executive Director, Arizona Board of Behavioral Health Examiners
1740 West Adams St. #3600
Phoenix, AZ 85007

Re. request for information on private practice by an LMSW / clinical associate licensees

Dear Tobi,

This letter follows up on your request for information regarding private practice by a licensed masters social worker (LMSW) / clinical associate licensee as you work to amend clinical supervision regulations.

As you know, ASWB is the nonprofit professional regulatory association whose members are comprised of the 64 social work regulatory authorities in the United States, Canada, and north American territories, including the Arizona Board of Behavioral Health Examiners. ASWB provides programs and services to regulatory boards in promoting uniformity and lessening burdens on state governments. Among its services, ASWB oversees the Model Social Work Practice Act (model law) reflecting best practice guidance for regulators and legislators and facilitating greater regulatory uniformity. First adopted in 1997, the model law is periodically reviewed and affirmed by ASWB member jurisdictions during its annual business meeting. ASWB also maintains a laws and regulations database on state and provinical social work regulatory requirements and policies in service to the regulatory community and the public. This information is compiled from research of jurisdiction statutes, regulations, and policies and from correspondence with regulatory entitites. In consulting both these resources, ASWB staff find that private practice by a clinical associate licensee is not suggested under the ASWB model law. Relevant portions of the model law follow on the next page, and information compiled from a review of state statues, regulations and policies is included in the Excel file shared with this letter.

ASWB Model Social Work Practice Act

A definition for private practice is provided in Section 109 of the model law. Private practice is exlicitly referenced in clinical scope of practice as defined in Section 106. By its very definition in the model law, private practice is restricted to licensed clinical social workers.

ASWB Model Social Work Practice Act

Section 109. Definitions.
(w) Private Practice means the provision of Clinical Social Work services ***by a licensed Clinical Social Worker*** *who assumes responsibility and accountability for the nature and quality of the services provided to the Client in exchange for direct payment or third-party reimbursement.*

Accountabiility
Section 106. Practice of Clinical Social Work.
The practice of Clinical Social Work is a specialty within the practice of Master's Social Work and requires the application of social work theory, knowledge, methods, ethics, and the professional use of self to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals, couples, families, groups, organizations and communities. The practice of Clinical Social Work requires the application of ***specialized clinical knowledge and advanced clinical skills*** *in the areas of assessment, diagnosis and treatment of mental, emotional, and behavioral disorders, conditions and addictions. Treatment methods include the provision of individual, marital, couple, family and group Counseling and Psychotherapy. The practice of Clinical Social Work may include Private Practice and the provision of Clinical Supervision.*

Research

ASWB staff periodically reviews all state and provincial jurisdiction statutes, regulations, and policies for topical areas maintained in the association's laws and regulations database. A comprehensive review for the regulation of scope of practice including private practice restrictions found that four of the 54 U.S. member jurisdictions permit private practice by a licensed masters social worker. This includes Colorado, Kansas, New York, and Ohio. However, in New York, the LMSW cannot perform activities restricted to the clinical scope of practice i.e., they cannot perform supervised clinical practice in a private practice setting. The states and the relevant provisions are included in the Excel file shared with this letter in a separate attachment.

I hope this information is helpful in your efforts to amend the clinical supervision regulations.

Sincerely,

Chief Executive Officer
Association of Social Work Boards

Gmail

Patricia Grant <patricia.grant@azdoa.gov>

Fwd: Concerns w/ BBHE Rulemaking on 7/5 GRRC Agenda!

1 message

Patricia Grant <patricia.grant@azdoa.gov> Wed, Jul 5, 2023 at 8:54 AM
To: Patricia Grant <patricia.grant@azdoa.gov>

---------- Forwarded message ---------
From: Alexis Susdorf <state48publicaffairs@gmail.com>
Date: Tuesday, July 4, 2023 at 10:52:18 AM UTC-7
Subject: Concerns w/ BBHE Rulemaking on 7/5 GRRC Agenda!
To: nicole.sornsin@azdoa.gov <nicole.sornsin@azdoa.gov>, grrccomments@azdoa.gov <grrccomments@azdoa.gov>

Members of GRRC,

On behalf of the Arizona Sensible Therapy Practices Coalition (ASTPC), we would like to reiterate our concerns on the Board of Behavioral Health rulemaking under GRRC consideration at the July 5th council meeting and respectfully request that the council decline this rulemaking.

As a reminder, ASTPC is a group of private practice owners and other interested parties in Arizona who seek to move Arizona's Counseling, Marriage and Family Therapy, and Clinical Social Work community forward in ways that advance transparency, accountability, and healthy functioning of the various paths of practice in Arizona so we can best serve the public and practice the professions for which we have such extensive training and passion. We do not believe the BBHE rulemaking under consideration is good policy for the points emphasized below:

1. The biggest professional issue with the rulemaking is the change of supervision hours for supervised private practice (SPP) provided from 1 supervision hour for every 20 hours of client service to 1 supervision hour for every 10 hours of client service. This change in supervision hour requirements comes with zero justification or reasoning. It was not modeled after other states and we are not seeing an increase in counselor malpractice that warrants the need for heightened supervision.

2.There is a massive financial aspect to future SPP providers and supervisors, which was not accurately conveyed in the Board rulemaking and adoption process. For future SPP providers, they will now have to pay double for supervision hours, which can be incredibly costly for these small business owners (one example given to me is a counselor that pays around $12,000 annually for supervision is now planning to pay around $24,000.) This is a huge financial impact for a small business owner.) In addition, supervisors have started to speak up that they will not be able to serve this new supervision requirement because it will mean less time in front of their clients. So, the effect will be SPP counselors providing less hours because they cannot obtain supervision hours, and in turn, squeeze SPP out of the market because they are not able to make a living in this model of service.

3. It is important to note that the current SPP are grandfathered in, meaning they are able to continue the 1:20 supervision ratio until they complete the required hours for full licensure. This "grandfather clause" was added late in the process after counselors spoke up. **So, our coalition members, and the others speaking out, do not stand the benefit either way. They are speaking up because it's the right thing for the profession, the clients, and the future workforce.**

4. The other issue we have continued to express is the lack of transparency and justification to BBHE members and the public through the rulemaking process. If you read the justification provided in the preamble of the rulemaking, nowhere does it mention this dramatic supervision hour change, and categorizes the rulemaking as merely legislation implementation (which this was not legislated) and a "cleanup and reorganization" of the rules. You have to look really closely at the shift in language, as the 20 to 10 number is covertly placed in the "reorganization." This lacks transparency and was a miscatogorization of the rulemaking.

The Arizona Sensible Therapy Practices Coalition appreciates the rich dialogue on this item at the GRRC work session last month. **We are committed to continued advancement and heightened accountability for the profession, but believe that the current rulemaking is not the appropriate policy to achieve this.** We hope for the opportunity to

work with BBHE over the next year to develop a new policy that improves the profession for all models of service and ultimately leads to the best outcomes for our community!

Thank you for your consideration!

Alexis
On behalf of the Arizona Sensible Therapy Practices Coalition

Alexis Susdorf

Owner, State48 Public Affairs

Phone: (480) 278-2973

Email: State48PublicAffairs@gmail.com

Website: https://state48publicaffairs.com/

January 12, 2023

Andrea Shirley
Empowered Resilience Counseling
4150 E Cannon Drive
Phoenix, AZ 85028

To Whom It May Concern:

I am writing in response to the proposed rule changes regarding the Supervised Practice option for completing the LAC to LPC Professional Counseling requirements. I would like to offer my general feedback, as well as speak to the specific impact on me as as professional.

First, I would like to validate that I understand there are legitimate concerns and potential needs for adjustments. My larger concern, however, is that the proposed solution might not resolve the identified issue or match what I understand to be the purpose of the licensure process. While I understand the inclination to increase supervision if there have been issues with trainees, I am concerned that the solution to implement more of the same process will not actually address concerns. More specifically, I would like to provide the following feedback/questions:

- What research has been implemented to understand the true nature of the problem and contributing factors, thus ensuring the solution meets the need?
- Are the issues identified specific to the supervised practice option? I am concerned that there could be issues regarding the supervision model as a whole across settings that increasing supervision of the same type in this setting only might not address. For multiple reasons, counselors in training do not have many avenues to address concerns without concern for their training and licensure. Some of these issues may be part of the reason that professionals are increasingly interested in other options, such as the supervised practice.
- Given the shortage of mental health workers, I have concern that increased barriers and decreased options could be detrimental to public access to care.
- I have concern that the changes could effectively eliminate options for training and becoming licensed, thus reducing the effectiveness of the model that was intended to improve service at a time during which the need is high. I would think that again, an unintended consequence could be fewer professionals entering the field, or fewer fully licensed professionals available to supervise those entering the field.
- Is there a way to propose a more balanced measure of responsibility and accountability in the rule changes for both the trainee and the supervisor? With all due respect, from an outward appearance, the bulk of the cost seems to fall on the person in training, while greatly providing financial benefit to the supervisors. I do not at all believe this is the intention, however, it does seem to be the outcome. My background and training in leadership would not indicate that holding a higher standard and consequence for those in training than those in leadership to be effective.

While my understanding of what precipitated the concerns generating the proposal is limited, here are some of my thoughts/suggestions that might address the identified concerns:

- Creating a method of assessing readiness for the supervised practice option rather than a sole focus on increased supervision as the solution. I would assume that the this skill would be a required aspect of supervision, and that this could be a very beneficial skill for the professional in training to acquire.
- Addressing issues of cost in some manner to create consistency across options and increase ability to meet supervision standards proposed.
- If this option is effectively eliminated, continuing to work to create options for accessibility to training to ensure a variety of services are available to the public and for trainees to pursue.

In addition to addressing my overarching concerns regarding the new rules proposal, I would also like to speak to the specific impact on myself as a professional. My reasons for choosing the supervised practice option seem relevant and are described below.

After being engaged in a professional capacity within community mental health settings for the 20 plus years of my career, and specific to this role for approximately two and a half years before starting the LAC process, I deliberately chose to take on the cost and liability of a supervised practice as was outlined. I was interested in ensuring a higher quality of supervision than I could receive in a setting in which individuals are frequently overwhelmed and overworked. I would like to add that, indeed, this has happened. Additional factors include an interest in gaining skill to meet the needs of the general population rather than specific populations, and to learn to establish a business practice that best meets practice standards.

Additionally, I have intentionally separated out one specific reason I have chosen the supervised practice option. I am an individual who lives with physical disabilities that are a result of an accident that occurred early in my adulthood. While I have been highly successful in this field, my long term goal has been to engage in a small private practice in which I could use my skills and training for the benefit of the community while also being able to sustain active employment throughout my lifetime. While this issue is highly personal, and I do not typically disclose this, I am assuming there are others with physical disabilities that will be impacted. I believe this is part of my professional responsibility and ethics to present this consideration.

In doing so, I would like to increase awareness that for a person who is living with physical disabilities, what can unintentionally be measured during a training and evaluation period in a community based setting is not the ability to provide quality and ethical care. Rather, the ability to survive a harsh and overwhelmed environment becomes the focus. For individuals such as myself, there is a risk of being evaluated on circumstances that do not actually measure my ability as a counselor, but instead measure my level of physical energy in what is well known to be a challenging environment. More succinctly, I chose this option as a means of creating a reasonable accommodation for myself, and to ensure that what I am seeking a license for is what is being evaluated. I would like to again emphasize that I have been successful in community based settings, and part of my work is currently in this type of setting. Due to these factors, I thought I may be able to use my voice on this matter effectively, without the concern of inadvertent bias that people living with disabilities may face.

Specific consequences of the rule change to me include but are not limited to the following:

1) The increase in supervision could be cost prohibitive. These costs include an inability to make a living wage comparable to my colleagues, a decreased ability to engage in quality professional training outside of supervision and thus increasingly limited to one professional perspective,

and a decreased ability to afford an office which would allow for in person assistance, which seems to also be a desired outcome now that the pandemic has become endemic.

2) I have been in practice for 2 years this month. I am serving some individuals who have been under my care long term and who will be significantly impacted by a sudden change in therapists as a result of referral if my practice closes.
3) I will be less apt to receive the opportunity to engage in the professional goal planning I have established over the course of last leg of this journey to ensure that I have learned and implemented best practice business aspects of private practice. This will leave me in a similar situation that I have witnessed many of my colleagues contend with when opening a practice and navigating issues specific to that type of environment, post supervision. I can't help but think that there are times that there are issues that arise later because there is not always a way to prepare and train for the business best practices aspect of counseling.

In summary, I would like to add that I would be interested, and willing, to be a part of creating solution. As a dedicated behavioral health professional for my entire lifetime, I am committed to my own growth, as well as growth and development in the field as a whole.

Thank you for taking the time to review my questions, concerns and feedback.

Sincerely

Andrea Shirley LAC

Gmail

BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

RULES FEEDBACK

1 message

Julia Poole <juliakpoole@gmail.com> Thu, Sep 15, 2022 at 11:50 AM
To: rulesfeedback@azbbhe.us

Hello,

I am writing to the board to advocate for additional policy under R4-6-212. Clinical Supervision Requirements. I think it is in the best interest of all parties involved, the Board, the associate licensed clinician, and the clinical supervisor, to require the clinical supervision verification form be completed and signed within 30 days of a clinical supervision contract being terminated. This helps ensure associate licensees receive accurate and timely verification of hours from their clinical supervisor and reduces the chances of lost communication, records, etc in situations involving multiple supervisors and varying lengths of time to complete supervision requirements.

While this may sound like best practice, in my experience as an associate clinician, it is not being required by our community mental health agencies and group practices due to it not being a Board requirement. I strongly believe if the Board required the documentation to be completed and provided to the associate within 30 days of the supervision contract being terminated, it would help streamline the application process and increase accountability for clinical supervisors to provide accurate, timely verification of hours.

Thank you for all that you do.

Julia Poole, LMSW

Gmail

Erin Yabu <erin.yabu@azbbhe.us>

Fwd: regarding proposed change to Board rule

1 message

Tobi Zavala <tobi.zavala@azbbhe.us> Mon, Dec 12, 2022 at 7:55 AM
To: Erin Yabu <erin.yabu@azbbhe.us>, BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Tobi Zavala, Executive Director

ARIZONA BOARD OF BEHAVIORAL HEALTH EXAMINERS
1740 W. Adams Street, Suite 3600, Phoenix, AZ 85007
Phone: 602-542-1617 Fax: 602-364-0890
Email: tobi.zavala@azbbhe.us
Board Website: www.azbbhe.us

---------- Forwarded message ---------
From: **Dana Vargas** <DanaV@sbhservices.org>
Date: Fri, Dec 9, 2022 at 8:13 AM
Subject: regarding proposed change to Board rule
To: Tobi Zavala <tobi.zavala@azbbhe.us>

Hello Tobi,

It is my understanding that the Board is proposing a change to Board rules regarding new LPCs having to wait 2 years before providing supervision to LACs. I would like to advise the Board, with all due respect, that I do not think this is a good idea.

I believe that making this change would detract from all parties involved, to include the LPCs, LACs, and even clients. In my experience, it took me about 4-6 months to get what I needed to provide supervision, and being able to do so has allowed me to continue my process of gathering knowledge, skills and abilities, as well as allowed me to share what I know and Board information with others. Your requirements to meet LPC are just that, and having met the criteria to be independently licensed also includes the

ability to start sharing that valuable knowledge with those at the LAC level so that they can best implement that into their practice and growth toward independent licensure. It allows recent knowledge and information to remain fresh and adds to the growth process for all involved. I believe this would take away from the learning and growing process for newly independent licensees as well as the so many associate level licensees that are needing valuable opportunities to enhance their knowledge, skills and abilities.

In light of this information, I respectfully request that LPCs be able to provide supervision after receiving their independent license and have the current training requirements met, is most beneficial for us as professionals as well as those clients with whom we work.

Thank you.

Dana Vargas, MS LPC BHP

Lead Therapist, In-Home Program

2345 W. Glendale Ave, Phoenix, AZ 85021

Cell (602) 359-0472

Fax (602) 254-3831

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Proposed Board Rules Clarification

Sheana Kupitz <sheanamkupitz@gmail.com> Fri, Dec 30, 2022 at 9:26 AM
To: BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Thank you for your response; I appreciate the opportunity to provide feedback! From my perspective, this rule is more negatively impactful than helpful to licensees, supervisors, and our system of care, as a whole. As someone who has been licensed (LMSW) with the Arizona board for 12 years, I have experience in both agency work and now private practice; both settings that will be disrupted by this revision.

From an agency perspective, retention is already a great challenge and in many instances the opportunity to take on a supervisory role to support the team after providing the necessary 24 months of direct client care is a welcome change that allows this individual (and the team) longevity and consistency. This in turn impacts the quality of care for the better, benefitting the clients served by these agencies. However, with this revision, many of these individuals who are newly independently licensed will not have the chance for these supervisory roles on the team, as the ability to receive supervision toward board licensure is a critical fixture of agency work. In turn, supervisory positions may go unfilled requiring more contracted supervisors, and whether these are contracted by individual licensees or by agencies this places additional burden on those in need of licensure and the agencies who employ them.

From a contracted therapist perspective, this is similarly impactful. Therapists who work for the required 24 months and attain an independent license do so in part to open up their opportunities to engage in the field, including the capacity to supervise and mentor others. By requiring another two years of licensure before allowing these licensees to expand their offerings to the community is of detriment to them, their career development, and may impact the availability of supervision for the board, as this reduces the number of supervisors available, overall.

Because supervision is deeply important to our system of care and the success of therapists working in our systems, I support the implementation of mechanisms by which we ensure quality of supervision. However, I think it's important to note that the success of a supervisor is not marked by years worked. I have met many supervisors who were inappropriate, clinically unsound, and ultimately unsuccessful with their teams after years and years of practice in the field, while conversely some of the best supervisors I've had the pleasure of knowing and working with were newly independently licensed, but committed to ethical practice, best practice techniques, and authentic support to their supervisees. It would be a shame to allow time served with a specific licensure level dictate who has the capacity to supervise and mentor our future therapists.

Finally, I use myself as a case in point. As noted above, I have been licensed with the AZBBHE for 12 years; however, my employment trajectory took me away from direct client care prior to my completion of the 24 months of service required to obtain my independent license. In this time (approximately 8/8.5 years), I was in supervisory and oversight roles. As a Clinical Supervisor, I developed and provided oversight to a case management team, as well as unlicensed and independently licensed clinicians. I was also utilized as a support to associate level licensed therapists; although, none were my direct reports, as I could not provide the board supervision they needed. As a Site Director, I was responsible

for the administrative and operational functions of clinics in both the East and West Valleys. In this role, I provided oversight to the Clinical Supervisor team and in conjunction with our Clinical Director, I was responsible for the clinical success of our clinics, as well as the financial and procedural health of our clinics. For the board to determine that my 12 years as a licensee in good standing with the board, coupled with my 8+ years of service in supervisory roles is not enough for me to be eligible to provide clinical supervision for the board upon receipt of my independent license (anticipated submission date: 02/28/23) feels discouraging, at best.

If there is concern about the supervisory capacities of those who are freshly independently licensed, I'd propose a more rigorous application process or an exemption process of sorts. Suggestions include:

- Additional training requirements about supervision for the first two years as a clinical supervisor for the board

- Required letters of recommendation (3) from those who can vouch for the supervisory ability of the newly independently licensed individual. These can be submitted by any license level/unlicensed individuals, as many times (specifically in agency work) those who most closely observe and work with a licensee in a supervisory capacity are associate level licensed, or unlicensed.

- A supervision requirement for new supervisors (perhaps six months or a year of oversight from a seasoned supervisor in good standing with the board).

It seems that if the goal is to ensure quality of supervision, monitoring the applications of those who want to supervise is far more valuable than depending on length of time in the field as a barometer for success in this capacity. Thank you for your consideration on this matter and thank you for your continued work to ensure the safe and successful practice of therapy in our state!

Sheana Kupitz, LMSW

480-452-4577
[Quoted text hidden]

Gmail

BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

feedback on proposed changes

Laura Fontaine <vivifywellness@gmail.com> Thu, Sep 1, 2022 at 1:25 PM
To: rulesfeedback@azbbhe.us

Hi,
I just wanted to give some feedback on a few of the proposed rule changes.

R4-6-217 (B) (2ai): One potentially controversial change that I noted was re: changing the amount of supervision for a supervised private practice from 1 hr of supervision/20 hrs of direct client contact to 1 hr of supervision /10 hrs of direct client contact. As a supervisor of LACs in private practice **I would be in favor of this**. I find that supervision time can get taken up with business/ethics of running the practice (insurance issues, appropriate coding of sessions, how to do superbills, reviewing Board rules, etc). Also for some LACs attempting to go into private practice very soon after graduation and getting their associate license they don't have the clinical skills yet to effectively treat clients in a solitary environment.

R4-6-217 (D) (4): proposing supervisors take 3 hours of supervision specific to supervising private practices. In theory I understand and would be ok with this change. However, I have scoured numerous continuing education sources and have not found a single one offering a CE course specific to supervising a private practice. I have checked: APA, ACA, AZ Trauma Institute, CE4LEss, Quantum Units, Clinical Best Practices Institute, Udemy, The Knowledge Tree, CE-Classes.com, Professional Psych Seminars, Continuing Ed Courses.net, PESI, Good Therapy, Steve Frankle Group, and Envision Services. I found trainings on running a private practice, growing your private practice, marketing a private practice, creating a group practice, etc in addition to various ones on supervision methods and supervision with various populations. Not one had a course specific to supervising a private practice. Unless the Board is going to create a training for this or provide the names of sources that *do* offer this, I think it is unreasonable that after checking 15 resources I was unable to find something that would meet this requirement and yet this rule would require me to find it somewhere or my ability to supervise would be jeopardized despite checking with 15 potential sources for CEUs. **Because of this I am NOT in favor of this rule change.**

R4-6-802 (C) (1c): proposing adding 3 hours of continuing ed specific to telehealth practice. **I am in favor of that change** with telehealth being so prevalent and here to stay.

R4-6-1106 (D) (2): proposing that a client's local emergency contact's address be documented in the record and on progress notes when providing telehealth. To me this does not seem necessary. If I am reaching out to an emergency contact, I don't need their address. I need a phone number. I can't imagine sending emergency services to the emergency contact person for my client. I would need my client's address, not their emergency contact. Also, when I am in session with a client, I don't have their progress note in front of me. I would still need to go back into their records so recording any of the emergency contact's information does not feel necessary to me because that is not what I would be referencing if I needed to contact this person. It feels especially unnecessary to obtain the emergency contact's address because I won't be sending help to the emergency contact and having it in the note does not actually help me at all if I do need to contact the emergency contact person. **For these reasons I am not in favor of this change.**

Thank you,
Laura Fontaine, MS, LISAC, LPC
she/her
EMDRIA Certified EMDR Therapist and Approved Consultant
Vivify Wellness
2345 S. Alma School Rd, #105
Mesa, AZ 85210
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Gmail

BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Feedback on Supervised Private Practice Proposed Rules

Erin Stone <erin.stone09@gmail.com> Fri, Aug 26, 2022 at 11:08 AM
To: rulesfeedback@azbbhe.us

Hello,
I wanted to provide some feedback on the proposed rule to provide one hour of supervision/meeting individually for every 10 hours of direct client contact.

I believe this rule is being proposed to impede and dissuade associate clinicians from opening a private practice. For someone who is looking to build their practice and see 25 - 30 clients per week, it is highly unlikely that any clinical supervisor has the availability to provide 3 hours of clinical supervision per week. That is asking for 12 meetings per month for someone who is looking to have a full caseload in order to make a living and sustain their practice. I see this as a barrier and a rule put in place to make this type of venture impossible, versus trying to help individuals obtain their license and support small business owners while still being adequately supervised as the current rule stands. We would have no associate clinicians owning their own private practice if this rule were to be put in place.

I would also like to propose that the supervised private practice owner (the licensed supervisee) be allowed to employ and provide clinical oversight to other licensees. Currently, in other settings and agencies, an associate clinician can be the highest clinical person and provide clinical oversight to others *as long as they have a supervisor who they report to*. In a supervised private practice scenario, the associate clinician employed by the private practice owner would be reporting to someone (the private practice owner), and there are checks and balances with the private practice owner having requirements to meet with their own clinical supervisor as specified in the rules. Potentially, an alternative requirement could be that associate clinicians employed by licensed supervisees be required to meet with a clinical supervisor for clinical supervision at least once for every 80 hours of direct client contact hours.

Thank you for your consideration,
Erin Stone

Arizona Board of Behavioral Health Examiners
1740 W. Adams St., Suite 3600, Phoenix, AZ 85007

FEEDBACK FORM

Board Fax: (602) 364-0890 **Email Address:** information@azbbhe.us

Please complete the following to provide feedback to the Arizona Board of Behavioral Health Examiners. Forms may be mailed, faxed or emailed to the contact information below.

My feedback is in reference to:

☐ Licensure ☐ Renewal ☐ Investigations

☐ Board staff/meetings ■ Board rules/statutes ☐ Other

Details: Hi, I am not sure if you are still accepting feedback for the proposed rule that those in Supervised Private Practice would need 1 supervision hour for every 10 hours of clients. I really believe that is a bit of overkill and is very taxing on the Supervisee. If you did 30 hours a week you would need 3 hours in that same week? That doesn't seem to make sense. It appears that this rule is to dissuade SPP, but if it is something that is allowed, we should not be putting barriers to being successful at it. Either allow SPP or don't. I know there are new therapists who might need more supervision and shouldn't be in private practice, but some of us have been practicing for years and this rule does not make sense whatsoever.

Do you wish to be contacted by Board staff? ■ Yes ☐ No

CONTACT INFORMATION: (*optional unless you wish to be contacted*)

Name: Troy Stone

Address:

City, State, Zip:

Preferred phone: (504) 939-1386

Preferred email: troystone12@gmail.com

Thank you for taking time to provide feedback to the Board. Please submit completed form by:

- Email to: information@azbbhe.us
- Fax to: (602) 364-0890
- Mail/deliver to: Arizona Board of Behavioral Health Examiners
  1740 W. Adams St., Suite 3600
  Phoenix, AZ 85007

Gmail

BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Feedback on proposed changes to supervised private practice

Vic Meadow <vic@faygelehcounseling.com> Tue, Dec 20, 2022 at 9:16 AM
To: rulesfeedback@azbbhe.us

To whom it may concern,

I'm writing to express my strong disagreement with the proposed rule change for supervised private practice that doubles the amount of required supervision from once every twenty hours to once every ten hours. This doubles the financial burden on new therapists who are often already struggling to make ends meet at a time when therapists are overburdened with increased client demand. The impact on associate level clinicians was not discussed in these proposed rule changes, which risk closing our practices. Most agencies and group practices in town that hire associate level clinicians pay very low rates, or pay a salary while mandating extremely high case loads. Supervised private practice allows new clinicians to make a living wage while having agency over the size of their case load. These proposed changes hugely increase the financial burden on associate level clinicians and threaten our ability to keep our practices open.
Thank you for your consideration,

Vic Meadow, LAC
(they/them)
520-955-6941 (text)
faygelehcounseling.com

Gmail

BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

SPP Changes

EJ Millstone <emillstone@gmail.com> Tue, Dec 20, 2022 at 9:59 AM
To: rulesfeedback@azbbhe.us

Hi there,

I'm writing as a supervising clinician. I would like to oppose the rule change that LACs in supervised private practice will be required to receive supervision every 10 hours of client contact.

This puts an undue financial burden on new clinicians trying to make a living seeing clients. Between increasing office rents, fees for telehealth, and low payment from clinics and competition from more seasoned therapists, I fear this will turn new therapists away from the field. Specifically, therapists who serve underserved populations such as BIPOC, trans and queer folk.

In the current climate, I am constantly turning away new clients who need counseling but cannot find an available clinician. Further burdening new LACs with costs will continue to shrink the availability of clinicians in Arizona, something we are already dearly struggling with.

Please reconsider requiring more supervision hours for these badly needed clinicians.

Thank you,

EJ Millstone, LPC CDWF (she/her)
Licensed Professional Counselor

520-241-1950

emillstone@movetowardgood.com

www.movetowardgood.com

4625 E. Broadway #119, Tucson, AZ 85711

Gmail BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Rules Feedback

Shelly Thome <shelly@getfocuscounseling.com> Thu, Dec 22, 2022 at 11:04 AM
To: "rulesfeedback@azbbhe.us" <rulesfeedback@azbbhe.us>

Good Morning,

Thank you for the opportunity to provide feedback on the proposed rulemaking changes. Though I can appreciate that language and guidelines must be updated regularly, I find that certain subpopulations of clinicians are having rules selectively enforced upon them as compared to other clinician groups.

Supervised Private Practice

Of particular concern is the increased frequency of supervision only for those in supervised private practice. If the new rules pass, supervision must occur once every 10 rather than 20 hours of direct client work. This creates a substantial change in the financial burden not identified under the economic impact statement for both the supervisee and supervisor.

- This creates a financial burden to the supervisee in doubling their supervision expense
- This creates a further financial impact when the supervisee also experiences a loss of income for the session times during which they can no longer see clients while attending supervision instead.
- Supervisors must also remove client sessions in order to accommodate this increased frequency of supervising individuals
- This can also cause undue barriers to many people obtaining a qualified supervisor who:
- Can accommodate this frequency in their practice schedule
    - Qualify under the new education requirements.

What is the initial and then the ongoing cost to the supervisor to attain and maintain the new education credentials?
A potential unintended consequence may be supervisors raising their rates significantly to provide supervision under all of the above conditions.

It does not feel as if individuals in agency roles are being asked to receive such high levels of supervision and incur the additional financial burden, as compared to those in supervised private practice (1 hour per month regardless of the number of direct client hours vs 1 hour every 10 direct client hours). If the overall focus is on client welfare, why are these supervision requirements not aligned across all restricted license therapists?

Is there data on Board complaints that necessitates these proposed changes to supervised private practice, or is it an impression that those in supervised private practice require more support? Wouldn't it be more appropriate to require a certain level of experience prior to opening a supervised private practice (much like the requirement that a clinical supervisor must have 2 years post unrestricted license)?

Telehealth

How might one demonstrate competency, and what are the criteria for this (R4-6-1106 (A) (2)?
How does an individual or organization provide evidence acceptable to the Board that the licensee does not practice behavioral health by telehealth (R4-6-802 (C) (c)?

- Do they sign a document to attest to this, or is there an additional burden of evidence to be provided?
- What are the acceptable trainings?

Again, I appreciate and respect rules that are created to protect client welfare and to assure that we are positive representations of our profession. However, selectively enforcing rules on certain populations within the profession creates equity concerns.

Thank you for considering the feedback prior to decisions on the proposed rulemaking.

Shelly

Shelly Thome, LPC, CCTP, CCTSI, CTMH
Owner and CEO
Focus Counseling
602-649-4040
www.getfocuscounseling.com

For Additional Assistance, in case of an emergency:
Warm line: 602-347-1100
Crisis line: 602-222-9444
Suicide Prevention: 988
Crisis: 911

RULES FEEDBACK

Joan Rapine <joan.rapine@pascuayaqui-nsn.gov> Thu, Dec 22, 2022 at 12:09 PM
To: BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Oh I really appreciate you asking (forgot about the whole public thing….

I'm comfortable with adding this:

There are trans/LGBTQ+ clinicians who don't fit into the agencies currently operating in Tucson, making it difficult for them to gain experience and appropriate supervision at an agency. In such cases supervised private practice might be their best way to gain experience and supervision. Doubling the supervision requirements adds financial stress, especially for clinicians with a full caseload (and in cases when supervisors' charges are high). Although money is not a main consideration, I believe it is important to keep in mind.

[Quoted text hidden]

Gmail BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Financial Impact of Board Rulemaking Changes

Pallavi Lal <gobeyondpotential@gmail.com> Fri, Dec 30, 2022 at 1:02 PM
To: erin.yabu@azbbhe.us, rulesfeedback@azbbhe.us

Good Afternoon Deputy Director Yabu,

I hope that you are having a prosperous Holiday Season.

I wanted to offer some feedback regarding the recent proposed changes for those in Supervised Private Practice.

As an owner of a SPP in Arizona, I am very much concerned about the additional financial and economic impact these new rules may have on my business, work/life balance as well as the continuing interests or availability of Supervisors willing to offer Supervision.

Aside from the increased financial investment on doubling my expenses for Supervision on a weekly basis; additional concerns arise regarding loss of income to allow for required Supervision. This directly reduces my availability for clients in my work week thus limiting my ability to serve a population in much need of Mental Health Services.

Furthermore, increasing practice hours during the work week to offset increased costs of Supervision and the overhead expenses of a Small Business, could lead to a decreased work/life balance; mimicking compassion fatigue and burnout as experienced by many colleagues in Community Mental Health Settings.

Other direct impacts as a result of increased Supervision requirements would decrease time with family, limited availability for Continuing education or Specialized Clinical Trainings, investing additional time in accumulating Direct hours towards my independent licensure. All these factors mitigate the efficacy and efficiency as Practitioners in SPP while we work towards adhering to a completely separate set of rules than our counterparts in Community Mental Health Settings or Fully Independent Private Practices.

This proposed shift in Supervision requirements can potentially cause adverse financial impact as Supervisors may also increase their rates for Supervision to compensate for loss of availability for Clients on their personal caseload and to adhere to additional Continuing Education requirements proposed.

While I understand that these Rules are in place to protect the general population and ensure ethical and moral guidelines are being maintained by ANY practicing Clinician under the umbrella of the AZBBHE; I wonder if effort invested would be more advantageous to ensure that Clinicians in SPP are set up for success through proper education and compliance with business practices prior to getting approved for SPP. In doing so, Clinicians are vetted to maintain high standards of practice from the beginning rather than adjusting practice policies and guidelines with limited notice from the Governing Board. Additionally, it is important to note that NO other LAC's or Supervisors in various practice settings whether Community Mental Health, Independently Licensed Private Practices or Fully Licensed Clinicians are required to adhere to these strict guidelines.

To state, "The Board believes most of the rulemaking will have minimal economic impact because it makes no substantive changes other than those required to be consistent with statute." is not conclusive nor sensitive to the needs of the professionals directly impacted by these changes: Supervisees in SPP and their Supervisors.

I thank you for your time and hope that the intended Rulemaking takes into consideration the financial and emotional duress this may have on those operating under the guidelines of Supervised Private Practice.

Be Inspired,

Pallavi Lal, MS, LAC
Mental Health Therapist
DBT, EMDR, Trauma
Expanding Horizons Counseling, LLC: Discover Your Authentic Self
480-359-6126
Like on FB: Be Still Everyday, Expanding Horizons Counseling
Please enjoy this Yoga Nidra practice: https://youtu.be/-PxNLFJ91Io.

For Additional Assistance, in case of an emergency:
Warm line: 602-347-1100
Crisis line: 602-222-9444
Suicide Prevention: 800-273-8255

January 13, 2023

Supervised Private Practice Reflections and Contributions for Rulemaking Discussion

- **Whereas:** Supervised Private Practice (SPP) Owners have elucidated the alarming impacts on the proposed supervision ratio change to our businesses, our clients, and our ability to maintain compliance. *And so too, SPP owners have thus brought awareness to the Board of these facts' discordance with the Rulemaking Filing's assertion that no such impacts will occur.*
- **Whereas:** SPP owners have become aware of the workload increase on Board Staff as related to regulating our practices and we share their desire to streamline the process and make compliance and regulation easier without compromising either accountability or compliance.
- **Whereas:** SPP owners understand and agree with the Board that we need and deserve strong learning opportunities, support, and connection throughout our careers, but especially now as associates. *In fact, it's what we see as the biggest asset of SPP over agency/group practice!*
- **Whereas:** We agree with the need to raise the bar for those struggling but know it can be done without handicapping those of us actively learning and growing as clinicians in this space.

We humbly and collaboratively propose the Board take the following actions:

TODAY

1. Strike the ratio change, in full, from the proposed rulemaking for 2022 to both avail themselves of SPP owners' insight, labor, data, and collaboration and to save the rest of this session's rulemaking from scrutiny at the GRRC (as our coalition will not pursue public dissent if the ratio change is stricken).

THIS YEAR

2. Consider shifting SPP from a supervision requirement rooted in variable metrics like direct contact hours to a fixed metric like the Gregorian (modern) Calendar. Consider, perhaps, that SPPs registered as part-time be required three (3) hours of supervision per month and SPPs registered as full-time be required five (5) hours of supervision per month. This contrasts with full-time associates in agency or group practice being required to have one (1) hour of supervision per month in order to count their hours. ****If an SPP grows from part-time to full time, they would of course increase their supervision.*
3. Consider shifting SPP site visits from variable metrics like "every 60 days" (which sets out different interval start/stop dates for every registered SPP owner) to a fixed, calendar-based model that would set the same date ranges for every SPP the Board is regulating. We propose one site visit per calendar/fiscal quarter, which would serve to create a uniform set of dates and deadlines for the Board and increase compliance by way of enhanced clarity and uniformity.
4. Consider measures for SPP that raise the bar for those struggling *without* restricting those who excel from doing their best work…as opposed to regulatory measures that aim to support those struggling but which stifle those who thrive. *Our biggest common trait as SPP owners is that we LOVE learning and want to be our best for this work and service—please believe and remember that.*
5. Explicitly create space for SPP owners to share our insights, experiences, and ideas as policymaking and regulation move forward. We have demonstrated that we have the insight, data, lived experience, values and orientation toward stewarding our field forward that is urgently needed in our professional climate.

Halina Brooke, MS, LAC, LAMFT
On behalf of the Arizona Coalition for Sensible Therapy Practices

Gmail

BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

feedback about proposed rule for supervised private practice

Awakening Peace <awakeningpeace@gmail.com> Tue, Jan 3, 2023 at 12:34 PM
To: "rulesfeedback@azbbhe.us" <rulesfeedback@azbbhe.us>

Hello,

I would like to give feedback regarding the proposed rule change for doubling the amount of supervision that associate therapists need to have to do supervised private practice. I know this is controversial but I support this change. I am concerned about inexperienced therapists being in their own solo private practices with very little oversight. I am an LPC and a supervisor in a group practice and have been for the past 8 years. We have had interns and associates leave to go start their private practice. They are typically people who are struggling with our policies and with relationships with other supervisors. This is concerning that they are able to go off on their own so as not to have as much oversight. I was in solo private practice as an independently licensed person and even then I was missing the support and guidance that comes from being in a group or agency. I think associates should be encouraged to work in agencies or groups while they are developing their clinical skills. Or if not, then they should have more supervision than is even required in these group settings. So again, I support the proposed rule that would increase the supervision requirement for associates in private practice.

Thank you,

RULES FEEDBACK

Rachel Bentley <pathbuilders@icloud.com> Mon, Aug 29, 2022 at 2:38 PM
To: rulesfeedback@azbbhe.us

While telehealth is convenient and may have some financial savings to both Clinician and Client, it is important to assess if long-term telehealth adequately serves the clinical needs of the client (e.g., accurate assessment, diagnosis, treatment) when a client and Clinician have never met face-to-face.

Respectfully,
Rachel Bentley, LMFT

Sent from my iPhone

Gmail

BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

RULES FEEDBACK

Michele Chinichian <micheleroya@gmail.com> Fri, Dec 23, 2022 at 5:35 PM
To: rulesfeedback@azbbhe.us

Hi, I would love to see more flexiblity for tele-health. The world is changing, more clients are becoming nomads as tehy have the flexiblity to work from anywhere in the world, yet could still benefit from consistent support. Families that live in numerous states spread out still want to do family therapy via tele-health but finding a therapist licensed in 4 states is challenging. More flexibility of these rules would greater serve client needs and better accommodate these changing times.

I appreciate your consideration,

Michele Chinichian, LCSW
Phone: (480) 409-2915

Gmail

BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

RULES FEEDBACK

kkruse.mft <kkruse.mft@gmail.com> Mon, Nov 21, 2022 at 11:46 AM
To: rulesfeedback@azbbhe.us

Hello,

In reading over the proposed changes for telehealth, it appears that the board is proposing that mfts will only be allowed to provide teleheath to clients over a span of 90 days. Is this correct? I think this would be highly detrimental to so many clients who are unable to access or have difficulty accessing in person services. I work with clients who live in very remote places in AZ, as well as clients whose demanding schedules would make it quite difficult to attend in person therapy. I am concerned about what would happen to them if they had to terminate telehealth services after 90 days.

Kimberly Kruse

Sent from my T-Mobile 5G Device

Gmail

BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Question

Darya Windsofchangecounseling.com <darya@windsofchangecounseling.com> Wed, Aug 24, 2022 at 9:02 PM

To: "rulesfeedback@azbbhe.us" <rulesfeedback@azbbhe.us>

To whom it may concern,

I just wanted to get a little bit of clarification on the proposed rule changes regarding Telehealth.

I am a Telehealth provider considering a move to Washington, and would like to retain my Arizona license and continue to see my Arizona clients. Am I to understand that under these proposed rule changes, if I continue to operate out of AZ and have an AZ designated receiver of certified mail/legal paperwork that I would register to be an out of state provider if I am myself out of state, despite my business being registered in AZ?

Furthermore, with this proposed change, am I to read that if I myself don't physically live in AZ I can only provide 90 days worth of services, despite registration? Does this sound accurate?

Please advise,

- Darya McClure MAS-MFT LMFT

Gmail BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Feedback

Lisa Menard <elizabethamenard@gmail.com> Thu, Aug 25, 2022 at 5:48 PM
To: "rulesfeedback@azbbhe.us" <rulesfeedback@azbbhe.us>

Hello,

I am writing to provide feedback on the telehealth section of the 2022 rules. The section that is concerning to me is as follows:

Under A.R.S. § 32-3271(A)(2), an individual shall not provide counseling, social work, marriage and family therapy, or substance abuse counseling by telehealth to a client located in Arizona for more than ninety days. The individual providing behavioral health services under A.R.S. § 32-3271(A)(2) by telehealth to a client in Arizona shall ensure the 90 days are consecutive and occur in one calendar year.

The way I am reading this rule sounds like there will be a limit on telehealth. My practice is 100% telehealth and I plan to keep it this way. I have found telehealth to be highly effective and significantly more convenient and accessible to my clients. I cannot think of any legitimate reason to limit this important service for clients and implore you to reconsider this limitation.

Thank you for giving me the opportunity to share my feedback.

Elizabeth Menard

Gmail

BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

RULES FEEDBACK

Elizabeth Diamond <drlibbydiamond@gmail.com> Thu, Aug 25, 2022 at 7:38 PM
To: rulesfeedback@azbbhe.us

Hello,

I just learned about the proposed rule for limiting telehealth to 90 consecutive days. This is very limiting to many who need and want to receive mental health care. Of course there are risks, but there are also important ways we can minimize those risks.

The advancements in telehealth have really improved people's access to care for those in rural areas, those with kids and limited childcare, and financial barriers to finding an in person provider. I can't understand why the board would want to decrease access by taking this away.

Thank you for your time in reading my concerns.

Libby Diamond, PhD, LMFT📱

RULES FEEDBACK

Kathryn Freeman <kathrynfreeman66@yahoo.com> Thu, Aug 25, 2022 at 8:56 PM
To: rulesfeedback@azbbhe.us

I am a LOC and I currently operate a fully remote counseling practice with contracted employees. This rule would take away my livelihood and affect the people working for me. Being able to offer services virtually is a benefit to the community and to counselors as well. This rule would be unfair and limit access to care to many people in need.

Thank You,
Kathryn

RULES FEEDBACK

Darcy Machado <machadotherapyandwellness@gmail.com> Thu, Aug 25, 2022 at 6:21 PM
To: rulesfeedback@azbbhe.us

Hello my name is Darcy Machado I'm an LCSW licensed and practicing telehealth in Arizona. I was made aware of the proposed changes in in October and would like some clarification on this proposed change:

"Under A.R.S. § 32-3271(A)(2), an individual shall not provide counseling, social work, marriage and family therapy, or substance abuse counseling by telehealth to a client located in Arizona for more than ninety days. The individual providing behavioral health services under A.R.S. § 32-3271(A)(2) by telehealth to a client in Arizona shall ensure the 90 days are consecutive and occur in one calendar year."

To clarify is the proposed change that therapists would no longer be able to see clients for more then 90 days via telehealth? As someone who works solely via telehealth this is extremely concerning to me. If this is the proposed change, I hope the Board has taken time consider how closing/ minimizing access to therapy negatively impacts clients that otherwise would not receive services. I look forward to your clarification.

Gmail

BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

RULES FEEDBACK

Minon Maier <minon.maier@me.com> Tue, Aug 30, 2022 at 10:14 PM
To: rulesfeedback@azbbhe.us

Regarding Proposed rule for Telehealth: Under A.R.S. § 32-3271(A)(2), an individual shall not provide counseling, social work, marriage and family therapy, or substance abuse counseling by telehealth to a client located in Arizona for more than ninety days. The individual providing behavioral health services under A.R.S. § 32-3271(A)(2) by telehealth to a client in Arizona shall ensure the 90 days are consecutive an

Limiting the time of Telehealth for clients is not clinically appropriate for all clients. Due to the ongoing pandemic, there are clients that cannot meet in person due to health risks.

Can there be exemptions for clients that require virtual appointments due to health concerns, ongoing pandemic, lack of transportation/resources, client preference or other reasons?

We continue to see the ripple effects of the pandemic on client's mental and emotional health. Limiting therapists and clients to only 90 days of Telehealth will cause lack of clinical care for clients in a variety of situations. It should be an ongoing option for all therapists and clients, along with ongoing assessment for clinical appropriateness of Telehealth.

The pandemic has shown that there are clients that do better clinical work when meeting remotely, in the safety/comfort of their home. I have found that clients feel more comfortable going deeper into their emotions when they are not in the therapy room. The other aspect to consider is an exemption for college-aged clients that have a strong therapeutic rapport but can only meet virtually due to attending college in Arizona with no method of realistic transportation to the therapist. Starting over with a new therapist that is closer to the college due to an in person mandate will be more damaging to the client's treatment than allowing the therapist and client to meet virtually.

Minon Maier
480.650.4835

Gmail

BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

feedback on the proposed rules for behavioral health examiners

Anna Odell <anna_odell@alumni.brown.edu> Tue, Sep 6, 2022 at 3:48 PM
To: rulesfeedback@azbbhe.us

To the Board of Behavioral Health Examiners in Arizona,

My name is Anna Odell. I moved to Flagstaff, Arizona Fall of 2021 from Austin, Texas. I want to comment on the proposed change in section R46-6-1106, Part B, which concerns how many days a patient in Arizona can receive mental health counseling via Telehealth. According to the 90 day rule, which was in effect in 2021 and 2022, I have been able to maintain my regular meetings with my social worker in Texas once a week. If the proposed change in which the 90 days that I can receive this health care has to be consecutive, I will only be able to have access to my long-term therapist for three months out of the year. This mental health care that I receive, and being able to maintain that care from my long-term provider, is non-negotiable for me. If this new alteration to the rules in section R46-6-1106, Part B goes into effect, I would be forced to leave Arizona and move to another state where I can still receive Telehealth with my current provider.

As a constituent of Arizona, I strongly suggest not implementing a 90 day **consecutive** day restriction on Telehealth.

Thank you for your time,

Anna Odell

--
Anna Odell
Brown University '20
Bachelor's of Science in Environmental Sciences
(512) 590-3624

Gmail

BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Feedback

Sophia Fleming <sophia@ihcounselingservice.com> Fri, Sep 9, 2022 at 11:35 AM
To: rulesfeedback@azbbhe.us

Hello,

I would like to offer my feedback regarding the following proposed change:

"Under A.R.S. § 32-3271(A)(2), an individual shall not provide counseling, social work, marriage and family therapy, or substance abuse counseling by telehealth to a client located in Arizona for more than ninety days. The individual providing behavioral health services under A.R.S. § 32-3271(A)(2) by telehealth to a client in Arizona shall ensure the 90 days are consecutive and occur in one calendar year"

My business is 100% telehealth, and I know I am not the only one. I am very careful who I take on as a telehealth client. My clients prefer telehealth and it supports work life balance for those who I treat. Please DO NOT accept this policy if this is meant for all Arizona licensed providers.

Thank you for your time and consideration.

Sophia Fleming, LCSW, SEP
Psychotherapist
Somatic Experiencing Practitioner
Integrative Healing Counseling Service, PLLC
www.ihcounselingservice.com
623-277-0228

Gmail BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Feedback/Questions on 2022 Proposed Rules

Kimberly Mahr <kimberly@bestdamnyou.com> Fri, Sep 9, 2022 at 12:57 PM
To: rulesfeedback@azbbhe.us

Hi!

I have some questions and concerns about one of the proposed changes on the table for the October RULEMAKING meeting(s).

R4-6-1106-B: "Under A.R.S. § 32-3271(A)(2), an individual shall not provide counseling, social work, marriage and family therapy, or substance abuse counseling by telehealth to a client located in Arizona for more than ninety days. The individual providing behavioral health services under A.R.S. § 32-3271(A)(2) by telehealth to a client in Arizona shall ensure the 90 days are consecutive and occur in one calendar year. "

1. Is this directed at providers who do not reside/work/practice within AZ state or who are not licensed to practice in AZ.... or is it also directed at licensed AZ providers who operate in AZ?

2. Is the limit 90 days PER year? Or does it allow 90 days consecutive, then a break, and then another 90 days consecutive?

I would like to understand *the objective* behind this rule. Many of us (who are licensed and operating in AZ) have been using telehealth as an extremely effective and safe modality to reach Arizona clients who live in remote, underserved areas as well as those who have limitations to mobility or access to in-person care within a specialty. To set limits on responsibly practicing telehealth providers is not acceptable.

I welcome any clarifications you may have, as well as request that my concerns be noted in the upcoming meeting(s) in October.

Thank you!
Kimberly

Kimberly

Gmail

BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Telehealth Rulemaking Proposal

Ryan Schulz <rmschulz1983@hotmail.com> Tue, Sep 13, 2022 at 9:06 PM
To: "rulesfeedback@azbbhe.us" <rulesfeedback@azbbhe.us>

Hello:

For the 2022 proposed rule making for telehealth, I would like to make a suggestion for the following proposed rule:

R4-6-1106.

B. Under A.R.S. § 32-3271(A)(2), an individual shall not provide counseling, social work, marriage and family therapy, or substance abuse counseling by telehealth to a client located in Arizona for more than ninety days. The individual providing behavioral health services under A.R.S. § 32-3271(A)(2) by telehealth to a client in Arizona shall ensure the 90 days are consecutive and occur in one calendar year.

Can it be clarified that this rule only applies to individuals who are not licensed in Arizona?

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BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Feedback

jbilliard@selahcounseling.net <jbilliard@selahcounseling.net> Sat, Dec 17, 2022 at 2:19 PM
To: "rulesfeedback@azbbhe.us" <rulesfeedback@azbbhe.us>

Proposed Rule Change for A.R.S. § 32-3271(A)(2)

I am writing to discuss the proposed rule change for Telehealth appts to not last more than 90 days. I am an elderly white female, that when first moved to Telehealth appointments during the pandemic, I was the first to say that it wouldn't work and that we couldn't effectively do the work that we do through an online platform.

However, since then I have maintained a hybrid of both Telehealth and in person clients. For my telehealth clients, it has really been a way that I can provide services to individuals that might not have transportation, are geographically remote and unable to find a provider in their area, or have either physical or emotional diagnosis that interfere with their ability to obtain counseling otherwise.

I am concerned that this limitation to services will limit vulnerable populations to obtain/maintain ongoing behavioral health services.

Jenny Billiard, LCSW
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BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Clarification for consents

Dedra Serafin <dedra.serafin@mindpath.com> Sun, Dec 18, 2022 at 1:38 AM
To: "rulesfeedback@azbbhe.us" <rulesfeedback@azbbhe.us>

In the upcoming rules 2022, I would like to suggest that if an agency uses an electronic means for consents and tx plan signatures and reviews these too should be allowed ***even if not on telehealth***.

MINDPATH Health has gone to an all-electronic consent format for all intakes and reviews, screenings, etc. *Wet signatures* will only be available for those without computer access and/or portal access.

If not possible, it will increase "paper copying costs and not automatically uploaded to the EMR but will need to be uploaded by a staff person causing increase risk for human error.

If that is already written allowing the suggestion above, then could I suggest a **rewrite** because **I didn't understand what it meant.**

A.R.S. § 32-3271(A)(2): 2. A person **who is *not a resident of this state*** if the person:

(a) Performs behavioral health services in this state ***for not more than ninety*** *days in any one calendar year* as prescribed by board rule.

(b) Is authorized to perform these services pursuant to the laws of the state or country in which the person resides or pursuant to the laws of a federally recognized tribe.

(c) **Informs the client of the limited nature of these services and that the person is not licensed in this state.**
Question: What if they are licensed but do not live in the state??

Dedra Serafin, RN, LPC, NCC

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Gmail BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

2022 Rulemaking Comment and Question

Michael A. Morton <mmorton2012@gmail.com> Mon, Dec 19, 2022 at 8:38 AM
To: BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us>

Dear Erin,

Thank you for you prompt response.

Yes! The clarification you are proposing re: NOT licensed in AZ makes since and I support it.

Also, you might want to review the last sentence of that proposed rule as it is not very clear.

My best to you this Holiday Season.

Respectfully, Michael Morton

Michael A. Morton
8850 North Treasure Mountain Drive
Tucson, AZ 85742-8414
505-270-2547

On Mon, Dec 19, 2022 at 8:24 AM BEHAVIORAL HEALTH - Rules Feedback <rulesfeedback@azbbhe.us> wrote:

> Mr. Morton,
>
> I just left you a message regarding your feedback. In summary, the proposed telehealth rule only applies to those who are NOT licensed in Arizona. We will be proposing modified language to ensure clarity.
>
> If this does not answer your questions, please let us know and we can go from there.
>
> Thanks,
> *Erin Yabu*
> Deputy Director
>
> Image result for az state seal
>
> **STATE OF ARIZONA**
> **BOARD OF BEHAVIORAL HEALTH EXAMINERS**
> 1740 W. Adams Street, Suite 3600, Phoenix, AZ 85007
> Phone: 602-542-1811 Fax: 602-364-0890
> Email: erin.yabu@azbbhe.us
> Board Website: www.azbbhe.us
>
>

On Fri, Dec 16, 2022 at 12:34 PM Michael A. Morton <mmorton2012@gmail.com> wrote:

> Hello,
>
> I am writing to voice my concern over the following proposed additions to the "Rules for 2022: R4-6-1106, Telehealth : Section B": (Bold/Underline my emphasis):
>
> "Under A.R.S. § 32-3271(A)(2), an individual **shall not** provide counseling, social work, marriage and family therapy, or substance abuse counseling by telehealth to a client located in Arizona **for more than ninety days**. The individual providing behavioral health services under A.R.S. § 32-3271(A)(2) by telehealth to a client in Arizona shall ensure the 90 days are consecutive and occur in one calendar year."
>
> **MY CONCERNS**
>
> 1. I can find no evidence-based research that justifies a limit to the number of 'days' , (or, the number of telehealth treatment sessions) if those 'days' or sessions are clinically appropriate.
>
> 2. Regarding: **"....**to a client in Arizona shall ensure the 90 days are consecutive and occur in one calendar year.": **I have no idea what that means.**
>
> 3. Please see *"Exploring the Efficacy of Telehealth for Family Therapy Through Systematic, Meta-analytic, and Qualitative Evidence"* at the end of my email that actually makes the case for Telehealth as a stand-alone intervention equal to or even better

than in-person therapy in some cases, including for individuals and families that had previously done in-person sessions. I offer the follow excerpts from this very well designed study for your consideration:

This systematic review and meta-analysis provides evidence that family-based therapy delivered via TH improves relational and mental health outcomes for family, parent, and child measures. Effects were equivalent to in-person delivery of interventions for many outcomes. In no studies included in the review were outcomes from TH found to be inferior to in-person delivery. These findings are preliminary, and should be interpreted in light of their limitations, including the small number of studies reviewed. Only 20 studies met inclusion criteria, a considerably smaller pool of research than has been examined for individual TH therapies.

Views about the suitability of cases for TH family therapy were congruent with those made in in-person work. No blanket contraindications for the use of TH were identified for this setting. As per in-person work, contraindications included imminent family violence risks and current severe disturbance in personal functioning with cognitive, neurological, or psychiatric origins that render participation unsafe or otherwise unhelpful for any participant. As with in-person consultation, such impairments may delay the timing of the intervention rather than presenting a blanket contradiction. An example of this may be presenting as drug affected on the day of an appointment.

Various therapeutic experiences and access/uptake issues were improved with the transition to TH delivery. Some felt that TH offered an improved ability for therapists to emphasize and align with others' experiences due to the equal visual presentation of faces on the screen. In this, being able to see one's own responses on the screen had potential benefits. Self-direction associated with use of TH also offered families a greater sense of ownership in their therapeutic process.

Some felt that TH promoted better equity in access and uptake. At the geographical level, there are benefits of TH for those living in remote areas. At the individual level, TH can better suit those with certain disabilities or preferences for interaction online.

We found congruence between the core practice and process elements of family therapy across in-person and TH modalities. Some unique benefits of practicing via TH were observed. Necessary accommodations made to therapeutic work with TH predominantly pertained to process rather than content changes, including the need to plan ahead for possible management of risk.

This study examined the efficacy and optimization of TH-delivered family therapy from multiple perspectives, aiming to inform future use of TH for family and systemic practice. The first study found that content from existing guideline documents was heavily weighted to operational rather than therapeutic aspects of therapy delivery. We identified a significant gap in information for practitioners to guide therapeutic adjustments that may be required when working with families over digital mediums, and especially with children. Study Two examined evidence for efficacy of TH in improving outcomes for families. Although the available literature was limited in volume, consistent results emerged. Meta-analyses demonstrated improvements in child behaviour problems for family therapy with equivalency between TH and in-person delivery from pre-to-post intervention and to follow-up. Relative to treatment as usual, internet resources, or wait-list control conditions for child behaviour problems, TH family therapy had superior improvement rates, pre- to post-intervention. Similarly, for family-oriented treatment of parental depression, meta-analyses showed that improvements were superior in TH relative to in-person delivery for pre- to post-intervention and to follow-up. Narrative review of individual studies excluded from meta-analyses found that TH delivery was equivalent to in-person delivery for a range of family, parent, and child outcomes, and frequently superior to minimal intervention control conditions. In the final study, qualitative analysis of one-on-one interviews with experienced family therapists found that core processes and practices of family therapy could be preserved in the online modality. Adaptations to delivery of therapy in TH were primarily process rather than content related. Taken together, the findings of these three studies provide considerable support for ongoing delivery of family therapy via TH.

Recommendations

The findings of these three studies provide considerable support for ongoing delivery of family therapy via TH. In this light we offer recommendations for further optimization of TH practice in family therapy contexts.

1. Progression in Guidelines

    a. Our evidence suggests a need for advanced clinical guidelines for enhanced engagement and therapeutic alliance. Guidelines offered by peak therapy and regulatory bodies would include but move beyond operational factors regarding the practical administration of TH delivery of services, to include critical points of difference in assessment, engagement and therapeutic alliance over TH media, for adults, and for children.
    b. Beyond the expectation for assessment of suitability, articulation of specific criteria for assessing the appropriateness of TH are needed. These are multi-factored, and range from operational constraints, to safety risks, to clinically based cautions and contraindications.

2. Enablers of Telehealth practice

    a. Further work is needed to address technology and access constraints to overcome obstacles that would otherwise preclude some families from TH services, including access for clients to software and necessary equipment, basic training in their use, and support for trouble-shooting.
    b. Similarly, evolving technologies may better enable the use of core family therapy techniques within TH services, for example, reflective teams, joint completion of genograms in sessions, and interactive play between children and therapist.

3. Training

    a. With rapid expansion of requirements for TH services comes the attendant need to train and support mental health workforces in the requisite skills. Where technology is likely to remain specific to local contexts and require in-house training, broader Family Therapy-specific training for TH would optimally be offered through accessible online training, consultation and support.

4. Research

    a. Our review of the existing literature shows some early encouraging replication of evidence and justifies further exploration. For example, efficacy data spanning longer post-treatment intervals, a focus on contraindications and iatrogenic effects would support practice and policy decisions about the continuation of TH interventions as an acceptable alternative to in-person interventions.
    b. Greater consistency in assessment of child, parent, and family outcomes across studies would assist.
    c. Inclusion of diverse samples, with exploration of limits to culturally safe TH practices will be important to applying this method at scale.
    d. Distinctions between forms of telehealth suitable for more than one therapist are yet to be systematically researched and further knowledge about the relative efficacies of co-therapy and team interventions via telehealth would provide valuable insights for future implementation.
    e. Mediators of change relative to in-person therapies and questions concerning pre-existing and presenting circumstances impacting efficacy are yet to be addressed.

Conclusion

Go to:

Findings of the current studies offer significant support for delivery by TH methods of family therapy services. The collective evidence suggests equivalent efficacy for relational and mental health outcomes from telehealth relative to face-to-face delivery. From both empirical review and grounded narrative perspectives, the studies included here provide a solid platform from which to advance telehealth methods for family therapy.

MY RECOMMENDATIONS

1. Table a decision on this language, and draft new language that is reflective of the current state of the research on this matter. This new language should include at least the following:

2. Do not place a limited number of "days" or "sessions" for Telehealth Treatment.
3. Mandate that an initial "Risk Assessment and Mitigation Plan" be included as an adjunct to the Treatment Plan in the clients file.
4. That this "Risk Assessment and Mitigation Plan" be reviewed and updated every 120 days and that update also to be added to the clients file.

Regarding the drafting of this new language as well as information to be required in the "Risk Assessment and Mitigation Plan", I would be happy to assist in the drafting of that information for the boards review and consideration.

Thank you for your consideration of my thoughts and recommendations on this matter.

Respectfully,

Michael A. Morton, PhD, AZ LMFT-15420 Linked In: https://www.linkedin.com/in/michael-morton-6552007/

(Currently employed in New Mexico doing Telehealth Therapy under my New Mexico License from Tucson. Not currently active in Arizona, though currently licensed and on Supervision Registry.)

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Exploring the Efficacy of Telehealth for Family Therapy Through Systematic, Meta-analytic, and Qualitative Evidence

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Associated Data

Supplementary Materials

Data Availability Statement

Abstract

Go to:

There is a current escalating need for telehealth (TH) options in family mental health services. In the absence of replicated evidence, TH guidelines from peak bodies are largely based on assumptions of the effectiveness of TH methods. New investments in TH would optimally be based in evidence of clinical efficacy. To this end, we conducted three studies in which we (1) systematically reviewed eight professional guidelines for TH family therapy, (2) examined replicated evidence for the efficacy of TH family therapy through systematic review of 20 studies and meta-analyses of 13 effects, and (3) synthesised clinical accommodations to TH methodology from a study of 12 experienced TH family therapists. The studies found (1) a predominant focus in existing TH guidelines on operational matters pertaining to TH and relative neglect of therapeutic process; (2) meta-analyses of efficacy for child behavioural problems ($k = 8$) and parental depression ($k = 5$) showed equivalent outcomes in TH and face-to-face therapy and enhanced outcomes in TH relative to treatment as usual, resource provision (i.e. written materials), or wait-list control. Narrative review of 20 studies for a range of relational and mental health outcomes aligned with these findings; and (3) therapists defined clear conditions for enhanced engagement

and therapeutic process via TH and reflected on cautions and accommodations for purposes of rapport building and mitigating risk. Given moderate-strong evidence for the efficacy of TH methods of family therapy for a range of conditions, we offer recommendations for future implementation of TH for family therapy.

Supplementary Information

The online version of this article (10.1007/s10567-020-00340-2) contains supplementary material, which is available to authorized users.

Keywords: Telehealth, Family therapy, COVID-19, Systematic review, Meta-analysis

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Delivery of psychotherapy through synchronous digital or other communication technology, referred to here as telehealth (TH), has been used for some decades to enhance access to care. This delivery format overcomes obstacles to receiving therapy such as geographic distance (Kuulasmaa et al. 2004), lack of access to resources due to financial constraints (Doss et al. 2020; Stuttard et al. 2015), and transport barriers (Syed et al. 2013). In recent months, with the advent of the COVID-19 pandemic, TH use has risen in response to public health restrictions on in-person contact (Aafjes et al. 2020). This has affected multiple modes of therapy, including family therapy, the focus of this paper. In response to the rapid shift to TH delivery, guidance for the provision of family therapy delivered by TH has been sought, including necessary accommodations from in-person to online delivery and use of technology to enhance therapeutic processes. The need to gather evidence for the efficacy of online delivery of family therapy, although previously recognised (Kuulasmaa et al. 2004), has become pressing during the COVID-19 pandemic. This paper addresses knowledge gaps in three ways, by (1) reviewing existing guidelines on the implementation of TH for family therapy, (2) reviewing the replicated evidence for the efficacy of TH in family therapy via systematic review and meta-analytic methods, and (3) describing further refinements for TH delivery of family therapy, through a qualitative study of 12 Family Therapists experienced in TH methods.

Previous research has examined use of TH for other modes of therapy, such as individual psychotherapy. These have included cognitive behaviour therapy (e.g. Lichstein et al. 2013), interpersonal therapy (Heckman et al. 2017), and behavioural activation therapy (Egede et al. 2015). In these contexts, systematic reviews and meta-analyses of trials of TH have established superior outcomes of TH relative to active or wait-list control (Ahern et al. 2018). Importantly, TH-delivered individual psychotherapy has also shown equivalent outcomes to in-person delivered therapy (Ahern et al. 2018; Drago et al. 2016; Norwood et al. 2018).

In contrast to this preliminary evidence-base for TH in individual psychotherapy, review of outcomes for TH in family treatment contexts has yet to be conducted. Caution is needed in extrapolating these findings to support the use of TH in the family therapy setting. Significant differences in the application of TH to family treatment contexts include accommodating more than one person “in the room” and managing the complexity of attending to family and communication dynamics during sessions. In addition, particular techniques used in family therapy add further complexity to the move from in-person to technology, such as use of visual aids including genograms and physically re-positioning family members. These have obvious operational and therapeutic implications for how successfully family therapy may be delivered and received.

The limited literature to date focuses largely on the technical nature of TH delivery, and its possible advantages for family therapy, such as supporting the requirement to not talk over one

another, and disadvantages, such as the potential for misunderstanding due to screen resolution limitations (Kuulasmaa et al. 2004). In contrast, impacts on the therapeutic process involved in delivering family therapy via TH have received limited attention.

In this context, we conducted three studies to examine technical and therapeutic considerations for delivering family therapy via TH. Study One aimed to examine current guidelines for TH delivery. Study Two aimed to examine the replicated evidence for the efficacy of TH in family therapy contexts, via a systematic review and meta-analysis. Study Three aimed to summarise the therapeutic processes core to effective TH consultations with families, via analysis of family therapists' descriptions of effective and ineffective TH consultations.

Study One: Review of Operational and Therapeutic Guidelines for Family Therapy TH Go to:

Study One aimed to review available guidelines for delivery of family therapy via TH.

Method

Search Procedure Grey literature for operational and therapeutic guidelines for TH was searched via the Google search engine on 10 April 2020. The search terms used were "guidelines", "telehealth", and "family therapy". Results from the first 10 pages (100 results) were screened for inclusion. Guidelines were included if they were publicly available and provided advice on the conduct of TH in a therapy setting involving family consultation. One additional resource was sourced on 3 June 2020. Resources were excluded if they were secondary citations from a higher peak body, advertisements, marketing, or individual blogs. Peer-reviewed literature was excluded and examined in the systematic review section of this paper.

Resource Selection Eight resources providing guidelines or advice for conducting TH in family therapy contexts met inclusion criteria. These are summarised below.

Results

Seven of the eight resources were designed to provide guidance for TH delivery of systemic, family and/or marriage therapy, or therapy with children and adolescents (AAFT 2020; Caldwell et al. 2017; Helps et al. 2020; ILB-MFT 2016; Myers et al. 2017; Rogers 2020; Tran-Lien 2020). One resource was for governing bodies to regulate use of TH (AMFTRB 2016). Four of the eight resources preceded the COVID-19 pandemic, and four were developed specifically in response to escalating need for TH delivery of therapy during the pandemic (AAFT 2020; Helps et al. 2020; Rogers 2020; Tran-Lien 2020).

Guidelines for Operational Arrangements

Ten themes related to operational guidelines were identified, as outlined in Table 1. The most commonly identified themes are summarised below.

Table 1

Level of detail provided for operational guidelines for Telehealth according to resource source

Theme	Guideline Document Source							
	AAFT	AAMFT	AMFTRB	ATA	CAMFT	Emerging minds	ILB-MFT	TP-NHSFT
Security	None	Moderate	Detailed	None	None	None	Brief	None
Risk/specific populations	None	Brief	Detailed	Detailed	None	None	None	Very brief
Consent and documentation	None	Moderate	Detailed	Brief	Moderate	Very brief	Moderate	None
Confidentiality	Brief	None	Moderate	None	None	Brief	Brief	Brief
Client identify	None	Brief	Moderate	None	None	None	Very brief	None
Working with children	None	None	Moderate	Detailed	None	Brief	None	None
Platform/devices/access	None	Brief	Moderate	Moderate	Moderate	Brief	None	Moderate
Workspace boundaries/room setup	None	None	None	Detailed	None	Brief	None	Moderate
Call interruptions	None	Brief	Brief	None	None	None	None	Very brief
Recording sessions	None	None	Brief	None	None	None	Very brief	Brief

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AAFT Australian Association of Family Therapy, *AAMFT* American Association for Marriage and Family Therapists, AMFTRB Association of Marital and Family Therapy Regulatory Boards, ATA American Telemedicine Association, CAMFT California Association of Marriage and Family Therapists, ILB-MFT Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists, TP-NHSFT The Tavistock and Portman NHS Foundation Trust

Technology Requirements for Conducting TH Six of the eight resources addressed at least one issue concerning platform for TH delivery, device use, access, or how to deal with call interruptions. Recommendations for use of particular platforms were infrequently provided, with greater focus on requirements of the platforms or devices to provide reliable, private, and quality connections (ARFTRB 2016; Caldwell et al. 2017; Helps et al. 2020; Myers et al. 2017; Tran-Lien 2020). Prior testing of platforms and devices was recommended to ensure client(s) could access the TH space (Rogers 2020), and plans be made in advance to deal with call interruptions due to technology failure or connection difficulties (AMFTRB, 2016; Caldwell et al. 2017; Helps et al. 2020). One specified the video image be stable and that all members of families and their interactions, including facial features and expressions, can be viewed (Myers et al. 2017).

Client Consent and Confidentiality Recommendations on this element of practice were made by most resources. Only two resources attended to prior written consent for recording sessions (AMFTRB 2016; Helps et al. 2020), and others referred to obtaining in situ verbal or written consent for TH (Myers et al. 2017; Tran-Lien 2020). Others provided detailed recommendations on risks and benefits of online therapy, training or credentials of the therapist in delivering TH therapy, privacy settings, alternative communication methods, and emergency procedures (AMFTRB 2016; Caldwell et al. 2017; ILB-MFT (Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists 2016). Two resources noted the need for a confidential space in which to conduct TH, from both the client(s) and therapists' perspective (AMFTRB 2016; Helps et al. 2020; Rogers 2020). The need to inform clients of the limits or risks to confidentiality from TH delivery was also advised by three resources (AAFT 2020; AMFTRB 2016; ILB-MFT 2016) and to safeguard electronic storage accessible only by authorised persons (AMFTRB 2016; ILB-MFT 2016). A recommendation for security regarding TH platforms and data storage was made by three resources (AMFTRB 2016; Caldwell et al. 2017; ILB-MFT 2016), including for password protection and that encryption be used for the therapists' electronic communication.

The need to verify client identity was advised by three resources, from noting that the identity of the client(s) should be verified by the TH provider (ILB-MFT 2016), to continuous verification across the period of engagement, through special procedures, such as passwords, codewords, or agreed upon phrases (AMFTRB 2016; Caldwell et al. 2017).

Risk and Client Safety One resource mentioned the need to assess risk indications that TH may be contra-indicated for some clients (Helps et al. 2020). Three others gave information on emergency planning, including the need to be aware of emergency resources in the client(s) location and to provide written information to the client(s) about emergency procedures (AMFTRB 2016; Caldwell et al. 2017; Myers et al. 2017), and the need to assess for physical risk of harm in the setting/environment in which the client accesses TH. Possible exclusions from TH in unsupervised settings included families with maltreatment histories (Myers et al. 2017).

Children and TH Somewhat surprisingly, only three resources specifically addressed working with children in the TH setting. Matters addressed included the need for children to be familiarised with technology through game play and exploration of platform features (Rogers 2020), and that consent and identity of the parent or guardian providing the consent be verified (AMFTRB 2016). Myers et al. (2017) made numerous recommendations about supervision of the TH session, safety risks for young people including the potential of the young person to act out and attack devices, and considerations that some children may not tolerate TH due to developmental or psychotic disorders. In addition, conduct of TH in non-neutral settings that may be sites of violence or neglect, or where a volatile caregiver or parent is present were noted contraindications.

Workspace Boundaries and Room Set-Up Three resources addressed these issues. Recommendations included obscuring the therapist's background where possible (Rogers 2020) and ensuring clients' space was free from interruptions, from the risk of being overheard (Helps et al. 2020), and was sufficiently large to accommodate all family members and to allow children to move around as needed (Myers et al. 2017).

Guidelines for Engagement and Therapeutic Processes on TH

Ten themes for therapeutic guidelines were identified (see Table 2). The most frequently mentioned themes are outlined below.

Table 2

Level of detail provided for therapeutic guidelines for Telehealth according to resource source

Theme	Guideline Document Source							
	AAFT	AAMFT	AMFTRB	ATA	CAMFT	Emerging Minds	ILB-MFT	TP-NHSFT
Assessment of appropriateness for telehealth	None	Moderate	Moderate	Brief	Brief	Brief	Moderate	None
Session structure	Detailed	None	None	None	None	Moderate	None	Brief
Rapport and engagement	Moderate	None	None	None	None	Moderate	None	Very brief
Visual cues and use of the body	Detailed	None	Moderate	Brief	None	Moderate	None	Moderate
Visual tools and genograms	Brief	None	None	None	None	Brief	None	Brief
Reflecting conversations	None	None	None	None	None	None	None	Brief
Managing emotions	Moderate	None	None	None	None	None	None	Brief
Therapist presence / state of mind	Moderate	None	None	None	None	None	None	None
Monitoring progress	None	Brief	Brief	None	None	Brief	Brief	None
Supervision	None	None	Detailed	Brief	None	None	None	Brief
Session Content	None	None	None	None	None	None	None	Detailed

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AAFT Australian Association of Family Therapy, *AAMFT* American Association for Marriage and Family Therapists, *AMFTRB* Association of Marital and Family Therapy Regulatory Boards, *ATA* American Telemedicine Association, *CAMFT* California Association of Marriage and Family Therapists, *ILB-MFT* Idaho Licensing Board of

Professional Counselors and Marriage and Family Therapists, *TP-NHSFT* The Tavistock and Portman NHS Foundation Trust

Assessing for Appropriateness for TH Six guideline documents (AMFTRB 2016; Caldwell et al. 2017; ILB-MFT 2016; Myers et al. 2017; Rogers 2020; Tran-Lien 2020) stated that assessments for appropriateness of TH should be conducted, and based on varying considerations such as the nature and severity of symptoms, clients' ability to use TH platforms, and risks and benefits of TH-delivered therapy. However, specific thresholds for indicators or contraindicators of use of TH were not provided.

In-Session Communication and Engagement Issues here included greater concentration demands on therapists and clients of TH relative to in-person work, and acknowledged a possible need to curtail session length (Helps et al. 2020). The need for new rituals was suggested, to signal different stages of the therapy session, such as beginnings and endings (AAFT 2020; Helps et al. 2020). Similarly, different approaches to promoting engagement and rapport and clear communication were advocated (AAFT 2020; Helps et al. 2020; Rogers 2020), for example, through visual cues, variation of voice (i.e. intonation, tempo), and physical signals such as waving or the thumbs-up sign (AAFT 2020; AMFTRB 2016; Helps et al. 2020; Myers et al. 2017; Rogers 2020). The additional need for therapists to maintain attentiveness in sessions given the more effortful nature of TH was also mentioned (AAFT 2020).

Managing Intensity of Emotion and Focus in TH Delivery Suggested strategies here included setting up a contract that outlines the planned response to escalation of emotion (Helps et al. 2020) and using directive problem-solving approaches to contain distress (AAFT 2020).

Therapist Self-Care The added utility of supervision and use of technology to facilitate supervision was mentioned by three resources (AMFTRB 2016; Helps et al. 2020; Myers et al. 2017), including sharing of recording of video conference sessions for review by supervisors (Helps et al. 2020)..

Use of Family Therapy Specific Skills and Tools Only two resources specifically mentioned ongoing use of tools such as use of genograms (AAFT 2020; Helps et al. 2020) and reflecting conversations (Helps et al. 2020).

Monitoring Client(s') Progress

This issue was included in some guidelines AMFTRB (Association of Marital and Family Therapy Regulatory Boards) 2016; Caldwell et al. 2017; ILB-MFT (Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists) 2016; Rogers 2020. In some instances, these were specific to monitoring the effectiveness and appropriateness of TH delivery of therapy (AMFTRB 2016; Caldwell et al. 2017; ILB-MFT 2016).

Session Content No guideline implied that the content of a session would be affected by the differences between TH and in-person work. Continued support for the family to set the agenda for the discussion was assumed throughout. One set of guidelines developed post COVID-19 restrictions observed that COVID-19-related topics were frequently raised, and needed time to discuss, including addressing children's worries about the virus, physical distancing, and contact between parents and children in separated families (Helps et al. 2020).

Brief Discussion

Go to:

Study One reviewed publicly available documents providing guidelines for provision of TH within family therapy settings. Half of the documents had been produced specifically in response to the COVID-19 pandemic. Perhaps reflecting the rapid move to provision of TH, content of the guidelines documents was heavily weighted to providing operational guidance, including use of technology and processes for obtaining client consent and managing confidentiality. Less attention was given to guidance for adapting therapeutic processes within the TH setting and somewhat surprisingly, few resources attended to ways of working with children in TH in relation to either operational or therapeutic guidelines. No guideline attended to the evidence for effectiveness of TH.

Study Two: Systematic Review and Meta-analysis

Go to:

The aim of Study Two was to conduct a systematic review of literature examining relational and mental health outcomes of family therapy via TH and, where possible, to conduct meta-analyses of commonly reported outcomes.

Method

This review was conducted in accordance with the preferred reporting items for systematic review and meta-analysis protocols (PRISMA) guidelines for systematic reviews and meta-analysis protocols (Moher et al. 2015).

Search Strategy

A systematic search of the following databases was conducted in April 2020: PsycINFO, CINAHL, FAMILY, ProQuest Psychology Journals, ProQuest Dissertations and Theses, and Google Scholar. Search terms were telemedicine OR telehealth OR “telemental health” OR telepsych* OR ehealth OR edelivery OR online AND “family health services” OR “family therapy” OR “family consult*” OR “clinical consult*” OR “group consult*” AND trial OR “randomi*ed control* trial*” OR “randomi*ed clinical trial*” OR “experimental design” OR “random sampl*” OR “case control”.

The search was restricted to English language peer-reviewed papers. The ProQuest Dissertations and Theses and Google Scholar searches were not restricted to peer-review literature to allow retrieval of grey literature. Given the large number of records from Google Scholar on irrelevant topics, screening was restricted to the first 50 returns. A total of 177 papers were retrieved. After removal of duplicates ($n = 15$), 162 papers remained for screening.

Study Selection

All papers ($n = 162$) were screened for eligibility by two authors (AB and AS) across two levels; title and abstract, and full text. Papers were included if: (a) they reported on a TH based delivery of a therapeutic intervention (i.e. synchronous audio or video consult); (b) the treatment was simultaneously received by more than one client (i.e. was a family or group); and (c) the paper reported on relational health or mental health outcome measures.

The title and abstract screen excluded 112 papers and a further 30 were excluded following full-text screen. Reasons for exclusion at this level are shown in Fig. 1. One additional paper that was already known to the authors was included. Twenty papers met eligibility criteria for inclusion. Of these, 9 reported on effects that were eligible for inclusion in meta-analysis.

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Fig. 1

Selection process of articles for inclusion in review and meta-analyses

Data Extraction

Two authors (AB and AS) extracted data from eligible papers. The data described study country, study design, treatment sample and size, intervention type and delivery formats, relevant outcomes and their measures, relevant results, and reported effect sizes. For meta-analytic categories, pre- and post-intervention means and standard deviations were extracted from studies for effect size calculation.

The quality of included studies was assessed by one author (AS) using the 12-item Methodological Index for Non-Randomized Studies (MINORS) scale (Slim et al. 2003). This scale assesses methodological quality for both non-randomised and controlled studies. Items are scored as 0 (not reported), 1 (reported but inadequate), and 2 (reported and adequate). An ideal score for a randomised controlled study is 24 and 16 for non-comparative studies. Additionally, one item from the Jadad Scale (Jadad et al. 1996) for Reporting Randomised Controlled Trials was included to assess randomisation. Studies received 2 points if described as randomised, and the method of randomisation was described and appropriate. Studies received 1 point if randomisation was mentioned but the method of randomisation was inappropriate. A score of zero was awarded if randomisation was not explicitly mentioned. A second author (AB) assessed 20% of studies for inter-rater reliability of study quality. Scores for each study are included in Supplementary Material.

Meta-analyses

Meta-analyses were possible for two outcomes, child behaviour problems and parent depression. Analyses were conducted using the Comprehensive Meta-Analysis software (Version 3; Borenstein et al. 2005). Effect sizes (Hedges *g*) were calculated for the interaction effect (between group (control and intervention) change from pre–post interventions) for each study. Effect sizes from individual studies were then combined to produce an aggregate effect size, using random-effects models. Given studies did not report pre–post correlations of child behaviour or caregiver depression, we used a conservative *r* of 0.70 as recommended by Rosenthal (1984) to calculate the group x time effect sizes. The I^2 statistic was used to assess the heterogeneity of the subgroups with scores of 0.25, 0.50, and 0.75 corresponding to low, moderate, and high levels, respectively (Higgins et al. 2003). Given there were not more than five studies in any subgroup, meta-regression moderation analyses could not be conducted to assess for age or gender differences in samples.

Results

Go to:

Characteristics of Included Studies

Details regarding the characteristics of included studies are shown in Table 3. The 20 papers reported on samples comprising families; mostly parent–child compositions ($n = 18$), with

others involving adult relatives ($n = 2$; *Glynn et al. 2010; *Rotondi et al. 2005). Most studies were conducted in the USA ($n = 16$), with three Australian and one Canadian study.

Table 3

Sample, study characteristics, and findings of included studies ($N = 20$)

Study; Country	Study design & sample (*N*)	Intervention (s) and study conditions	Assessment time points	Attrition	Relevant outcome (s)	Outcome measure (s)	Relevant findings
*Anderson et al. (2017)	Uncontrolled experimental trial Adolescents 13–18 years with anorexia nervosa (AN) and their parent(s)	TH (video) FBT. 20 sessions over 6 months	Baseline, post-treatment, 6-month follow-up	0	Adolescent weight (BMI), eating disorder symptoms, depressive symptoms, self-esteem	EDE BDI RSE	Significant increase in BMI and reductions in eating disorder symptoms from baseline to post-treatment and to 6-month follow-up. Significant improvement in depressive symptoms and self-esteem from baseline to follow-up
*Comer et al. (2017a); USA	RCT families; child 4–8 years, child diagnosis of obsessive–compulsive disorder (OCD) (*N* = 22)	TH (video) FB-CBT; F2F FB-CBT 12 sessions over 14 weeks (both conditions)	Baseline, post-treatment, 6-month follow-up	2 families (1 TH, 1 F2F)	Child OCD symptoms Family accommodation of OCD symptoms	ADIS-IV-C/P CY-BOCS CGI-S/I CGAS FAS-PR	Child OCD symptoms and family accommodation of OCD symptoms improved from baseline to post-treatment, and to follow-up in both conditions; no significant difference between TH and F2F. 60–80% had clinically significant improvement across both conditions
*Comer et al. (2017b); USA	RCT Families; children 3–5 years, child diagnosis of behavioural disorder (*N* = 40)	TH (video) PCIT; F2F PCIT	Baseline, mid-treatment, post-treatment, 6-month follow-up	12 families (6 TH, 6 F2F)	Child behaviour problems	K-DBDS CGI-S/I CGAS ECBI CBCL	Both conditions had large-to-very-large positive effects on children's behavioural difficulties. Most outcomes were comparable across conditions; significantly higher rate of "excellent responses" in TH PCIT than in F2F PCIT
*Dadds et al. (2019); Australia	RCT (× 2) Study 1: Rural families; child 3–9 years, child diagnosis of oppositional defiant or	Both studies—TH (video) IFICCP; F2F IFICCP	Both studies: Baseline, post-treatment, 3-month follow-up	Study 1: 11 families (7 TH, 4 F2F) Study 2: 7 families (6 F2F, 1 VTC)	Child behaviour problems Parent depression Parent anxiety	SDQ BSI	Large improvements in child behavioural difficulties in both studies; no significant difference between conditions. Moderate improvements in parent depression and anxiety in both studies; no significant difference between treatment conditions

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Outcome Measures: *AAQ-II* Acceptance and Action Questionnaire–II, *ADIS-IV-C/P* Anxiety Disorders Interview Schedule for Children and Parents for DSM–IV, *ASDS* Acute Stress Disorder Scale, *BDI* Beck Depression Inventory, *BPRS* Brief Psychiatric Rating Scale, *BRIEF* Behavior Rating Inventory of Executive Functions, *BSI* Brief Symptom Inventory, *CAFAS* Child and Adolescent Functional Assessment Scale, *CBCL* Child Behavior Checklist, *CES-D* = Center for Epidemiological Studies Depression Scale, *CGAS* Children's Global Assessment Scale, *CGI-S/I* Clinical Global Impression-Severity and Improvement Scales, *CSQ* Caregiver Strain Questionnaire, *CY-BOCS* Children's Yale-Brown Obsessive- Compulsive Scale, *DASS* Depression Anxiety Stress Scales, *DBD* Disruptive Behaviour Disorder Rating Scale, *EATQ-R* Early Adolescent Temperament Questionnaire, *ECBI* Eyberg Child Behavior Inventory, *EDE* Eating Disorder Examination (Interview), *FAD-PS* Family Assessment Device Problem-Solving subscale, *FAS-PR* Family Accommodation Scale–Parent

Report, *FAS* Family Attitude Scale, *FES* Family Empowerment Scale, *ICS* Issue Change Scale, *IFIRS* Iowa Family Interaction Rating Scale, *IFS* Issue Frequency Scale, *ISS* Issue Severity Scale, *K-DBDS* Kiddie-Disruptive Behavior Disorders Schedule, *K-SADS-PL* Schedule for Affective Disorders and Schizophrenia-Present and Lifetime Versions, *SDQ* Strengths and Difficulties Questionnaire, *MSPSS* Multidimensional Scale of Perceived Social Support, *PCIT* Parent–Child Interaction Therapy, *PCL-S* Posttraumatic Stress Disorder Checklist-Specific, *PECI* Parent Experience of Child Illness, *PHQ-9* The Patient Health Questionnaire, *PPF* Parental Psychological Flexibility Questionnaire, *PSDRS* Problem-Solving Discussion Rating Scale, *PSI* Parenting Stress Index, *PTC* Parenting Tasks Checklist, *RSE* Rosenberg Self-Esteem Scale, *SSRS* Social Skills Rating System, Interventions: *ACT* Acceptance and Commitment Therapy, *CAPS* Counsellor-Assisted Problem-Solving, *F2F* Face-to-Face in-person delivery, *FB-CBT* Family-Based Cognitive-Behavioural Therapy, *FBT* Family-based Therapy, *FPS* Family Problem-Solving Therapy, *IFCM* Issue-Specific Family Counselling Model, *IFICCP* Integrated Family Intervention for Child Conduct Problems, *IRC* Internet-resource comparison, *MFG* Multi-Family Group, *TAU* Treatment As Usual, *TH* Telehealth, *TOPS-Family* Teen Online Problem Solving with Family, *TOPS-TO* Teen Online Problem Solving with Teen Only, *WC* Wait-list Control

Twelve studies were described as randomised controlled trials (RCT); others were feasibility studies or pilot trials ($n = 4$), experimental trials ($n = 2$), modified randomised controlled field experiments ($n = 1$), and case–control studies ($n = 1$). Papers were published between 2002 and 2019. In total, the included studies reported on 1992 families or parent–child/adult-relative dyads, with a mean sample size of 99.6 (SD = 91.81, range = 10–322).

The included studies drew on a range of interventions, including Family Problem-Solving Therapy (FPS; $n = 5$), Family-Based Cognitive Behavioural Therapy (FB-CBT; $n = 2$), and Parent–Child Interaction Therapy (PCIT; $n = 1$). Two studies used a multi-family group (MFG) approach for individuals with a psychotic illness and their adult relatives. One study used an Acceptance and Commitment Theory (ACT) framework, and one used the Triple P: Positive Parenting Program intervention. One study used family-based treatment (FBT) for anorexia nervosa. All other studies described a non-specific cognitive-behavioural and/or skills-based approach (see Table 3).

Study Quality

The average score for quality assessment ratings of included studies was 18.9 out of a possible maximum of 26. When the Jadad scale item (item 13) was removed, no studies exceeded a score of 24. Scores for each included study are presented in Online Resource 1. Many studies either reported inadequate information or did not address study blinding or prospective calculation of sample size, and many studies reported a loss of > 5% of the sample to follow-up. Twenty percent of studies were double rated. Inter-rater agreement on study quality was 100%.

The Replicated Evidence: Meta-analytic Findings

Across the 20 included studies, there were 37 relevant effects relating to mental health and/or relational health outcomes. Meta-analyses were possible for thirteen effects from eleven studies related to the efficacy of TH in addressing child behavioural problems ($k = 8$) and parental depression ($k = 5$). The remaining effects could either not be meaningfully clustered into a domain with at least one other similar effect ($k = 22$), or the required statistical information was not given in text nor provided by authors upon request ($k = 2$).

Child Behavioural Problems

In the pre- to post comparison (see Fig. 2), the efficacy of the TH interventions for child behavioural problems was somewhat superior to the control interventions (in-person, internet resources, treatment as usual, or wait-list control), with a small effect size. The *Q* statistic assessment of heterogeneity confirmed studies in the meta-analysis shared the same effect size ($Q = 2.828$, $p = 0.900$, $I^2 < 0.001$). Publication bias did not appear to be an issue, with a visual inspection of the funnel plot showing an even dispersal of studies, and Egger's

regression confirming the included studies were symmetrically distributed [p (2-tailed) = 0.66]. The classic Fail-Safe N was calculated and revealed that an additional 10 studies with an effect size of zero would be required to render the current findings non-significant.

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Fig. 2

Meta-analyses of the effect of telehealth interventions for child behavioural problems. *E-Health* telehealth delivery, *F2F* face-to-face, *IRC* internet-resources comparison, *TAU* treatment as usual, *WLC* wait-list control

Subgroup analyses revealed the effect size did not differ across studies, based on control group type $Q_{between} = 1.40$, $df = 3$, $p = 0.706$, or the outcome measure used (i.e. Child Behavior Checklist, Eyberg Child behaviour Inventory, or Strengths and Difficulties Questionnaire), $Q_{between} = 0.34$, $df = 2$, $p = 0.846$. Although Fig. 2 shows significant differences between TH and provision of resources but not between TH and in-person delivery, when considered collectively the effect sizes did not differ based on comparison type.

For the four studies that collected follow-up data, meta-analysis showed a non-significant trend for persisting improved outcomes in TH relative to control, also with small effect size. Subgroup analyses revealed the effect size did not differ across studies, based on the control group type, $Q_{between} = 0.56$, $df = 1$, $p = 0.454$, or the measure used, $Q_{between} = 0.93$, $df = 1$, $p = 0.336$.

Parental Depression As shown in Fig. 3, the efficacy of the TH interventions appeared to be superior to control interventions, all in-person comparisons, at both pre- to post intervals, Hedges $g = -0.23$ (95% CI −0.57, −0.07) $p = 0.011$, and pre to follow-up, Hedges $g = -0.33$ (95% CI −0.47, −0.11) $p = 0.002$, for parental depression. Both were small effects. The heterogeneity among effect sizes was low in both pre to post ($Q = 1.161$, $p = 0.445$, $I^2 < 0.001$) and pre to follow-up ($Q = 0.877$, $p = 0.831$, $I^2 < 0.001$).

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Fig. 3

Meta-analyses of the effect of telehealth interventions for parental depression. *E-Health* telehealth delivery, *F2F* face-to-face

Publication bias did not appear to be an issue, with a visual inspection of the funnel plot showing an even dispersal of studies, and Egger's regression confirming the included studies were symmetrically distributed at pre to post (p (2-tailed) = 0.12) and pre to follow-up (p (2-tailed) = 0.34). The Fail-Safe N analyses show that the addition of two and seven studies at each timepoint comparison with an average effect size of zero would render the current findings non-significant.

Narrative Summary of Individual Studies

The included individual studies reported effects relating to family outcomes, child outcomes, and outcomes for individuals with a psychotic illness and their adult relatives. Study findings for effects

not included in the meta-analysis are described below and details of study interventions are included in Table 3.

Family Outcomes Included studies assessed a range of negative (e.g. distress, conflict) and positive (e.g. problem solving) family outcomes. Many studies reported improvements in outcomes following engagement with TH. However, changes in outcomes from pre- to post intervention and to follow-up were not different from changes observed in comparison conditions for any outcomes.

A family counselling intervention delivered via TH (videoconferencing) with parent–teenager dyads led to significant reductions in the severity and frequency of family problems to post-intervention. Improvements were maintained at 6-month follow-up (*Glueckauf et al. 2002). There was no evidence of any significant differences between this intervention delivered via TH or via telephone or in-person delivery.

One study of families with children with traumatic brain injury (TBI) used a web-based family problem-solving therapy with a counsellor via TH (videoconferencing) sessions. Improvements to post-treatment were observed for family problem solving. These were not maintained to 18-month follow-up (*Narad et al. 2015). Other effects were mixed and depended on differing levels of severity of TBI of adolescents. For family conflict, significant decreases were observed at 18-month follow-up only for adolescents with severe TBI. For adolescents with moderate severity of TBI, levels of effective family communication remained steady across assessment timepoints for the TH group. Declines at 12-month follow-up were observed in the control group who received internet resources.

The use of TH (videoconference) delivered family-based cognitive-behavioural therapy (FB-CBT) in families with a child with obsessive–compulsive disorder (OCD) led to improvements in family accommodation of OCD symptoms which were maintained at 6-month follow-up (*Comer et al. 2017a, b). Immediate and 6-month follow-up improvements were comparable to those in the in-person condition.

Parent Outcomes Parent mental health outcomes were assessed in four of the included studies. Relative to primary care, a hybrid TH approach for caregivers of a child with attention-deficit hyperactivity disorder demonstrated significantly greater improvements in caregiver stress, depression, and caregiver strain (Stoep et al. 2017). This intervention comprised videoconference-delivered psychiatry sessions and skills-based behavioural training.

In other studies, interventions were implemented for child conduct disorders utilising the Integrated Family Intervention (*Dadds et al. 2019) and family problem solving following adolescent traumatic brain injury (*Wade et al. 2019). No differences were noted between TH and in-person delivery. Improvements in parent anxiety and depression at post-intervention were maintained to 3 months (*Dadds et al. 2019), and depression and distress at post-intervention maintained 9 months after baseline (*Wade et al. 2019). TH intervention (videoconferencing) in acceptance and commitment therapy for parents with a child with life-threatening illness was piloted in a non-controlled feasibility study. Small but non-significant improvements in parent depression, anxiety, stress, and PTSD symptoms were noted at post-intervention (*Rayner et al. 2016).

Child Outcomes Studies reported a diverse array of child outcomes. One study explored the impact of TH (videoconferencing) FB-CBT on child OCD symptom severity. Improvements comparable to the in-person FB-CBT condition were noted for TH in OCD symptoms and in clinician-rated functioning, and maintained at 6-month follow-up (*Comer et al. 2017a, b).

*McGrath et al. (2011) examined a family-centred coaching intervention with online resources accessed by families and weekly TH (telephone) coaching for families with a child diagnosed with oppositional defiant disorder (ODD), attention-deficit hyperactivity disorder (ADHD), or an anxiety disorder. Successful outcomes, defined as children no longer meeting diagnostic criteria, were observed in higher rates in the TH groups relative to treatment as usual control. Effects were maintained to 8 months post baseline for the ODD group and to 12 months for the ADHD and anxiety groups (*McGrath et al. 2011). *Sibley et al. (2017) examined a 10-session family therapy skills-based TH (video-conferenced) intervention for adolescents with attention-deficit hyperactivity disorder (ADHD) and their parents. Parent and teacher-rated severity of inattention symptoms improved post-treatment. Findings reflect within-group change over time, as no control group was used. A further study examined the feasibility and preliminary effects of family-based treatment (FBT) delivered via TH (videoconferencing) in a pilot trial for adolescents with anorexia nervosa (*Anderson et al. 2017). Significant improvements in weight and eating disorder symptoms were apparent at post-treatment and maintained at 6-month follow-up. Adolescents rated the treatment as moderately positively, whereas mothers and fathers rated the treatment very positively.

Two studies utilised TH for families where a child had TBI. Family problem-solving therapy delivered by videoconferencing improved daily functioning of children relatively more than an internet resource control group, with effects evident 12 months after treatment completion (*Wade et al. 2015). Similarly, compared to individual therapy, a TH (videoconferencing)-delivered problem-solving program resulted in more improved executive functioning (parent report) post-treatment in adolescents (*Wade et al. 2018). Interaction effects between family stress levels and executive function were noted.

*Davis et al. (2016) examined the benefit of a TH intervention, delivered by videoconference or by telephone, in treating paediatric obesity on child behavioural outcomes. The sample did not display clinically significant levels of behavioural problems at baseline and there were no group by time changes over the course of the intervention. This study was not included in the meta-analysis of the same category, as no quantitative statistics were made available for analysis.

Adults with Psychotic Illnesses and Their Relatives Two studies examined outcomes for individuals with a psychotic illness (schizophrenia and schizoaffective disorder) and their adult relatives from participation in an online support program with TH therapy/facilitated synchronous chat for persons with schizophrenia, family member groups, or multi-family groups (*Glynn et al. 2010; *Rotondi et al. 2005). Mixed findings were observed. Relative to the treatment as usual control groups, for individuals with psychotic disorder, TH intervention reduced stress in one study (*Rotondi et al. 2005) but did not reduce distress or impact clinical symptomatology in another study (*Glynn et al. 2010). In neither study were improvements in perceived social support observed (*Glynn et al. 2010; *Rotondi et al. 2005).

For adult relatives of individuals with a psychotic disorder, participation in TH did not alter perceived social support or stress (*Rotondi et al. 2005) or alter anxiety/depression or somatisation symptoms, reflective of distress (*Glynn et al. 2010), relative to treatment as usual. Relatives were found to have improved levels of family relationship stress but not perceived social support over time. However, these were not examined in comparison with change in the control group (*Glynn et al. 2010).

Brief Discussion

Go to:

This systematic review and meta-analysis provides evidence that family-based therapy delivered via TH improves relational and mental health outcomes for family, parent, and child measures. Effects were equivalent to in-person delivery of interventions for many outcomes. In no studies

included in the review were outcomes from TH found to be inferior to in-person delivery. These findings are preliminary, and should be interpreted in light of their limitations, including the small number of studies reviewed. Only 20 studies met inclusion criteria, a considerably smaller pool of research than has been examined for individual TH therapies.

Study Three: Qualitative Exploration of Family Therapist Experiences with TH

Go to:

Study Three aimed to explore family therapists' perspectives on delivering family therapy via TH and to understand elements of therapy that are more or less effective through TH delivery relative to in-person experiences. In addition, the study aimed to understand perceptions of risk of use of TH.

Method

Participants Participants were family therapists ($n = 12$; three male and nine female) at a specialist public health funded family services centre. Invitation to participate was extended to all practitioners with experience delivering family/group therapy via a TH (videoconferencing) medium. Participation was voluntary, and required informed consent. Most (10 of 12) participants had conducted between 6 and 12 family telehealth sessions. One participant had completed about 18, and one had completed about 30. For most (10 of 12) participants, use of telehealth was new (i.e. since the beginning of the COVID-19 pandemic). There were two exceptions to this: one participant had some prior experience with family therapy telehealth in a previous role, and one had prior experience with the use of telehealth but only with individuals rather than groups or families.

Procedure Approval was provided by the La Trobe University Human Ethics Committee (Project ID: HEC20118). The study was performed in accordance with the ethical standards of the 1964 Declaration of Helsinki. Each practitioner participated in a structured, one-on-one audio-recorded interview (approximately 60 min) with AB. Interview questions are presented in Table 4. Participants were not familiar with the interview questions prior to the interview.

Table 4

Interview questions for exploration of family therapist experiences with TH

Interview question	Domain
What core considerations would guide your judgement that a case was suitable or unsuitable for a TH medium? (E.g.: client ages, presenting problems, reflective capacity, risk, intra-family dynamics, etc.)	Suitability for TH
What would you consider essential for an online therapist to do in establishment of rapport and empathy with all family members?	Rapport
How might you handle moments of conflict between family members in the 'online' room—e.g. is there any difference in what you would say or do, or feel?	Conflict management
What accommodations would you make for younger children?	Working with children
Under what conditions would you not resume a treatment online that had commenced in person?	Continuation of in-person therapy via TH
Are there any core principles or practice elements of family therapy that seem less effective via TH?	Perceived drawbacks of TH interventions with families
Are there any core principles or practice elements of family therapy that seem more effective via TH?	Perceived efficacy of TH interventions
How would your crisis management practice change when using a TH medium, to manage risky behaviour in the room (e.g. a child starts head banging; a family member threatens another family member)	Managing risk in the moment
What additional vulnerabilities might you feel as the therapist? What might assist you to feel more comfortable with respect to these?	Wellbeing of the therapist in a TH context

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Data Analysis

Audio-recorded interviews were transcribed verbatim using transcription software and checked by a member of the research team. Transcript data were then subject to qualitative content analysis (Bengtsson 2016; Elo and Kyngäs 2008; Hsieh and Shannon 2005) at the manifest level. Using a deductive, predetermined coding system aligned with the interview structure, one independent coder (FP) extracted and coded transcript data using a standardised coding table. Codes and themes were reviewed by two second independent coders (AB, JM). Nine key domains were identified. Data analysis occurred across four stages: (a) decontextualization (deconstruction of the transcript into meaning units); (b) recontextualization (identification of codes); (c) categorization (identification of themes); and, (d) compilation (drawing of group-level conclusions and variations, with conferencing between coders and checking of the original text).

Results

Go to:

Findings are organised by the domains corresponding to interview questions (see Table 4), including a high-level summary of key themes and significant variations in therapists' views.

Suitability for TH

Views about the suitability of cases for TH family therapy were congruent with those made in in-person work. No blanket contraindications for the use of TH were identified for this setting. As per in-person work, contraindications included imminent family violence risks and current severe disturbance in personal functioning with cognitive, neurological, or psychiatric origins that render participation unsafe or otherwise unhelpful for any participant. As with in-person consultation, such impairments may delay the timing of the intervention rather than presenting a blanket contradiction. An example of this may be presenting as drug affected on the day of an appointment.

A series of cautions characterised by risk or complexity (e.g. history of trauma, sexual assault or suicidal ideation) emerged about the suitability of TH for cases. Suggested accommodations to manage these circumstances centred on 'slowing the work down' and included spending more time than usual understanding client situations, priorities, and the nuances of potential risk, and setup of risk management plans prior to therapy. A well-paced therapeutic process was key to maintaining trust and rapport, together with making open and collaborative choices with clients; devoting more time to 'talking about the talking'; and allowing more time to develop the foundations of a therapeutic relationship with new clients.

Rapport

Relative to in-person contexts, the TH environment was seen to require (i) more time and (ii) additional accommodations to content and process for purposes of establishing rapport, described below. TH engagement was augmented by a first telephone contact with all family members to establish individual connections before commencing TH sessions. Equally important were transparent discussions about client comfort with the TH therapy modality; establishing a mutual understanding of how to communicate about the process when it is not working well and being more directive than usual to facilitate equal contributions to group conversations.

Technological factors impacted rapport, including looking directly at the camera while talking with clients to emulate eye contact, and using names when addressing clients to compensate for the challenges of deploying direct gaze and body orientation as one would in person. Consideration was also given to the influence of TH features on client experience, e.g. muting different voices at different times and using a particular screen viewing modes. Explanations were offered when doing anything off-screen such as using a notepad, providing a clear explanation to avoid confusion about practitioner inattention.

Conflict Management

Therapists noted a lower overall threshold in the TH context for intervening with conflict during a session, and a focus on methods of remaining in control if conflict occurred. All therapists noted the critical importance of mitigating the possibility of conflict prior to therapy. Preliminary discussions with clients about how conflict would be resolved in the absence of the practitioner were felt to be essential, given concerns that clients might be more inclined to abruptly walk out of a TH consult than from the therapy room in-person. Successful TH interventions included establishing permission and processes for discussing 'hot issues' during the session; addressing the need to intervene, and post-session regulatory strategies. Several therapists found online breakout rooms useful for speaking to clients separately where conflict had occurred or was imminent.

One key variation was noted. Some therapists felt that conflict was more difficult to manage when family members were on separate screens, as this blurs the detection of early signs of conflict, while others felt a greater sense of control when family members joined from separate devices, in separate spaces, as the risk of physical conflict was felt to be lower.

Managing Risk in the Moment

All therapists reported that managing risk via TH was more delicate than managing risk in-person. The unanimous emphasis was on risk mitigation rather than risk management in TH. As such, efforts were consistently made to ensure best possible risk assessment prior to engaging in therapy. As with in-person work, therapists agreed that imminent safety risks would contraindicate suitability for TH therapy. Immediate intervention in a context of risk would be largely congruent with intervention in the in-person setting (i.e. the need to slow down and stop where necessary and allow for breaks in instances of escalation; post-session follow-up to determine client safety; readiness to contact police, or provide details of support services or contact services on client's behalf).

A common concern pertained to the consequence of technology failure, with the need to invest in pre-session preparation, to ensure therapists were aware of clients' locations and alternate contact methods in case of an emergency, including phone numbers and email addresses. The normal practices of notifying police would apply if a reportable concern about dangerous behaviour arose.

Therapists agreed that given the physical distance of the therapist, TH brings increased shared involvement of the client in risk management, shared responsibility for their own self-regulation, and support of others' self-regulation, with the assistance of emotion coaching strategies.

Working with Children

Views about suitability of TH for children varied. Common to all was the need for advance preparation and active alignment with parents to ensure the space for the session worked well for the children and was equipped with drawing and play materials, active engagement of young children, sustaining their involvement in the session through shorter sessions, and leveraging different types of play. In this, a need for therapists to manage their own expectations was evident (e.g. being prepared that the session might need to be brief or to end early).

Most therapists reported the need to be more engaging, e.g. via maximising interactive methods and minimising verbal discussion, creating a playful atmosphere by utilising virtual backgrounds, and introducing various types of play. Therapists also found it helpful to bring attention to the TH medium as a point of interest and to use its novel features (e.g. online whiteboards) to engage children in session.

Continuation of In-Person Therapy Via TH

As to the question of continuing an already established therapy process via an online medium, no differences were noted relative to those that would apply to consideration of continuing in-person therapy. These standard cautions as outlined above in the 'Suitability for TH' section would equally apply.

Cautions for continuing via TH amounted to concerns about participating safely and included situations where the client had inadequate support in scenarios of risk management while using TH. Ongoing monitoring of the efficacy and suitability of the medium across the course of treatment was noted by all.

Perceived Drawbacks of TH Interventions with Families

Several therapists reported that some therapeutic techniques felt more difficult or perhaps less effective online (e.g. triadic questioning when members were on different devices). The same held for pragmatic activities (e.g. moving people around the room to create a family sculpture) and several felt that their use of warmth, humour, and the ability to accurately read non-verbal cues were somewhat compromised. Nevertheless, there was uniform agreement that the core elements of family therapy were more or less maintained with the transition to TH.

Perceived Efficacy of TH Interventions

Various therapeutic experiences and access/uptake issues were improved with the transition to TH delivery. Some felt that TH offered an improved ability for therapists to empathise and align with others' experiences due to the equal visual presentation of faces on the screen. In this, being able to see one's own responses on the screen had potential benefits. Self-direction associated with use of TH also offered families a greater sense of ownership in their therapeutic process.

Some felt that TH promoted better equity in access and uptake. At the geographical level, there are benefits of TH for those living in remote areas. At the individual level, TH can better suit those with certain disabilities or preferences for interaction online.

Wellbeing of the Therapist in a TH Context

Several therapists reported that the usual boundaries that exist between in-session and out-of-session work done in-person were difficult to maintain when using TH. Some reported feeling

detached from their work when using TH: they were disempowered and at times helpless about what they perceived as a limited capacity to detect and adequately respond to nuances of expression. To preserve wellbeing, therapists expressed a need for quality supervision; the importance of seeking and maintaining collegial support; the availability of reliable technology (to mitigate stress associated with the technological challenges of operating via TH); a manageable workload; being accepting of the constraints associated with TH; prioritising self-care activities such as breaks and exercise; and incorporating co-therapy to ease feelings of isolation.

Brief Discussion

Go to:

We found congruence between the core practice and process elements of family therapy across in-person and TH modalities. Some unique benefits of practicing via TH were observed. Necessary accommodations made to therapeutic work with TH predominantly pertained to process rather than content changes, including the need to plan ahead for possible management of risk.

Discussion

Go to:

This study examined the efficacy and optimization of TH-delivered family therapy from multiple perspectives, aiming to inform future use of TH for family and systemic practice. The first study found that content from existing guideline documents was heavily weighted to operational rather than therapeutic aspects of therapy delivery. We identified a significant gap in information for practitioners to guide therapeutic adjustments that may be required when working with families over digital mediums, and especially with children. Study Two examined evidence for efficacy of TH in improving outcomes for families. Although the available literature was limited in volume, consistent results emerged. Meta-analyses demonstrated improvements in child behaviour problems for family therapy with equivalency between TH and in-person delivery from pre-to-post intervention and to follow-up. Relative to treatment as usual, internet resources, or wait-list control conditions for child behaviour problems, TH family therapy had superior improvement rates, pre- to post-intervention. Similarly, for family-oriented treatment of parental depression, meta-analyses showed that improvements were superior in TH relative to in-person delivery for pre- to post-intervention and to follow-up. Narrative review of individual studies excluded from meta-analyses found that TH delivery was equivalent to in-person delivery for a range of family, parent, and child outcomes, and frequently superior to minimal intervention control conditions. In the final study, qualitative analysis of one-on-one interviews with experienced family therapists found that core processes and practices of family therapy could be preserved in the online modality. Adaptations to delivery of therapy in TH were primarily process rather than content related. Taken together, the findings of these three studies provide considerable support for ongoing delivery of family therapy via TH.

The current findings, focussed on family therapy, expand the meta-analytic evidence for TH in other contexts, mirroring findings of the superiority of individual therapies via TH relative to wait-list or information only controls, and equivalent outcomes to in-person delivery of therapy (Ahern et al. 2018; Drago et al. 2016). Consideration of the therapeutic alliance may offer some insight into the equivalence of outcomes in TH and in-person therapy. Normatively, the therapeutic alliance accounts for considerable variance in therapeutic outcomes (Fluckiger et al. 2018). Novice TH therapists in our third study echoed concerns voiced elsewhere (Bee et al. 2008), that the formation of this critical alliance could be impacted in TH relative to in-person interactions through alterations in interpersonal communication. However, in some (Jenkins-Guarnieri et al. 2015) but not all review studies (Norwood et al. 2018), and for many Study 3 experienced therapists, the alliance was observed to be unaffected by TH delivery. As found in our third

qualitative study, key to this are alterations to accommodate the digital environment, in pursuit of establishing rapport and empathic connection, which may be integral to good outcomes in TH.

As with prior research (Gros et al. 2013), therapists in our qualitative study also emphasised the need to engage in pre-therapy connection and preparation strategies, such as prior telephone or digital conversations with clients, for risk mitigation and for optimised outcomes. Other scholars have suggested that it is advantageous for the pre-therapy connection meetings to take place in-person, rather than through technology (Kuulasmaa et al. 2004). It remains to be seen whether initial in-person meetings would strengthen therapist–client connections or whether conducting this meeting over telehealth would be sufficient for this purpose.

Uniquely, our qualitative results suggest some advantage of TH delivery in family therapy over face-to-face, as reported in previous research with individual or couples therapy (Richardson et al. 2015). Key factors for perceived efficacy from the client and therapist perspectives include ease of talking in telehealth, where turn taking is clearer, and ease of revealing vulnerability for some clients, invoked by a sense of distance in TH that may be conducive to disclosure (Kysely et al. 2020). Accessibility is also key. The TH platform removes obstacles to attendance for many families in compounding circumstances that render the logistics of attending in-person difficult, as with families living in remote regions, and high-needs single parent families.

Limitations

Findings should be interpreted in light of the studies' limitations. First, the grey literature on TH Guidelines comprised a mix of pre-COVID-19 resources and others specifically generated in response to the rapid uptake of TH due to the pandemic. Studies eligible for the meta-analyses were limited by the heterogeneity in measurement methods and outcome foci. As such, a small number of studies focused only on child behaviour outcomes and parental depression were subject to meta-analysis. In relation to the qualitative study, our participants were a homogenous sample of therapists from one service, most of whom had limited pre-COVID-19 TH experience. However, due to this recent transition to TH delivery, they were well positioned to reflect on differences between TH and in-person delivery. In all three studies, examination of cultural and gender diversity was not possible. Consumer participation in the research was also not possible at this stage but is now planned.

Recommendations

The findings of these three studies provide considerable support for ongoing delivery of family therapy via TH. In this light we offer recommendations for further optimisation of TH practice in family therapy contexts.

1. Progression in Guidelines

    a. Our evidence suggests a need for advanced clinical guidelines for enhanced engagement and therapeutic alliance. Guidelines offered by peak therapy and regulatory bodies would include but move beyond operational factors regarding the practical administration of TH delivery of services, to include critical points of difference in assessment, engagement and therapeutic alliance over TH media, for adults, and for children.
    b. Beyond the expectation for assessment of suitability, articulation of specific criteria for assessing the appropriateness of TH are needed. These are multi-factored, and range from operational constraints, to safety risks, to clinically based cautions and contraindications.

2. Enablers of Telehealth practice

a. Further work is needed to address technology and access constraints to overcome obstacles that would otherwise preclude some families from TH services, including access for clients to software and necessary equipment, basic training in their use, and support for trouble-shooting.
b. Similarly, evolving technologies may better enable the use of core family therapy techniques within TH services, for example, reflective teams, joint completion of genograms in sessions, and interactive play between children and therapist.

3. Training

a. With rapid expansion of requirements for TH services comes the attendant need to train and support mental health workforces in the requisite skills. Where technology is likely to remain specific to local contexts and require in-house training, broader Family Therapy-specific training for TH would optimally be offered through accessible online training, consultation and support.

4. Research

a. Our review of the existing literature shows some early encouraging replication of evidence and justifies further exploration. For example, efficacy data spanning longer post-treatment intervals, a focus on contraindications and iatrogenic effects would support practice and policy decisions about the continuation of TH interventions as an acceptable alternative to in-person interventions.
b. Greater consistency in assessment of child, parent, and family outcomes across studies would assist.
c. Inclusion of diverse samples, with exploration of limits to culturally safe TH practices will be important to applying this method at scale.
d. Distinctions between forms of telehealth suitable for more than one therapist are yet to be systematically researched and further knowledge about the relative efficacies of co-therapy and team interventions via telehealth would provide valuable insights for future implementation.
e. Mediators of change relative to in-person therapies and questions concerning pre-existing and presenting circumstances impacting efficacy are yet to be addressed.

Conclusion

Go to:

Findings of the current studies offer significant support for delivery by TH methods of family therapy services. The collective evidence suggests equivalent efficacy for relational and mental health outcomes from telehealth relative to face-to-face delivery. From both empirical review and grounded narrative perspectives, the studies included here provide a solid platform from which to advance telehealth methods for family therapy.

Supplementary Information

Go to:

Below is the link to the electronic supplementary material.

Supplementary material 1 (DOCX 28 kb)(28K, docx)

Funding

Go to:

No funding was received for this research.

Data Availability

Go to:

The data that support the findings of Study 3 are not publicly available due to privacy and ethical approval restrictions. Data were not collected for Study 1 or Study 2.

Compliance with Ethical Standards

Go to:

Conflict of interest

The authors declare that they have no conflicts of interest or competing interests in relation to this research.

Ethical Approval

Study Three involved research with human participants. The study was performed in line with principles of the Declaration of Helsinki. Approval to conduct the study was obtained from the La Trobe University Human ethics committee (Date: 23 April 2020/No. HEC20118) and written informed consent was obtained from all participants prior to participating in this study.

Informed Consent

The authors confirm that participants provided informed consent for publication of their anonymous, grouped data.

Footnotes

Go to:

Publisher's Note

References

Go to:

References marked with an asterisk indicate studies included in the systematic review in Study 2.

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December 29, 2022

To the Esteemed Members and Staff of the Arizona Board of Behavioral Health Examiners:

We are a coalition of Supervised Private Practice (herein referred to as "SPP") owners, who must, with passionate urgency and the utmost respect, submit our concerns about the proposed rule changes of 2022/2023 as discussed in the Notice of Proposed Rulemaking. Despite our fears and the absence of formal structures within which to caucus, we've come together to share our experiences, call your attention to the real impacts on our lives and our clients' and supervisors' lives, and advance the dialogue to protect the public and clinicians of all stages of practice alike. In the below text, we hope to elucidate:

- Our concerns about the content of the proposed changes and their devastating impact.
- A discussion of the crucial function of SPP in the milieu of Arizona practice pathways.
- Our heartfelt plea for sensible, strong, equitable, and transparent supervision practices (and their regulation) across all settings, from agency to group practice to SPP.

Please do not hesitate to reach out with any follow-up questions or to set up a meeting. It is our hope that the below discussion will guide you toward policymaking that supports all clinicians and clinical settings here in Arizona, which best stewards the public's trust and safety as well as a strong and effective clinical community for years to come.

With Humble Sincerity,

Halina Brooke, MS, LAC, LAMFT
on behalf of the Arizona Coalition for Sensible Therapy Practices

CONTEXT: Why we didn't come forward before, and why we must now.

Before expounding upon our concerns for the proposed rule changes, we feel it prudent to contextualize why we're coming forward now, why we do so without a list of members' identifying information, and why our effort is at once deeply thoughtful and somewhat guarded. The rulemaking process and its public meetings came on the heels of a summer in which all of us (owners and supervisors of SPPs) were mandated to submit new contracts within a span of under two weeks. We also became the only associate-level clinicians in the entire state whose offerings must be disclaimed widely across our marketing and informational media (while the rest of the state's associates only need bring this forth in clinical documents, informed consent, and as necessary over the course of treatment).

The fast turn-around of the contracts left us anxious and many of us didn't have time to consult our counsel. The additional and specific disclaimers we needed to add to our media left us at a disadvantage to our same-level peers working in other settings when offering our services to the public. Some clients even asked us if it meant we were under discipline from the Board. Others of us had already paid extensive attorneys' fees to seek and apply guidance on informing the public of our status as SPPs—hundreds of dollars of consult rendered obsolete by the new mandatory text. And, we're all already on a registry with the Board. We experienced angst, and for many of us (but not all), this angst rested on a foundation of trauma and fear from prior toxic supervision or workplaces. We do hope this helps to paint a picture of why no one wanted to be the squeaky wheel in a rulemaking process whose preamble said we wouldn't even be impacted: our section was simply being "moved."

We decided to wait and see which of our professional associations would speak for us, as some of us did reach out to those we saw as leaders in these organizations. On the first day of public comment in late October, it seemed that two organizations sent no representatives and the third send someone who asked excellent questions out of concern for agency and group supervisors but did not speak to the interests of SPP owners and our clients. On the second day, the recording indicates that no one attended. We began to connect and vulnerably share our fears with one another. We started to broach the topic, with our supervisors, of how we could try to accommodate the changes should they come to fruition. Over the next two months, we realized how dire the consequences would be: for ourselves, our businesses, and especially our most vulnerable clients and the citizens of Arizona.

UNEXAMINED: The vast and dire consequences of proposed rule changes.

Article 5 of the Preamble of the Filing states that Supervised Private Practice is [only] being moved from R4-6-211 to R4-6-217. However, it omits the substantive changes within this transition, the most significant change of which is the doubling of supervision requirements, and thus the doubling of the time and financial burden of SPP owners to continue in our practices. Article 8 of the same document is meant to disclose the economic, small business, and consumer impact of the rule change. It attestants that "the Board believes most of the rulemaking will have minimal economic impact because it makes *no substantive changes* other

than those required to be consistent with statute." The only impacts named are one-time, nominal costs of a 3-hour biennial course for some supervisors and a one-time out-of-state telehealth providers' fee. In contrast, any mention of the supervision ratio change was completely omitted from this section as well. Let us return to the rule change of doubling SPP owners' supervision ratio and thus our time and expenditures for same:

> For reference, an agency or group practice worker with a productivity requirement of 35 direct hours of client care a week, or 140 hours a month, only needs one hour of supervision in that month. At present, an associate who works similar hours in SPP would need seven (7) hours of supervision in that same month and the proposed rule changes would double that to fourteen (14) hours. That would mean that SPP owners seeing a similar caseload would go from needing seven times the amount of supervision as their peers in agencies to a whole FOURTEEN times the amount per month. For those paying average market rates for supervision ($150/hr), that would bring supervision expenses for an SPP owner working these hours to over $2,000 a month. *Of note, and to preempt the response that SPP owners typically work fewer direct hours, it would still come out to ten (10) hours and over $1,500 a month for those seeing 25 clients a week and six to seven (6-7) hours or $1,000 a month for those seeing 16 clients per week.*

This has a robust and tragic economic, small business, and consumer impact. When asked, here is what a sampling of SPP owners said about how doubling of our supervision ratio will impact ourselves and our families, our businesses and those of our supervisors, our professional development, and our ability to serve our mental/behavioral health clientele:

- Supervision costing more than housing and office rental (combined, in some cases).
- Needing to discontinue specialist consultations or trainings for high needs clinical conditions like Eating Disorders, Autism, OCD, or Prolonged Grief because their entire consult budget would now be earmarked to their general/practice supervisor. *While our supervisors are highly qualified, it is best practices to consult niche experts and trainings for myriad reasons.*
- Needing to terminate some clients or decreasing care for some clients so they stay under x hours per week due to supervisor being unable to commit to the increase in supervision.
- Needing to terminate care for low-fee clients and only take full-fee to make ends meet, meaning that the most vulnerable clients lose out on needed care while therapists need to choose between giving back and staying above water.
- Having to halt progress through specialized advanced trainings from PhD programs to DBT, EFT, Gottman, or SE skills and/or certification, which restricts professional growth.
- Losing their supervisor entirely, and not being able to count the hours between one supervisor terminating and adding another, which pushes independent licensure farther down the road.
- Losing the time and budget they need to care for an elderly relative, child, or themselves.

- Finding themselves losing the self-care ability they finally got back when they left agency work.
- Realizing they might not be able to afford the healthcare they or their family needs.
- Slower progression to independent licensure and thus, the ability to scale their small business to serve niche and underserved communities.
- Inability to offer their time and expertise for giving back to the community because their schedules and bank accounts are taking such a hit.
- Feeling stuck between a rock and a hard place because they've already chosen to build and invest in their practice based on the rules at that time, so they lose tens of thousands of dollars and many months if they close, but staying open is also a financial hardship.

BELONGING: Our Role as SPP owners in the Arizona Mental/Behavioral Health Community

It is natural to experience distress when something new or different emerges in a setting whose norms are fairly consistent. It's also natural to stand so close to the forest that we forget about the larger world (the rest of the US in this case) out there that might already have experience and success with what might feel new to us. Thus is the case with supervised private practice in Arizona. Washington, Colorado, Florida and countless other states have a proven track record that Supervised Private Practice works, has not been the downfall of the group or agency template, has not increased risk for harm to clients, and has in fact both raised the bar for supervision and expanded the public's options for quality psychotherapy services. It is certainly not the right fit for every associate, but neither are the other paths to independent licensure. Much like how we offer our clients *informed consent* when starting treatment and ensuring that we are a good fit for their unique needs, associates should have access to the variety of tracks that allows for them to choose the right fit.

- Community Mental Health: The chance to serve the community, knock out direct contact hours at rapid pace, work with very intense and unusual cases, lots of resourcing and behavioral work with clients, and likely healthcare benefits. Downsides include feeling ill-equipped for complicated clients, physically unable to fulfill high productivity burdens, very little chance for advancement in a niche treatment model, and minimal opportunity for deeper, non-crisis therapy work with clients.
- Small Group Practice: A less intense environment than CMH but still the chance at a high rate of completion of direct hours, the chance to wet one's feet in a private practice ambiance, and the opportunity to learn a niche treatment model if the specific practice allows. Downsides include often low pay (with some practices offering as low as 40% of the client's fees), minimal or no health insurance, and tension if an associate chooses to go out on their own.
- Supervised Private Practice: The chance to practice with the hours and setting that fits one's individual needs, purity of supervision since the supervisor's financial interests aren't tethered to one's productivity, working with the populations that feel like the best fit, and the opportunity to direct more of one's revenue toward specific business

and training expenses and endeavors. Downsides: finding health insurance, needing to manage the business side, and truly needing to have high insight and strong clinical skills to maintain a thriving practice and maintain ethics and competence.

In all three contexts, associates can thrive or suffer. Many people end up choosing door number three because the first or second options didn't work out, either due to the above-mentioned factors or because supervision ended up falling short or even leaving the associate traumatized. Others choose door number three straight away because they've worked in related fields, like education or social services, enter the field with more lived experience or wisdom than a typical graduate, and need the semi-autonomous environment so that they can best continue to develop as therapists and serve the community.

Unfortunately, there are also some who don't realize that SPP isn't a highway to financial windfall and that it takes real effort, competence, and ethical mindedness. Stories have echoed in the recent months that some associates in private practice are receiving board complaints and falling under fire for ethical shortcomings. While the dominant conclusion is that this means that *all* supervised private practice is wrong and was a bad idea in the first place, that is a hasty generalization that also serves to obscure what we're really seeing: the adjudications illustrate that the Board process works—quite well in fact—and that it's keeping the public safe!

Further, SPP is a consumer-driven business model. SPPs, by default, are not funded by insurance contracts, employee wellness plans, Medicaid, or court/government contracts. As private-pay relationships with no intermediary, the success of these clinician-owners is built solely upon client continuity, which is singularly tied to whether the consumer finds value and safety in the relationship and care. When private-pay practices don't succeed, the market weeds out those who struggle to serve this population. When we as SPP owners *do* succeed, however, it is a cause for celebration and a testament that newer clinicians can blend robust skill, healthy rapport, ethical stewardship, and innovative methods in offering healing and growth alongside our longer-tenured counterparts. And, many of us *are* thriving as our clients do the same under our care.

COLLABORATION: Shared values and shared aspirations for our professional community.

Without detouring too far from the key points of our address to you, we in this Coalition join the Board and Staff in its commitment to ethical and safe practice. We know that our supervision as SPP owners is vital and we aspire toward an Arizona whose agency-based, group-based, associates can know that their supervision is as safe, thorough, and accountable as ours. Many of us have either experienced distressing supervision ourselves, at prior positions, or fear for our colleagues who are currently struggling with such situations at some agencies and groups. We ask that you turn your focus toward their plight as well.

Regarding concerns about SPP: If the Board and Staff wish for associates to think more deeply about Supervised Private Practice's many risks and burdens before jumping in, we humbly ask

that the measures taken don't also serve to handicap good, responsible associate clinicians from doing their best work and using the resources from the businesses they've worked hard to build to continue preserving their own wellness, honing their skills through continued trainings and mentorship, and serving the community in the best way they can. Perhaps alternatives can better achieve the attested goal. For example, a one-time course that hopeful SPP owners must take to inform themselves of the risks, burdens, and extra responsibilities this kind of practice requires, might be a reasonable alternative.

As the business owners and clinicians who live the reality of practice ownership during our associate years, we are on the front lines of this experience and are an integral asset to you as you move forward with regulation designed to center the wellbeing of the state we all love. We humbly ask for a seat at the table to create whatever this gatekeeping measure might be, and we urgently ask you to please choose not to advance the proposed rules change as set forth in the filing. Let's work together to build the strongest emerging cohort of psychotherapists Arizona has ever seen, instead of an even greater barrier and divide between the various paths to independent licensure!

Again, if we can be of any service, answer any questions, or provide further feedback, our coalition is available at azsensibletherapypractices@gmail.com . Thank you so much for your consideration.

In Collaborative Spirit,

Halina Brooke, MS, LAC, LAMFT
on behalf of the Arizona Coalition for Sensible Therapy Practices

June 30, 2023

To the Members & Staff of the Governor's Regulatory Review Council:

My name is Halina Brooke and I am writing as a leader in the Arizona Sensible Therapy Practices Coalition. The below communication is meant to speak to concerns and questions raised during the dialogue related to the AZBBHE rule change proposal during the study session. It is our hope that this information will deepen your understanding of our professional climate here in Arizona as well as sort facts from fears and guide you toward a unanimous vote to deny the doubling of Supervised Private Practice's supervision expenses and time.

What are the differences between Arizona and other states that let associates own businesses?

As far as we've learned from our research, out of all of the states that allow associates to own their own practices, Arizona is both the strictest and most elaborate in structure. In Hawaii, Washington, Colorado, and North Carolina for example, the requirement is closer to simply having a business license like any other business.

What can independently licensed business owners do that associate-level business owners can't?

Independently-licensed clinicians are allowed to have employees and offer services beyond psychotherapy. Under supervised private practice, our businesses must remain small, single-person setups that only provide psychotherapy services. We've found it worthwhile anyway, and we understand that this is designed to curtail potential ethical struggles. We also feel the constriction of not being able to grow until we earn an independent license. That said, we appreciate how readily board staff is available to answer our questions about interpreting this rule, like when we want to hire web developers, cleaning staff, or assistants. Especially considering that we are barred from growing our businesses in scope or workforce, more restrictions, like the doubling our supervision fees to up to $24,000 a year that you're considering this week, would be an economic disaster.

Post-Graduate Experience in Behavioral Health: Is it like a medical residency?

No. Medical Residencies (per the American Medical Association) and Psychology Post-Grad placements (per the American Psychological Association) are rigorously supervised and include extensive and standardized competencies, educational experiences, daily to weekly mandatory rounds on patients, and seasoned clinicians' eyes on newer licensees' work in operating rooms or via videos of psychotherapy sessions, for example. In contrast, post-grad hours in our professions of social work, counseling, and marriage/family therapy are simply the labor of direct client care hours. In order for us to earn access to independent licensure, Arizona requires us to have supervisors view video of or attend only ten (10) of the 1600 hours we work with clients. And, in order for associates to count worked hours toward independent licensure in any given month, they need only one contact hour with a supervisor if they're employed by someone else (or potentially seven times that amount if they own their psychotherapy business).

If it's not structured to meet specific competencies, then what is the purpose of two-tier licensure?

We would posit that no one wants their uber driver to have gotten his license yesterday. Joking aside, field experience is very important to becoming a proficient therapist. Practice hours allow for skill development and continuing, specialized education. The system is broken, as every state's requirements are different, the quality of everyone's hours is different, and many associates are denied credit for worked hours due to decades of absent oversight and accountability for agencies' and group practices' supervisors by our Board. We would love to see a transparent accountability structure and a space for dialogue to help our profession provide a valuable and fair associateship experience. However, that is not why we're here at present, so we're hoping to start with denying this rule change.

What really happens at agencies? Is it really true that agencies are cocoons of support?

No. While there have been no formal data collection attempts made by our Board about Arizona-specific agencies, there are myriad articles detailing agency-related burnout in the professional research journals. So too, a simple request for the "productivity requirement" data from the agencies, overlaid with salary information, would yield most of the picture. Add in case studies we'd be happy to provide, and you'll see that most agency experiences are bereft of support and oversight, are marked with high supervisorial turnover, and often include fraudulent and deceitful practices around promising and not delivering supervision services. Associates work for two things: pay and supervision toward independent licensure. When the latter is denied due to willful deceit or neglect, there is no recourse.

Are SPP owners really as isolated as was asserted at the study session?

Absolutely not. Just like we shared at our January Board meeting, we are the farthest thing from isolated. We have a rich community that includes strong clinical mentorships, online groups for community and support, monthly consultation and learning groups in various areas of the state, and relationships built on our shared passion for service and the learning curve around business ownership. And, business ownership affords us the chance to direct our education/consultation budget to where we need it, as well as the chance to design a schedule that allows for rich consultations and community support—something many of us found absent when we were employed or contracted at agencies or groups.

Is there any data about SPP-related complaints? What about over the last 20 years of agency-related malfeasance?

No, as we mentioned in prior correspondence, our written and verbal requests for this data have been met with the response that there isn't any data available to us, or any data at all. If we had the data and could see what the actual concerns were, we might be able to collaborate on finding actions to mitigate them, but we're all flying blind right now. We would also posit that, just because an SPP owner gets a complaint doesn't mean that they've made the error while an SPP owner or because they were an SPP owner. Take the case of a colleague of mine and former SPP owner, KT, for example. The complaint submitted about her was found to be without merit but, when the board chose to dig elsewhere within her files and laptop, they uncovered a mistake she had made as a graduate student

while under direction of an agency supervisor and interning at an agency—they used it to drive her disciplinary order. I will stop before I go down a due process rabbit hole, but it is noteworthy that cases like this might be used to assert that SPP is the issue, when it may not be so.

Is it really true that associate/lower-tier licensees make the most clinical/ethical mistakes?

We were surprised to hear this claim during the meeting. As far as we know, this data has not been collected about Arizona. In pouring through the body of research about mental health clinician discipline, only one data set that addressed length of time in practice was found. Wilkinson, et al. (2019) found that the average time in practice for a discipline recipient was OVER A DECADE. Associates are not more fallible, and we would posit that they are, overall, more careful. So too, SPP owners have so much more oversight than other associates that it would be hard for us to make more mistakes. We also have far more to lose if we do.

Wilkinson, T., Smith, D. and Wimberly, R. (2019), Trends in Ethical Complaints Leading to Professional Counseling Licensing Boards Disciplinary Actions. Journal of Counseling & Development, 97: 98-104. https://doi.org/10.1002/jcad.12239

What is the composition of the Arizona Board of Behavioral Health Examiners?

Our Board has historically been dominated by agency staff as members, which has been consistent through the administrations of governors of all parties. At present most of our board's professional members either are agency staff or have spent most of their careers as agency staff. The rest, at first glance, appear to be group practice owners. All but one of our current board members either works for an agency or financially benefits from the labor of associates. The one person we know of on the board who supervises an SPP was the only one who raised questions at the meeting about the change potentially being too much, suggesting a smaller change to the supervision ratio. We are absolutely not suggesting that financial interests of board members drove this rule change. However, it is at least noteworthy that no SPP owners (past or present) were solicited to collaborate on the drafting or consideration. That said, our coalition has visited the Capitol and met with Boards and Commissions staff to both learn about the process of applying to sit on a board and share our concerns about representation. We are very excited to hopefully see some movement and consideration here.

Thank you for your consideration to both clinicians and clients of mental health care in Arizona.

In Service to Arizona,

Halina Brooke, MS, LAC, LAMFT
on behalf of the Arizona Sensible Therapy Practices Coalition

Halina@recoursecounseling.com
Cell: 602.339.1053

DEPARTMENT OF ENVIRONMENTAL QUALITY
Title 18, Chapter 14

Amend: R18-14-101, R18-14-102, Table 1, R18-14-103, R18-14-104, Table 2, Table 3, R18-14-105, R18-14-108, Table 4, Table 5, R18-14-109,Table 6, R18-14-110, Table 7, R18-14-111, R18-14-112, R18-14-202, Table 1, R18-14-301

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: August 1, 2023

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

FROM: Council Staff

DATE: July 17, 2023

SUBJECT: **DEPARTMENT OF ENVIRONMENTAL QUALITY**
Title 18, Chapter 14

Amend: R18-14-101, R18-14-102, Table 1, R18-14-103, R18-14-104, Table 2, Table 3, R18-14-105, R18-14-108, Table 4, Table 5, R18-14-109,Table 6, R18-14-110, Table 7, R18-14-111, R18-14-112, R18-14-202, Table 1, R18-14-301

Summary:

This regular rulemaking from the Department of Environmental Quality (Department) seeks to amend twelve (12) rules and eight (8) tables in Title 18, Chapter 14, Articles 1, 2, and 3 related to Water Quality Protection Fees, Public Water System - Design Review Fees, and Certified Operator Fees, respectively. Specifically, the proposed rule amendments would increase water quality protection fees as authorized by House Bill (HB)2406 during the 2022 legislative session. The Department indicates it last increased water quality permit fees in 2011 and the fees for Operator Certification in 2016. This proposed rule would increase the water quality protection fees for the aquifer protection permits (APP), reclaimed water permits, drinking water engineering review, the Arizona Pollutant Discharge Elimination System permits (AZPDES) programs, and the Underground Injection Control (UIC) permit program, as well as the operator certification program.

The Department indicates the proposed amendments would increase the fees to address the direct and indirect costs of the Department's relevant water quality protection duties, including employee salaries and benefits, professional and outside services, equipment, travel, and other necessary operational expenses directly related or associated with these permits and the enforcement of the programs. Additionally, the Department indicates it proposes to amend some fee requirements for water quality protection services. The Department states, without increasing fees, it will become increasingly difficult for the Department to administer and enforce the federal Clean Water Act (CWA) and Safe Drinking Water Act (SDWA), which protect human health and the environment. The Department states improper implementation or enforcement of these statutes could result in the federal government revoking Arizona's primary implementation and enforcement authority within its jurisdiction (primacy) and the U.S. Environmental Protection Agency (EPA) becoming the primary regulator in Arizona. The Department states these proposed fees will have an annual adjustment by Consumer Price Index (CPI).

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

The Department cites both general and specific statutory authority for these rules.

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

As noted above, the Department is proposing to increase several fees. Pursuant to A.R.S. § 41-1008(A)(1), "an agency shall not [c]harge or receive a fee or make a rule establishing a fee unless the fee for the specific activity is expressly authorized by statute." The Department has cited specific statutory authority for the fees charged as listed in the "implementing statutes" in Section 2 of the Preamble.

Additionally, pursuant to A.R.S. § 41-1008(A)(3), "an agency shall not… increase a fee in an amount that exceeds the percentage of change in the average consumer price index as published by the United States department of labor, bureau of labor statistics between that figure for the latest calendar year and the calendar year in which the last fee increase occurred." The Department indicates in Section 6 of the Preamble that "these proposed fees will have an annual adjustment by Consumer Price Index (CPI)."

As such, the Department has complied with its statutory requirements regarding the proposed fee increases.

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 indicates it reviewed an Audubon Society study that addressed the Economic Impact of Arizona's Rivers, Lakes, and Streams, which can be found at the following link: https://www.audubon.org/economic-impact-arizonas-rivers-lakes-and-streams.

4. Summary of the agency's economic impact analysis:

The rulemaking was made to collect fees for water quality protection programs, which will go into the water quality fee fund (WQFF). The amended fees included in this rulemaking are projected to raise about $2.8 million; however, these increased fees alone will be insufficient to cover the full cost of the current $11.9 million program deficit. Costs would be primarily incurred by permittees - ranging from private and public wastewater treatment plants to mining companies - and certified operators.

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 rules impose the least burden and costs to persons regulated by the rules.

6. What are the economic impacts on stakeholders?

Stakeholders are identified as applicants and permittees of the drinking water, APP, UIC, reclaimed water, and AZPDES permitting programs, as well as individuals certified by the Operator Certification program. The Department anticipates that this rulemaking will affect 17,000 to nearly 38,000 permitted facilities or activities, as well as an unknown number of facilities or activities in the future. The Department anticipates the increased fees will have a moderate impact on these persons – as compared to the minimal impact of a less than Consumer Price Index (CPI) increase, or the significant impact of a greater than CPI increase. The rulemaking's economic impact results from the increase in fees on those identified above.

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

The Department indicates it made no changes between the Notice of Proposed Rulemaking published in the Administrative Register on April 28, 2023 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?

The Department indicates it received eight (8) comments on this rulemaking from various stakeholders and entities, including the City of Phoenix and the Arizona Mining Association. The comments are summarized in Section 11 of the Preamble along with the Department's responses. Copies of the written comments have also been provided with the final materials for the Council's reference. Council staff believes the Department has adequately responded to the comments on these proposed rules.

9. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?

The rules do not require the issuance of a permit, license, or agency authorization. These rules establish fees for water quality protection services (Article 1), public water system design review (Article 2), and certified operators (Article 3). The Department indicates the requirements for a permit, license, or agency authorization (for which ADEQ charges such fees) are established elsewhere in rule, specifically Title 19, Chapter 9.

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. The Department indicates, while the CWA and SDWA are applicable to some of the Department's water quality programs, these federal laws do not specify funding structures for the programs.

11. Conclusion

This regular rulemaking from the Department seeks to amend twelve (12) rules and eight (8) tables in Title 18, Chapter 14, Articles 1, 2, and 3 related to Water Quality Protection Fees, Public Water System - Design Review Fees, and Certified Operator Fees, respectively. Specifically, the proposed rule amendments would increase water quality protection fees as authorized by House Bill (HB)2406 during the 2022 legislative session. The Department indicates it last increased water quality permit fees in 2011 and the fees for Operator Certification in 2016. This proposed rule would increase the water quality protection fees for the aquifer protection permits (APP), reclaimed water permits, drinking water engineering review, the Arizona Pollutant Discharge Elimination System permits (AZPDES) programs, and the Underground Injection Control (UIC) permit program, as well as the operator certification program.

Pursuant to A.R.S. § 41-1032(A)(1), the Department is requesting an immediate effective date for these rules in order to preserve public safety and protect human health and the environment by ensuring necessary funding for water quality protection services. The Department states delaying the effective date would put all water quality protection services, inspections and enforcement at risk, for all programs. Specifically, drinking water inspections would occur at less frequency potentially jeopardizing the health and safety of consumers. Council staff believes the Department has provided adequate justification for an immediate effective date.

Council staff recommends approval of this rulemaking.

ARIZONA DEPARTMENT
OF
ENVIRONMENTAL QUALITY

Katie Hobbs
Governor

Karen Peters
Director

6/16/2023

Nicole Sornsin, Chair
Governor's Regulatory Review Council
100 N. 15th Ave., Ste. 302
Phoenix, AZ 85007

Re: Regular Rulemaking: Title 18. Environmental Quality, Chapter 14. Department of Environmental Quality – Permit & Compliance Fees, Articles 1, 2, and 3

Dear Chair Sornsin:

The Arizona Department of Environmental Quality (ADEQ) hereby submits this final rulemaking package to the Governor's Regulatory Review Council (GRRC) for consideration and approval at the Council Meeting scheduled for August 1, 2023.

The following information is provided for your use in reviewing the enclosed rules for approval pursuant to A.R.S. § 41-1052 and A.A.C. R1-6-201:

I. Information Required by A.A.C. R1-6-201(A)(1)
   a. The public record closed for all rules on May 30, 2023.
   b. The rulemaking activity does not relate to a five-year review report.
   c. The rule does not establish a new fee.
   d. The rule contains fee increases.
   e. Pursuant to A.R.S. § 41-1032(A)(1), ADEQ requests an immediate effective date for these rules in order to preserve public safety and protect human health and the environment by ensuring necessary funding for water quality protection services. Delaying the effective date would put all water quality protection services, inspections and enforcement at risk, for all programs. Drinking water inspections would occur at less frequency potentially jeopardizing the health and safety of consumers.
   f. The Department certifies that the preamble discloses reference to any study relevant to the rule that ADEQ reviewed and either did or did not rely on in its evaluation of or justification for the rule.
   g. No new full-time employee is necessary to implement and enforce the rule.
   h. A list of documents enclosed under A.A.C. R1-6-201(A)(2) through (8), which are enclosed as electronic copies:
      1. This cover letter.
      2. The Notice of Final Rulemaking (NFRM), including the preamble, table of contents, and text of each rule.

3. An economic, small business, and consumer impact statement that contains the information required by A.R.S. § 41-1055.
4. The written comments received by ADEQ concerning the proposed rule. ADEQ received no comments at the oral proceeding.
5. ADEQ received no analysis regarding the rules' impact on the competitiveness of businesses in this state as compared to the competitiveness of businesses in other states; therefore, no such analysis is included in this submittal.
6. No material is incorporated by reference.
7. The general and specific statutes authorizing the rule, including relevant statutory definitions:
   a. Authorizing statutes (general): A.R.S. §§ 49-104(C)(1), 49-210, 49-241, 49-242.
   b. Implementing statutes (specific): A.R.S. §§ 49-211, 49-241.02, 49-242(E), 49-255.01(J), 49-352(A), 49-353(A)(2), 49-361.
8. For purposes of R18-14-108, "complex" is defined in A.A.C. R18-1-501(9), which is enclosed. R18-14-301(A) provides that definition terms from A.A.C. R18-5-101, which is enclosed, apply to Article 3.

II. Additional items required by GRRC:
   a. Exemption Memo Request.
   b. Governor's Office initial written approval.
   c. Governor's Office final written approval

Thank you for your timely review and approval. Please contact Trevor Baggiore, Division Director, Water Quality Division, 602-771-2321 or baggiore.trevor@azdeq.gov, if you have any questions.

Sincerely,

Karen Peters, Director
Arizona Department of Environmental Quality

Enclosures

NOTICE OF FINAL RULEMAKING

TITLE 18. ENVIRONMENTAL QUALITY

CHAPTER 14. DEPARTMENT OF ENVIRONMENTAL QUALITY

PERMIT AND COMPLIANCE FEES

PREAMBLE

1. Articles, Parts, or Sections Affected (as applicable)	**Rulemaking Action**
R18-14-101	Amend
R18-14-102	Amend
Table 1	Amend
R-18-14-103	Amend
R-18-14-104	Amend
Table 2	Amend
Table 3	Amend
R18-14-105	Amend
R18-14-108	Amend
Table 4	Amend
Table 5	Amend
R18-14-109	Amend
Table 6	Amend
R18-14-110	Amend
Table 7	Amend
R18-14-111	Amend
R18-14-112	Amend
R18-14-202	Amend
Table 1	Amend
R18-14-301	Amend

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

Authorizing statutes: A.R.S. §§ 49-104(C)(1), 49-210, 49-241, 49-242

Implementing statutes: A.R.S. §§ 49-211, 49-241.02, 49-242(E), 49-255.01(J), 49-352(A), 49-353(A)(2), 49-361

3. The effective date of the rule:

Pursuant to A.R.S. § 41-1032(A)(1), ADEQ requests an immediate effective date for these rules in order to preserve public safety and protect human health and the environment by ensuring

necessary funding for water quality protection services. Delaying the effective date would put all water quality protection services, inspections and enforcement at risk, for all programs. Drinking water inspections would occur at less frequency potentially jeopardizing the health and safety of consumers.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 29 A.A.R. 938, April 21, 2023

Notice of Proposed Rulemaking: 29 A.A.R. 955, April 28, 2023

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

Name: David Lelsz, Ph.D.

Address: Arizona Department of Environmental Quality
1110 W. Washington St.
Phoenix, AZ 85007

Telephone: (602) 771-4651

E-mail: lelsz.david@azdeq.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:

Summary

This proposed rule would increase water quality protection fees as authorized by House Bill (HB) 2406 during the 2022 legislative session. The Arizona Department of Environmental Quality (ADEQ) last increased water quality permit fees in 2011 (17 A.A.R. 568) and the fees for Operator Certification in 2016 (21 A.A.R. 2597). This proposed rule would increase the water quality protection fees for the aquifer protection permits (APP), reclaimed water permits, drinking water engineering review, the Arizona Pollutant Discharge Elimination System permits (AZPDES) programs, and the Underground Injection Control (UIC) permit program, as well as the operator certification program. This rule would increase the fees to address the direct and indirect costs of ADEQ's relevant water quality protection duties, including employee salaries and benefits, professional and outside services, equipment, travel, and other necessary operational expenses directly related or associated with these permits and the enforcement of the programs. In addition, ADEQ proposes to amend some fee requirements for water quality protection services. Without increasing fees, it will become increasingly difficult for ADEQ to administer and enforce the federal Clean Water Act (CWA) and Safe Drinking Water Act (SDWA), which protect human health and the environment. Improper implementation or enforcement of these statutes could result in the federal government revoking Arizona's primary implementation and enforcement authority within its

jurisdiction (primacy) and the U.S. Environmental Protection Agency (EPA) becoming the primary regulator in Arizona. These proposed fees will have an annual adjustment by Consumer Price Index (CPI).

Background

Water Quality fees have not been adjusted since 2011 and Operator Certification fees have not been adjusted since 2016. Inflation has increased approximately 43% since the last adoption of water fees, and 34% since the inception of Operator Certification fees. The Water Quality Division (WQD) faces an 11.9 million-dollar structural deficit relative to WQD's costs. Without remedy, this deficit will impact ADEQ's long term ability to effectively implement state and federal water quality programs.

ADEQ is currently experiencing an annual budgetary shortfall of revenue for its WQD. The current fee approach assumes that WQD's permitting and permit support programs would be self-sustaining through permit fees. However, WQD annually requires an influx of revenue from non-fee income to cover its costs. In addition, the WQD has many other required program responsibilities that don't fit into the fee-for-service model. Even with the influx of non-fee income, the WQD does not have sufficient income to meet all federal and state obligations. The Division estimated an $11.9 million gap for fiscal year (FY) 24. The amended fees included in this rulemaking would raise about $2.8 million to help close that gap. In order to close the remaining gap, state leadership made a one time general fund appropriation of $9.5 million. This appropriation will either need to be renewed or obtained from a difference source for the WQD to have sufficient funding in FY25 and beyond.

ADEQ was granted authority through HB 2406 in the 2022 legislative session to update fees for multiple water programs. Programs fees that will be included in this rulemaking are the CWA, the SDWA, UIC, and the APP in Arizona Administrative Code (A.A.C.) Title 18, Chapter 14, Articles 1, 2, and 3. Adjustments in fees will correspond to only what is necessary for implementing existing federal and state programs and be restricted to the increase in costs due to inflation since the inception of the relevant fees.

Adjusting these fees will allow ADEQ to better protect human health and safety, including supporting the resolution of the following pressing water quality issues: 27 drinking water systems in the State that are serving drinking water exceeding the federal health standards; and over 50 wastewater systems that are operating out of compliance with State law. This approach will also allow ADEQ to increase our inspection frequency, maintain our ability to issue environmentally protective permits and maintain the improvements we have made in our permitting time frames all while protecting vital surface and groundwater sources of drinking water.

ADEQ approached stakeholders in September and October 2022 with the prospect of an adjustment to water permitting and Operator Certification fees that would fully fund all Water Quality Programs, but would entail an increase to those fees that exceeded the costs due to inflation alone. The feedback ADEQ received was that while the need to fund those programs is vital the negative consequences of a dramatic increase in cost to our stakeholders would have deleterious impacts to their priorities. Feedback included concerns about the timing of the fee increase, its magnitude, and need to pass the cost of the increased fees on to customers and taxpayers. In addition, concerns were raised about the impact that an increase to Operator Certification fees would have on the professionals that operate important drinking water and wastewater infrastructure.

Explanation of Proposed Fee Increases

ADEQ uses the water quality fee fund (WQFF) to implement various water quality programs, such as APP, reclaimed water, AZPDES and the Operator Certification program. In FY23, and in previous years, this fund had to be supplemented with money from other sources to operate those programs. All flat fees, hourly fees, and maximum fees for all programs would increase by Consumer Price Index (CPI), and would continue to increase or decrease based upon CPI annually. Fees for Operator Certification would increase based upon CPI, with an annual increase or decrease based upon CPI as well. While ADEQ has authority to increase permitting fees above CPI, for this rulemaking ADEQ has decided to raise fees only by CPI.

Consumer Price Index Limit on Fee Increases

In response to stakeholder input, and in accordance with A.R.S. § 41-1008(A)(3), ADEQ has limited the increase in this proposed rule to the percentage of change in the average CPI as published by the United States Department of Labor, Bureau of Statistics between that figure for 2023 and the calendar year in which the last fee increase occurred: 2011 for permitting fees, and 2016 for operator certification fees. The CPI for any year is the average of the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items published by the United States Department of Labor, as of the close of the 12-month period ending on June 30 of that year, available at: https://data.bls.gov/pdq/SurveyOutputServlet?data_tool=dropmap&series_id=CUURS48ASA0,CUUSS48ASA0. This CPI is a better representation of Arizona's rapidly expanding economy and population than the national CPI. Accordingly, ADEQ proposes increasing fees for water quality protection services (Article 1) and public water system design review (Article 2) by approximately 43%, and certified operator fees (Article 3) by approximately 34%.

Annual CPI Adjustments

ADEQ proposes adjusting water quality service fees every August 1 to the nearest $10 by multiplying by the CPI for the most recent year and dividing by the CPI for the base year (2023). Again, the CPI

for any year is the average of the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items ending on June 30 of that year, available at: https://data.bls.gov/pdq/SurveyOutputServlet?data_tool=dropmap&series_id=CUURS48ASA0,CUUSS48ASA0. There is about a two-week lag from the reference month (June) to the date on which the index is released by the Bureau of Labor Statistics, U.S. Department of Labor (that is, the CPI for June is released in mid-July). The first adjustment would occur on August 1, 2024.

Section by Section Explanation of Proposed Rules:

In order to make reasonable progress toward the goal of addressing water quality issues, ADEQ proposes the following amendments to 18 A.A.C. 14, Articles 1, 2, and 3:

Article 1

R18-14-101	Amend the definition of "water quality protection service" to clarify it includes pre-application consultation for permits, as well as review of annual reports.
R18-14-102 Table 1	Amend to increase hourly rate and maximum fees for water quality protection services (including APP, AZPDES, and reclaimed water permits), and adjust those fees annually by CPI. Additionally, amend to adjust hourly rate and maximum fees for the UIC program annually by CPI. The proposed amendment also revises subsection (B) to eliminate the provision waiving the fee for the Department's first hour of review.
R18-14-103	Amend to eliminate the initial deposit requirement for water quality protection services subject to an hourly fee in subsection (B). The proposed amendment also removes subsection (C) to align with the Agency's review practice for water quality protection services requests.
R18-14-104 Table 2 Table 3	Amend to increase annual fees for water quality protection services subject to an hourly fee (including APP, AZPDES, and reclaimed water permits), and adjust those fees annually by CPI. Additionally, amend to adjust annual fees and annual waste disposal fees as applicable to UIC regulated facilities, subject to an hourly rate fee, annually by CPI.
R18-14-105	Amend subsection (A) to align with the Agency's billing practice of providing total fees paid to date and maximum fees paid on an as requested basis. The proposed amendment also revises subsection (B) to align with the

	elimination of the initial deposit requirement for water quality protection services subject to an hourly fee in R18-14-103(B).
R18-14-108 Table 4 Table 5	Amend to increase APP water quality protection services flat fees (including Types 2, 3, and 4 general permits), and adjust those fees annually by CPI.
R18-14-109 Table 6	Amend to increase AZPDES water quality protection services flat fees (including initial and annual), and adjust those fees annually by CPI.
R18-14-110 Table 7	Amend reclaimed water general permit fees (including renewal), and adjust those fees annually by CPI.
R18-14-111	Amend to adjust UIC regulated facility services flat fees annually by CPI.
R18-14-112	Amend to eliminate flat fees for dry well registration and transfer of registration in subsections (1) and (2) as those facilities are subject to fees under the UIC program. The proposed amendment also increases flat fees for certificate of approval for sanitary facilities and subdivisions, and adjusts those fees annually by CPI.
Article 2	
R18-14-202 Table 1	Amends to increase flat rate fees for design review services for public water systems (including priority review fees), and adjust those fees annually by CPI.
Article 3	
R18-14-301	Amends to increase certified operator fees (including certification or renewal), and adjust those fees annually by CPI.

Immediate Effective Date.

Pursuant to A.R.S. § 41-1032(A)(1), ADEQ requests an immediate effective date for these rules in order to preserve public safety and protect human health and the environment by ensuring necessary funding for water quality protection services. Delaying the effective date would put all water quality protection services, inspections and enforcement at risk, for all programs. Drinking water inspections would occur at less frequency potentially jeopardizing the health and safety of consumers.

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:

ADEQ reviewed an Audubon Society study that addressed the Economic Impact of Arizona's Rivers, Lakes, and Streams, which can be found here: https://www.audubon.org/economic-impact-arizonas-rivers-lakes-and-streams

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 following discussion addresses each of the elements required for an economic, small business and consumer impact statement under A.R.S. § 41-1055.

Identification of the rulemaking: 18 A.A.C. 14, Articles 1, 2, and 3, amending R18-14-101 through R18-14-105, R18-14-108 through R18-14-110, and R18-14-112; R18-14-202; and R18-14-301; and their respective tables. These rules are designed to collect fees for water quality protection programs, which will go into the water quality fee fund (WQFF) - not to change the conduct of any regulated entities. The hourly fees, flat fees, and maximum fees would be increased throughout the noted articles. When ADEQ originally set its permitting fees in 2011 and its Operator Certification fees in 2016, those fees were based on conservative assumptions, including costs associated with the minimum level of staffing that ADEQ believed was necessary to implement the permitting, compliance and enforcement programs, effectively, efficiently, and within licensing time-frames. Though using the best available information at the time, the actual costs of implementing the above programs is more than originally projected. The fees collected through the hourly and flat fees did not raise the revenue needed to properly conduct those programs, and outside funding had to be secured.

ADEQ's goal in this rulemaking is to establish water quality protection fees that will help sustain those programs while avoiding disproportionate impact on any one group of stakeholders. The amended fees included in this rulemaking are projected to raise about $2.8 million; however, these increased fees alone will be insufficient to cover the full cost of those programs. State leadership approved a bill that will help ADEQ close the gap for FY24. No new fees are being proposed in this rulemaking.

This rulemaking addresses the continued shortfall created by the elimination of the General Fund from ADEQ's budget in 2011 and the subsequent increase in program costs due to inflation, and includes increases to the following categories of fees:

- Hourly-based fees for individual permits or water quality protection services subject to variable review times;
- Flat fees for water quality protection services subject to predictable average times for review, such as for general permits;
- Annual fees to cover the costs of administering permit coverage; and
- Flat fees for operator certification.

Description of Water Quality Programs: ADEQ is responsible for developing permit programs for AZPDES, APP, UIC, and reclaimed water, as well as ensuring safe potable water for the public through (among other things) public water system design review and operator certification. *See* A.R.S. §§ 49-203(A)(2), (5), (6) and (7); and 49-351. These programs help protect human health and the environment by ensuring clean and safe water for consumption, recreational use, and agricultural use, among other things, through permitting, inspections, compliance, and enforcement of federal and state requirements. The permitting programs protect both surface water and groundwater through the issuance, management, and modification of permits that ensure pollutant limits are set at levels protective of human health and the environment. The safe drinking water program protects the drinking water for Arizonans, by conducting site inspections and monitoring for compliance. Complaints are investigated, and data involving compliance and/or noncompliance is compiled and tracked. Assistance for the regulated community is provided, and oversight is given when non-compliance events take place to ensure proper remediation.

Regulatory Universe: ADEQ's Water Quality Programs are responsible for protecting and enhancing public health and the environment by ensuring healthy drinking water in public water systems and by controlling current and future sources of surface and groundwater pollution. ADEQ's Certified Operator program establishes guidelines to ensure that only certified operators make decisions about process control or system integrity that affect public health. The program establishes minimum standards for certification and recertification of the operators of drinking water and wastewater systems.

ADEQ currently regulates more than 450 facilities with Individual Aquifer Protection Permits with approximately 150 of these facilities also requiring an Individual AZPDES permit to allow for a safe surface water discharge. As many as 4,000 facilities require a Type 2, 3, or 4 general permit for the APP or reclaimed water programs; these are generally for smaller discharge volumes or activities not requiring extensive Departmental review. ADEQ issues approximately

100 to 150 Certificates of Sanitary Facilities per year for new housing subdivisions. ADEQ's stormwater program accounts for approximately 11,000 to 30,000 permits (Construction, Multisector, and De Minimis) at any time. In addition to ADEQ's own permitting program, all 15 Arizona Counties and some cities have delegated programs for issuing and inspecting on permitted facilities in their jurisdictions.

Current Appropriation: The budget required for the FY24 Water Quality Program is approximately $19.2 million. The Program has operated at a deficit since the fees-related rulemakings in 2011. Without a fee increase, the fees ADEQ generates through the permitting and operator certification processes will only be approximately $7.3 million. This rule is designed to help address the FY24 deficit, and allow for future, slower increases in fees through CPI. Again, while this fee rulemaking will not generate revenue sufficient to cover all necessary costs, an inflation adjusted fee increase is necessary and fair to all stakeholders.

Recent Implemented Efficiencies: ADEQ has continued to do more with fewer resources; despite the fact that ADEQ's budget is roughly $64.8 million less than it was in 2008 (in FY08 dollars). ADEQ has reduced the average time to obtain an environmentally protective permit by 76%, while decreasing its workforce by 36%. The AZPDES program permit backlog is one of the lowest in the country. Under our Safe Drinking Water Act programs, 66% fewer systems are delivering water that does not meet federal limits, and 99.8% of Arizonans are served healthy drinking water every day. While ADEQ continues to execute its mission with fewer resources, the current revenue flowing to the Water Quality Fee Fund is insufficient to maintain those advances.

Regulatory Objective: ADEQ preserves and protects human health and the environment by establishing and implementing controls for current and future sources of ground and surface water pollution, ensuring safe and clean drinking water is provided by public water systems, and certifying operators of public water systems. *See* A.R.S. §§ 49-203(A)(2) (AZPDES permit program); (A)(5) (APP permit program); (A)(6) (UIC permit program); (A)(7) (permit program for the direct reuse of reclaimed water); 49-351 (potable water systems); 49-352 and 49-361 (operator certification).

EPA requires states to adopt programs that are at least as stringent as the federal CWA and SDWA programs in in order to receive primary implementation and enforcement authority within its jurisdiction (primacy) for those programs. ADEQ must meet certain criteria and benchmarks to maintain primacy. If ADEQ is unable to adequately fund these programs, the EPA may step in and regain primary regulatory authority over these water quality programs. Most in the regulated community agree that ADEQ should implement the CWA and SDWA programs instead of EPA.

Resource Reduction Impacts: Without remedy, the WQFF deficit will impact ADEQ's long term ability to effectively implement state and federal water quality programs. For instance, this may impact ADEQ's inspection frequency as well as our ability to issue environmentally protective permits and maintain the improvements we have made in our permitting time frames all while protecting vital surface and groundwater sources of drinking water. Increasing fees for the water quality programs themselves will allow ADEQ to utilize previously reallocated funds to address other items, such as the Auditor General's findings, that included developing all required aquifer water quality standards, conducting key ongoing groundwater monitoring of the State's aquifers, monitoring for agricultural pesticides in groundwater and surrounding soil, or reducing the number of impaired surface waters within the State. Additionally, failure to adequately fund the CWA and SDWA programs could cause ADEQ to lose primacy of these programs and corresponding grant funds. If the programs revert back to EPA, Arizona would lose control over enforcement and permitting decisions, and EPA would become the main regulatory body for those programs.

Least burden and cost; description of alternatives: A.R.S. § 41-1052(D)(3) requires ADEQ to demonstrate it has selected the alternative with the least burden and cost necessary to achieve the underlying regulatory objective. Similarly, A.R.S. § 49-104(B)(17) requires that fees be "fairly assessed and impose the least burden and cost to the parties subject to the fees" and be based on "the direct and indirect costs of the department's relevant duties … directly related to issuing licenses … and enforcing the requirements of the applicable regulatory program." For this rulemaking, ADEQ interprets those requirements to mean collecting fee amounts that will help the Department provide clean water resources to communities within the State, and meet the objectives of protecting all waters from pollution. *See* A.R.S. §§ 49-203(A)(2) (AZPDES permit program); (A)(5) (APP permit program); (A)(6) (UIC permit program); (A)(7) (permit program for the direct reuse of reclaimed water); 49-351 (potable water systems); 49-352 and 49-361 (operator certification). The Department believes the fees are "fairly assessed" because the fees are based on "the direct and indirect costs" of the applicable programs.

Alternatives: ADEQ has involved the regulated community in discussions regarding alternative fee increases. ADEQ considered a fee increase that would completely eliminate the annual deficit for the WQFF, but would cause stakeholders to internalize the full burden of the $11.9 million deficit. The current proposed fee increase will impact the parties subject to fees in a fair and proportional way, however, it will not completely bridge the gap necessary to meet the budget shortfall.

ADEQ's goal in this rulemaking is to establish water quality protection fees that will help sustain the programs while avoiding disproportionate impact on any one group of stakeholders.

ADEQ has aggressively pursued federal grant opportunities, and used EPA grants to develop and maintain its regulatory programs. Notwithstanding aggressive budget reductions that resulted in loss of staff through reductions in force and layoffs, fee increases are necessary to help cover the cost to implement and administer the programs.

ADEQ's ability to raise revenue is limited by the powers and duties granted it through statute, specifically A.R.S. §§ 49-104(C) and 49-203(A)(8). While ADEQ can impose civil and criminal penalties of up to $25,000 per day, both civil and criminal penalties obtained under an environmental enforcement action must be deposited in the General Fund (A.R.S. §§ 49-262(E) and 49-263(G)).

ADEQ considered the impact that a fee raise would have on the parties subject to the increases, and determined that the least amount of fees necessary to help the Department bridge the deficit would be fair and proportional to the parties impacted.

Cost/Benefit: The probable costs for this rule are the $2.8 million in increased fees necessary for ADEQ to close the $11.9 million deficit needed to maintain the water quality programs. These costs would be primarily incurred by permittees - ranging from private and public waste water treatment plants to mining companies - and certified operators.

The probable benefits are:

- Ability to address some of the issues raised in the '21 Auditor General's Report: As noted above, increasing fees for the water quality programs themselves will allow ADEQ to utilize previously reallocated funds to address other items, such as the Auditor General's findings.
- Maintain or improve our advances in providing drinking water that meets federal Standards: Under our Safe Drinking Water Act programs, 66% fewer systems are delivering water that does not meet federal limits, and 99.8% of Arizonans are served healthy drinking water every day. Increased revenue will allow us to maintain and improve this performance.
- Maintain or improve our ability to issue environmentally protective permits, quickly: ADEQ has reduced the average time to obtain an environmentally protective permit by 76%, while decreasing its workforce by 36%. This includes the individual permit in the

Aquifer Protection Permitting Program, Reclaimed water and Arizona Pollution Discharge Elimination System Permits programs. Increased revenue will allow us to maintain and improve this efficiency.

- Ability of Arizona to implement the federal Clean Water Act program and federal Safe Drinking Water Act program: ADEQ obtained primacy for the AZPDES program in 2002, and primacy for safe drinking water systems in 1978, with federal approval for expansion of the initial programs in the years since. *See* 43 FR 38083; 67 FR 49916. If EPA were to subsume these programs due to lack of ADEQ's financial ability to operate them, there could be a time lag with no oversight of these programs. EPA does not have the bandwidth to expeditiously begin running a program that ADEQ has run for several decades. ADEQ maintaining primacy means that there will not be a delay in either reviewing or issuing permits, or inspecting and ensuring that permittees follow local, state, and federal rules that benefit Arizonans.

- ADEQ maintains control over non-compliance events: The CWA and SDWA have reporting requirements that permittees must follow. Because Arizona has primacy over those federal programs, facilities and operators have to submit required information to ADEQ for transmittal to EPA. This allows ADEQ to maintain a positive working relationship with the regulatory community, and monitor and quickly respond if the information provided by permittees shows a facility is in non-compliance and negatively impacting human health and the environment. If ADEQ was unable to provide this compliance assistance service, EPA would have to step in, causing delay in problem solving.

- Rulemaking oversight: When EPA adopts a new regulation, Arizona has the authority to review that regulation and determine whether to adopt it and incorporate it into its rules with or without tailoring the requirements to our unique circumstances. If the CWA and SDWA programs are reverted back to the EPA, Arizona would lose the ability to implement the programs with tailored regulations for Arizona that align with federal regulations.

- Outreach to regulated community: Throughout the year, ADEQ staff participates in numerous conferences and training seminars with the goal of educating the regulated community about ADEQ's water quality requirements and policies. These include providing updates to the community on new rules, and helping ensure compliance with permits. It is unlikely that EPA would participate in such events in Arizona.

For these reasons, ADEQ believes that the benefits exceed the cost.

Rules More Stringent than Corresponding Federal Law. Not applicable. While the CWA and SDWA are applicable to some of ADEQ's water quality programs, these federal laws do not specify funding structures for the programs.

Probable Impact on Political Subdivisions of this State Directly Affected by this Rulemaking: Political subdivisions represent approximately 40 percent of the individual water quality permitting universe and they will bear the greatest impact. This is because they own or operate facilities and/or conduct multiple activities requiring both APP and AZPDES permit coverage. Larger municipalities also typically own and operate multiple, more complex, and larger facilities. Smaller communities will likely be affected more so than large communities because they have a smaller population over which to spread the costs.

Many municipalities operate wastewater treatment facilities (WWTPs), which require various APP, AZPDES, and reclaimed water permits. Many municipalities also have reclaimed water permits. The typical municipality will also pay annual or renewal fees on most of these permits. For Articles 1 and 2 (water quality protection services and public water system design review, respectively), the fees will increase by a CPI adjustment of approximately 43%. For Article 3 (operator certification), the fees will increase by a CPI adjustment of approximately 34%. ADEQ has classified the increases as moderate for all parties impacted. The proposed fee increases do not fully fund the programs, but help ADEQ minimize the deficit. While a less than CPI adjusted increase would likely result in a minimal impact, the funds raised would also be insufficient to meet the needs of the programs. A greater than CPI increase might more fully fund the programs, but would have caused a substantial impact to all those affected.

Examples of the impact of the fee increases can be best shown by the impact on different classes of customers. A large municipality might have multiple wastewater treatment plants requiring an individual APP and, sometimes an individual AZPDES. In this example we will assume that the plant in question has a discharge volume of ten million gallons or more. That municipality would currently pay $8,500 per year for the APP discharge and $4,000 year for the AZPDES discharge, for a total of $12,500 per year. Under the fee model proposed in this rulemaking, that municipality would pay $12,130 per year for the APP discharge and $5,708 for the AZPDES discharge, for a total of $17,838. ADEQ considers this a moderate increase in cost for a large municipality that may have multiple plans for which it is responsible. The same holds true for any municipality regardless of size; since fees are tied to discharge volume, smaller municipalities

will have correspondingly smaller annual fee burdens. By way of an example, the table below demonstrates the change to individual AZPDES annual fees, as is described above:

Permitted Discharge Volume (GPD) or Minor/Major Industrial	**Current Annual Fee**	**New Annual Fee**
Less than 99,999	$250	$357
100,000 to 999,999	$500	$714
1,000,000 to 9,999,999	$2,500	$3568
10,000,000 or more	$4,000	$5,708
Minor	$500	$714
Major	$2,500	$3,568

The CPI increase that applies to ADEQ Operator Certification will be approximately 34%. Municipalities or private companies may, and often do, reimburse employees for these expenses. ADEQ recognizes, however, that many operators in smaller communities are financially responsible for their own certifications. The increase of 34% reflects an adjustment that will aid the administration of the program. Operators have to renew their certification every three years. Currently, an operator with four certificates, the highest number available, pays $300 every three years. The increase of 34% would require that an operator with all four certifications pay $402 every three years. Under the new fee model, the cost for renewing the highest number of certifications is moderate. The table below demonstrates the comparison between current fees and new fees for operator certifications:

Description	**Current Fee**	**New Fee**
New certification	$65	$87
An operator that has not held a lower grade level for the required amount of time requests the Departments determination on experience and education in order to be admitted to a higher grade certification examination	$150	$201

An applicant that requests a certificate based on reciprocity with another jurisdiction	$250	$334
An operator submitting a certificate renewable shall submit a fee for each certificate (see below)		
If the operator has multiple certificates; the first certificate	$150	$201
Each additional certificate with the same expiration date	$50	$67

Reduction of Impact on Small Businesses: A.R.S. § 41-1035 requires state agencies to reduce the impact of a rulemaking on small businesses, if any of the following methods are legal and feasible in meeting the statutory objectives which are the basis of the rule making:

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 listed methods are not generally relevant to a rule establishing fees. *See* A.R.S. § 49-104(B)(17) (requiring fees be "fairly assessed" and based on "direct and indirect costs.")

Probable Impact on Small Businesses: Small businesses with facilities that require APP or AZPDES permit coverage include small construction companies, truck stops and gas stations, and mobile home and recreational vehicle parks. Generally, these types of small businesses do not operate facilities requiring reclaimed water permits, although a small golf course could have a reclaimed water general permit for use of treated effluent for irrigation. Truck stops and gas

stations likely have general APP permits for drywells and will also be assessed the increased APP fees. Small businesses tend to have a smaller customer base over which to spread the costs of the increased fees.

Truck stops, gas stations, and mobile home and recreational vehicle parks that are not within incorporated communities served by centralized sewer, would likely require on-site wastewater treatment. The APP Type 4.23 general permit is for larger on-site facilities (up to 24,000 gallons per day).

Water and wastewater operators in Arizona who are certified, who seek to become certified, or seek additional certifications bear the costs of paying the fees for renewals, examinations, reciprocity, or early examination. ADEQ's Operator Certification program has approximately 6,800 certified operators who hold approximately 12,000 certificates. About 3,800 operators hold multiple certifications; about 1,500 operators hold all four certifications.

An operator certified in Arizona can have a maximum of four certificates, meaning they are certified in each of the four classes of facilities: water treatment plants, water distribution systems, wastewater treatment plants, or wastewater collection systems. An operator with four certificates could pay a maximum renewal fee of $402 every three years.

These rules do not make any changes to current costs for examination or professional development hours (PDHs). An operator will still be responsible for costs or fees paid to the examination contractor or for PDHs. The current cost to sit for an exam at Gateway is $89, which is paid to Gateway. Generally, the fee can be up to $109 for examinations held off-site from Gateway. The exam fee covers costs for Gateway and ABC operator certification examinations; ADEQ does not receive any part of this examination fee.

It is likely that most small businesses that require permitting or operator certification will be smaller waste water treatment plants or smaller municipalities, and to the extent that the small businesses reimburse operators, the increased fees will moderately impact them – as compared to the minimal impact of a less than CPI increase, or the significant impact of a greater than CPI increase.

Identification of Persons Directly Affected by the Rule Making: Applicants and permittees of the drinking water, APP, UIC, reclaimed water, and AZPDES permitting programs will be affected by these rules, as well as individuals certified by our Operator Certification program. Permittees include businesses, individuals, political subdivisions, federal agencies, and non-profit organizations. Other entities that may be indirectly impacted by the rules include customers of

permittees. This rulemaking does not directly impact the fees of ADEQ's delegated government entities. A.A.C. R18-14-107 establishes authority for counties or other local governments to set independent fees for implementing ADEQ delegated water protection programs.

ADEQ anticipates that this rulemaking will affect 17,000 to nearly 38,000 permitted facilities or activities, as well as an unknown number of facilities or activities in the future. ADEQ anticipates the increased fees will have a moderate impact on these persons – as compared to the minimal impact of a less than CPI increase, or the significant impact of a greater than CPI increase.

Probable Effect on State Revenues: ADEQ estimates that fees from this rulemaking will directly affect state revenues by increasing revenues to the WQFF Fund by $2.8 million annually.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

No changes were made to the rules.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

The proposed rule was posted on ADEQ's website and published in the Arizona Administrative Register on April 28, 2023. A virtual oral proceeding regarding the proposed rule was held on May 30, 2023. Close of comment was May 30, 2023. ADEQ received no comments at the oral proceeding. ADEQ received the following written comments on the proposed rule.

Comment 1: Stephen Griffin, PhD, founder & CTO of InnovaQuartz LLC & SilicaPhysics LLC, and Technical Advisor to Trimedyne, Inc., email dated May 15, 2023:

"An increasing population as well as newly emergent challenges regularly confront our State's scientists and technicians charged with maintaining our water quality, from trace precipitation drug residues in wastewater to perfluorinated alkyl substances (PFAS) in our surface and groundwaters. While nobody likes paying higher fees for government services, absent some billionaire's largess in bequeath of an adequate trust, ADEQ really needs our support for fee increases AND for legislation that provides additional funding from other sources."

ADEQ Response 1:

ADEQ appreciates the comment.

Comment 2: Catherine Land Evilsizor, email dated May 15, 2023:

"ADEQ should absolutely charge and/or receive funding via the legislature adequate to operate. Water quality is essential to all life.

I am in favor of raising fees to cover the cost of the important work of ADEQ for our state."

ADEQ Response 2:

ADEQ appreciates the comment.

Comment 3: City of Phoenix, letter dated May 30, 2023, regarding ADEQ Water Quality Funding Sources:

"The City strongly supports ADEQ's efforts to obtain a reliable annual funding source to support the water quality goals of Arizona, rather than relying solely on permittee fees. To this end, the City supports Senate Bill (SB) 1391 which would allocate $9,060,000 to the Water Quality Fee Fund, in addition to the one-time $9,500,000 appropriation from state general funds for Fiscal Year 2023-2024.

If SB 1391 fails to pass, the City urges ADEQ to continue to investigate and pursue reliable, sustainable funding for the protection of public health and the environment rather than return to a fully fee-based approach, especially considering the increased state-wide program activities ADEQ will need to fund based on the Auditor General's report. Permittees already pay for the cost of getting a permit and for any of the unfunded conditions required by permits. Adding increased permit fees that are not directly related to the cost of obtaining a permit unfairly places the burden of ADEQ's water quality division on those already paying to mitigate and minimize their own impacts on water quality. Instead, permittees should only be charged for the direct cost of permitting (fee-for-service). Placing the sole responsibility for funding ADEQ's water quality program on permittees would place an unreasonable and non-justifiable burden on a few entities and would not provide a reliable and consistent funding source."

ADEQ Response 3:

ADEQ appreciates the comment. In accordance with statutory authority, ADEQ is not "charg[ing] or receiv[ing] a fee or mak[ing] a rule establishing a fee unless the fee for the specific activity is expressly authorized by statute…" A.R.S. § 41-1008(A)(1). Further, A.R.S. § 49-104(B)(17) requires that fees be "fairly assessed and impose the least burden and cost to the parties subject to the fees" and be based on "the direct and indirect costs of the department's relevant duties … directly related to issuing licenses … and enforcing the requirements of the applicable regulatory program."

Comment 4: City of Phoenix, letter dated May 30, 2023, regarding Operator Certification Fees:

"The City does not support ADEQ's proposal to increase the fees annually for the Operator Certification program. ADEQ has not provided sufficient justification for the proposed increases. No additional functions or efficiencies were identified by ADEQ that would be added to the Operator Certification program as a result of operator certification fee increases. An annual adjustment using the CPI would result in a significant and continually growing burden on operators.

For example, over the course of three years, the cost for an operator with two certifications would rise by $36. Many operators have three or even four different certifications they keep up to date. This reflects just the first three years. With the proposed annual CPI adjustment, these fees will continue to rise over time and become increasingly burdensome for individual operators and for companies that reimburse employees for these expenses. This is one of the most significant financial implications to the City from these fee increases, due to the sheer number of operators we employ.

The City is also concerned the increased fees could result in operator workforce depletion. The water and wastewater industry are currently experiencing a workforce crisis, struggling to recruit, train, and retain employees, and approximately one-third of the water sector workforce will be eligible to retire within the next several years. This fee increase will further exacerbate the workforce crisis, leaving the state with less certified operators available to operate water and wastewater systems. The City believes that this increase will disincentivize an individual obtaining multiple types of operator certifications and that this additional financial burden on the individual operators, as consumers, would further jeopardize the public health and the environment."

ADEQ Response 4:

ADEQ appreciates the comment. ADEQ stands by the assertion in the preamble that the impact to individual operators is moderate. ADEQ has included within the preamble an example of an operator with four certificates to illustrate the cost increase. Similarly, the impact to businesses and municipalities that reimburse their employees would also be moderate. Fees for operator certification have not been adjusted since 2016. Those fees were based on conservative assumptions, including the minimum number of staffing and resources necessary to effectively implement the program. Though ADEQ used the best available information at the time, the actual costs of implementing the programs exceeded the 2016 projections, causing a deficit. Without increasing the costs of certification, the deficit that follows would jeopardize ADEQ's ability to ensure safe operation of drinking water and waste water systems. Again, an inflation adjusted fee increase is necessary and fair to all stakeholders.

ADEQ is working to create and improve a robust operator certification program to ensure that the workforce does not deplete. Though still developing, these measures will likely include items such as training and community outreach to encourage the next generation of operators and ADEQ is happy to partner with other organizations, such as the City of Phoenix, in that effort. Protecting human health and the environment is ADEQ's top priority, and an aspect of attaining those goals is ensuring that the program is sufficiently funded. ADEQ has added supplemental information regarding operator certification into the preamble.

Comment 5: City of Phoenix, letter dated May 30, 2023, regarding AZPDES Multi Sector General Permit ("MSGP"):

"The proposed fee increase will be magnified when passed along by multiple MSGP permit holders across Arizona to others involved in an AZPDES Sector (for example, in Sector S Air Transportation fueling, hangar, air service, airport, etc.) or between AZPDES Sectors (for example, Air Transportation, Land Transportation, Warehousing, Manufacturing, etc.). Increasing fees will cause the biggest impact to small businesses. Permit fees are a barrier to business entry and endanger small business sustainability. Fees based solely on acreage do not work for all small businesses/co-permittees. For example, mobile providers have no leasehold or location/storage area and are only working in small areas but are expected to pay an amount based on acreage. For a mobile provider operating at all three Phoenix airport locations, this is an increase from $1,050 to $1497 annually based on the increase from $350 to $499 annually for sites that are <=1 acre.

The City requests that ADEQ consider the following:

- Fee waivers for the following small business partners: mobile mechanics and wash service providers.
- De minimus fees for mobile providers based on the business rather than the facility acreage. For example: if located at one to three facilities $100 annual fee; if located at four to six facilities $200 annual fee. This would lower the cost barrier to business entry into the field.
- Phase in fee increases over multiple years to reduce impacts to small businesses or assess a lower annual fee, as noted in the bullet above.
- If ADEQ retains the 5-year No Exposure Certificate ("NEC"), the fee should be prorated and refunded if the business closes during that 5-year period or provide the option of either paying for a 5-year NEC up front or paying an annual fee (similar to vehicle registrations).

The cost burden for a No Exposure Certificate ("NEC") holder is excessive, particularly considering that the owner is certifying there is no potential for contaminates to be discharged to stormwater infrastructure and when compared to a site that has filed a Notice of Intent ("NOI"), especially considering a site with a filed NEC has already taken certain active measures and Best Management Practices to not expose activities to stormwater, and because an NEC only requires a review from ADEQ once every five years. The City requests ADEQ evaluate the ideas for NEC fee adjustments as noted in the bulleted list above."

ADEQ Response 5:

ADEQ appreciates the comment. A.R.S. § 41-1051(D)(3) requires ADEQ to demonstrate it has selected the least burden and cost necessary to achieve the underlying regulatory objective. ADEQ has interpreted the statutory requirements regarding fees to mean that the Department may collect fee amounts that will help provide clean water resources to communities within the State, and meet the objectives of protecting all waters from pollution. *See* A.R.S. §§ 49-104(B)(17) (requiring fees be

fairly assessed, among other things); 49-203(A)(2) (AZPDES permit program); (A)(5) (APP permit program); (A)(6) (UIC permit program); (A)(7) (permit program for the direct reuse of reclaimed water); 49-351 (potable water systems); 49-352 and 49-361 (operator certification). ADEQ stands by its statement in the preamble that small businesses requiring permitting will experience a moderate impact from the fee increase, because it only corresponds to an increase in CPI.

While ADEQ understands that permit fees are a requirement that impacted businesses will need to incorporate into their business models, the alternatives the City suggests: fee waivers, de minimus fees, and phased in fees, do not allow for proper implementation of the water quality programs, inhibiting ADEQ's ability to meet its regulatory objectives. To use the example provided, for NECs, an ADEQ employee will spend approximately 10 hours reviewing the documentation submitted by the party seeking the certificate in order to approve or deny the submission. The party receives the benefit of the NEC in not having to obtain further permits such as an MSGP, and ADEQ retains rights to inspect the property. By not charging a fee, or charging a de minimus fee for NECs, ADEQ would not be able to fully cover the cost of the program.

When the fees were established in 2011 ADEQ did its best to calculate what an appropriate fee model would be in order to protect the environment. Today, though there is a moderate impact to these small businesses, a less than CPI increase or another model such as those suggested by the City would mean that the programs are not receiving adequate support to operate. The goal with this rulemaking is to establish fees that help ADEQ sustain the water quality programs while not disproportionately impacting any one group of permittees. A CPI increase remains appropriate given the circumstances. ADEQ commits to exploring alternatives to the permit fee structures in the future.

Comment 6: Arizona Mining Association (AMA), letter dated May 30, 202[3]:
"As a general matter, AMA supports an adequately funded Water Quality Division. The Division does important work that benefits all Arizonans, not just AMA members. This past legislative session, AMA supported ADEQ receiving additional funds outside of permit fees to support its non-permitting activities, and we anticipate doing the same in future years. Such non-permit sources of funding are important because, as explained below, statutory limits exist on the types of expenses that ADEQ may recover through permit fees in some of its key water quality programs.

With respect to the current proposed rule, AMA supports ADEQ's proposal to increase its fees for water quality protection services and public water system design reviews by approximately 43%, and certified operator fees by approximately 34%. These increases allow the agency to keep up with the significant inflation that has occurred since the fees were last adjusted. AMA also supports the proposed annual Consumer Price Index ("CPI") adjustments for the various water quality fees.

In particular, AMA appreciates ADEQ's recent successful efforts to streamline the process for reviewing and then issuing environmentally protective permits. These commendable efforts make it more palatable for the regulated community to support an increase in permitting fees. As part of the planned increase in fees, we encourage ADEQ to continue moving forward with and improving on its permit streamlining efforts."

ADEQ Response 6:

ADEQ appreciates the comment.

Comment 7: Arizona Mining Association (AMA), letter dated May 30, 202[3], regarding statutory limits:

"Although AMA supports the proposed fee increases, it is important to note that the statutes for both the aquifer protection permit ("APP") program and the Arizona Pollutant Discharge Elimination System ("AZPDES") permit program place limits on the fees that ADEQ can charge for processing permits. A.R.S. § 49-241.02(A) gives ADEQ authority to establish fees by rule but only "to pay the expenses incurred in implementing the [APP] program." The APP program is found in A.R.S. Chapter 49, Chapter 2, Article 3. Similarly, A.R.S. § 49-255.01(J) only authorizes ADEQ to establish fees (including maximum fees) by rule "to pay expenses incurred in implementing the AZPDES program." The AZPDES program is found in A.R.S. Title 49, Chapter 2, Article 3.1. Other programs such as ambient monitoring, adopting water quality standards, identifying impaired waters, establishing total maximum daily loads ("TMDLs"), and implementing voluntary nonpoint source measures are found in separate articles and are not part of the statutorily defined APP and AZPDES programs. Based on these statutory limits, ADEQ should ensure the fees it is proposing for APP and AZPDES water quality services are not used to support or fund activities outside of the permitting programs."

ADEQ Response 7:

ADEQ appreciates the comment. In accordance with ADEQ's statutory authority, the fees charged for the APP and AZPDES permit programs are based on "expenses incurred in implementing the [ ] program[s]." *See* A.R.S. §§ 49-241.02(A) and 49-255.01(J). The increased permit fees ADEQ proposes correspond to only what is necessary for implementing the APP and AZPDES programs and are restricted to the increase in costs due to inflation since the inception of the relevant fees. The programs will also not be self funded, as a CPI-only based approach does not fully solve the deficit the programs face. ADEQ is relying on the legislative appropriation mentioned in the preamble to provide the remaining funds for FY24.

Comment 8: Arizona Mining Association (AMA), letter dated May 30, 202[3], regarding the findings of the 2021 Auditor General's Report:

"AMA finally requests that ADEQ remove all references to needing funds to implement the findings of the 2021 Auditor General's Report of ADEQ's Water Quality Division in the preamble to the final version of this rule. Setting aside any questions about the accuracy or legitimacy of many of the findings in the 2021 Report, all of the findings relate to ancillary activities that are outside the scope of the main permit programs administered by ADEQ. For the reasons described above, addressing the findings should not be paid for by the fees collected under ADEQ's water quality protection fees rule."

ADEQ Response 8:

ADEQ appreciates the comment. ADEQ acknowledges the findings of the 2021 Auditor General's Report are regarding programs ancillary to the main permitting programs administered by ADEQ. The statements in the preamble involving resolution of those findings is intended to show that ADEQ does not currently have sufficient funding to conduct permitting program services it is required to conduct. The most recent rulemaking for water quality fees in 2011, and for operator certification in 2016, was an attempt to make the permit programs fully funded based upon fees. Since 2011, the cost of issuing permits has risen with the cost of inflation. To meet the increased monetary needs of the permit programs, ADEQ has utilized funding from other areas of the Department that could be re-allocated. With the proposed fee increases, the permit programs would ideally be closer to, but not fully, self sustaining. Without the need to fund the permitting programs from other sources within the Department, ADEQ can address the ancillary findings of the Auditor General's Report, which will further the goals of protecting and enhancing human health and the environment. ADEQ has clarified the preamble.

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:

Not applicable.

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. These rules establish fees for water quality protection services (Article 1), public water system design review (Article 2), and certified operators (Article 3). The requirements for a permit, license, or agency authorization (for which ADEQ charges such fees) are established elsewhere in rule, specifically 18 A.A.C. 9.

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. While the CWA and SDWA are applicable to some of ADEQ's water quality programs, these federal laws do not specify funding structures for the programs.

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:

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 18. ENVIRONMENTAL QUALITY

CHAPTER 14. DEPARTMENT OF ENVIRONMENTAL QUALITY PERMIT AND COMPLIANCE FEES

ARTICLE 1. WATER QUALITY PROTECTION FEES

ARTICLE 2. PUBLIC WATER SYSTEM DESIGN REVIEW FEES

ARTICLE 3. CERTIFIED OPERATOR FEES

ARTICLE 1. WATER QUALITY PROTECTION FEES

R18-14-101. Definitions

In addition to the definitions in A.R.S. §§ 49-201, 49-241.02, 49-255, 49-331, and A.A.C. R18-9-101, A.A.C. R18-9-701, and A.A.C. R18-9-A901, the following terms apply to this Article:

1. "APP" means an Aquifer Protection Permit.
2. "Complex modification" means:
   a. A revision of an individual Aquifer Protection Permit for a facility within a mining sector as defined in A.R.S. § 49-241.02(F)(1); and
   b. A revision of an individual Aquifer Protection Permit for a facility within a non-mining sector due to any of the following:
      i. An expansion of an existing pollutant management area requiring a new or relocated point of compliance;
      ii. A new subsurface disposal including injection or recharge, or new wetlands construction;
      iii. Submission of data indicating contamination, or identification of a discharging facility or pollutants not included in previous applications that requires reevaluation of BADCT; or
      iv. Closure of a facility that cannot meet the clean closure requirements of A.R.S. § 49-252 and requires post-closure care, monitoring, or remediation.
3. "Courtesy review" means a design review service that the Department performs within 30 days from the date of receiving the submittals, of the 60 percent completion specifications, design report, and construction drawings for a sewage collection system.
4. "Priority review" means a design review service for an APP Type 4 permit application that the Department completes using not more than 50 percent of the total review time-frame for the applicable Type 4 permit application as specified in 18 A.A.C. 1, Table 10.
5. "Request" means a written application, notice, letter, or memorandum submitted by an applicant to the Department for water quality protection services. The Department considers a request made on the date it is received by the Department.

6. "Review hours" means the hours or portions of hours that the Department's staff spends on a request for a water quality protection service. Review hours include the time spent by the project manager and technical review team members, and if requested by the applicant, the supervisor or unit manager.
7. "Review-related costs" means any of the following costs applicable to a specific request for water quality protection service:
   a. Presiding officer services for public hearings on a permitting decision,
   b. Court reporter services for public hearings on a permitting decision,
   c. Facility rentals for public hearings on a permitting decision,
   d. Charges for laboratory analyses performed during the review, and
   e. Other reasonable and necessary review-related expenses documented in writing by the Department and agreed to by an applicant.
8. "Standard modification" means an amendment to an individual Aquifer Protection Permit that is not a complex modification.
9. "UIC" means Arizona's Underground Injection Control Program.
10. "Water quality protection service" means:
    a. Reviewing a request for an APP determination of applicability;
    b. Pre-application consultation, ~~Issuing~~ issuing, renewing, amending, modifying, transferring, or denying an aquifer protection permit, an AZPDES permit, a UIC permit, a UIC application for an aquifer exemption or an injection depth waiver or a reclaimed water permit;
    c. Reviewing supplemental information required by a permit condition, including annual reports and closure for an APP;
    d. Performing an APP clean closure plan review;
    e. Issuing or denying a Certificate of Approval for Sanitary Facilities for a Subdivision;
    f. Registering or transferring registration of a dry well;
    g. Conducting a site visit;
    h. Reviewing proprietary and other reviewed products under A.A.C. R18-9-A309(E);
    i. Reviewing, processing, and managing documentation related to an AZPDES general permit, including a notice of intent, notice of termination, certificate of no exposure, and waiver;
    j. Registering and reporting land application of biosolids; or
    k. Pretreatment program review, inspection, or audit.

R18-14-102. Hourly Rate and Maximum Fees for Water Quality Protection Services

A. The Department shall assess and collect an hourly rate fee for a water quality protection service, except for APP minor permit amendments specified under A.A.C. R18-9-A211(C)(1), (2) and (3) and A.A.C. R18-9-B906(B), unless a flat fee is otherwise designated in this Article, and UIC minor modifications specified under A.A.C. R18-9-C633(A).

B. Hourly rate fees. The Department shall calculate the fee using an hourly rate of ~~$122~~ $174, adjusted annually under subsection (D), except for the UIC program, where the Department shall calculate the fee using an hourly rate of $145, adjusted annually under subsection (D). These rates shall then be multiplied by the number of review hours to provide a water quality protection service, plus any applicable review-related costs, up to the maximum fee specified in subsection (C), adjusted annually under subsection (D). ~~The Department shall not charge an applicant for the first 60 minutes of Department pre-application consultation time costs for the project manager.~~

C. Maximum fees for a water quality protection service assessed at an hourly rate in Table 1, adjusted annually under subsection (D).

D. The Director shall adjust the hourly rate and maximum fees listed in subsections (B) and (C) every August 1 to the nearest $10, beginning August 4, 2023, by multiplying the hourly rate or maximum fee by the Consumer Price Index (CPI) for the most recent year, and then dividing by the CPI for the year 2023. The CPI for any year is the average of the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items published by the United States Department of Labor, as of the close of the 12-month period ending on June 30 of that year.

Table 1. Maximum Fees

Program Area	Permit Type	Maximum Fee
APP	Individual or area-wide	~~$200,000~~ $285,400
APP	Complex modification to individual or area-wide	~~$150,000~~ $214,050
APP	Clean closure of facility	~~$50,000~~ $71,350
APP	Standard modification to individual or area-wide (per modification up to the maximum fee, and modification can be reassigned under A.A.C. R18-1-516):	

	▪ Maximum fee (cumulative per submittal)	~~$150,000~~ $214,050
	▪ Modification under A.A.C. R18-9-A211(C)(1) through (3)	No fee
	▪ Modification under A.A.C. R18-9-A211(C)(4) through (6)	~~$5,000~~ $7,135
	▪ Modification under A.A.C. R18-9-A211(C)(7), (D)(2)(b) through (i), and (k) through (l)	~~$15,000~~ $21,405
	▪ Modification under A.A.C. R18-9-A211(D)(2)(a) and (j)	~~$25,000~~ $35,675
	▪ Modification under A.A.C. R18-9-A211(B) that is not classified as complex modification under R18-14-101(2)	~~$25,000~~ $35,675
APP	For an APP issued before July 1, 2011, the fee for a submittal required by a compliance schedule is assessed per submittal and cumulative up to the maximum fee. The applicable maximum fee for all compliance schedule submissions shall be according to one of the three maximum fee categories listed below. The maximum fee is for the lifetime of the APP unless a new compliance schedule is established in the APP due to a modification that is classified as both a significant amendment under A.A.C. R18-9-A211(B) and a complex modification under R18-14-101(2)	
	▪ For a permit with a compliance schedule where one or more submissions require a permit modification that requires a determination or reevaluation of BADCT, the fee is assessed as described above for each standard modification, with a maximum fee for the permit's entire compliance schedule of:	~~$150,000~~ $214,050
	▪ For a permit with a compliance schedule where one or more submissions require a permit modification, but no determination or reevaluation of BADCT is required, the fee is assessed as described above for each standard modification, with a maximum fee for the permit's entire compliance schedule of:	~~$100,000~~ $142,700
	▪ For a permit with a compliance schedule requiring one or more submissions that require ADEQ review but do not require a permit modification, the maximum fee for the permit's entire compliance schedule is:	~~$100,000~~ $142,700
APP	For an APP issued on or after July 1, 2011, the fee for a submittal required by a compliance schedule is assessed per submittal and cumulative up to the maximum fee for the lifetime of the APP	~~$100,000~~ $142,700
APP	Determination of applicability	~~$15,000~~ $21,405
APP	Reviewing proprietary and other reviewed products under A.A.C. R18-9-A309(E)	~~$15,000~~ $21,405
AZPDES	Individual permit for municipal separate storm sewer system	~~$40,000~~ $57,080
AZPDES	Individual permit for wastewater treatment plant (based on gallons of discharge per day)	
	▪ 3,000 to 99,999	~~$15,000~~ $21,405
	▪ 100,000 to 999,999	~~$20,000~~ $28,540
	▪ 1,000,000 to 9,999,999	~~$30,000~~ $42,810
	▪ 10,000,000 or more	~~$50,000~~ $71,350
AZPDES	Individual permit for a facility or activity that is not a wastewater treatment plant or a municipal separate storm sewer	~~$30,000~~ $42,810
AZPDES	Amendment to an individual permit	~~$12,500~~ $17,838
AZPDES	Approval of a new or revised pretreatment program under AZPDES	~~$10,000~~ $14,270

AZPDES	Consolidated individual permit for multiple AZPDES individual permits, as allowed under A.A.C. R18-9-B901(C)	Aggregate of the applicable maximum fees
Reclaimed	Reclaimed water individual permit	~~$32,000~~ $45,664
UIC	Area Area Modification / Renewal	$200,000 $150,000
UIC	Classes I, II, III, V Individual Classes I, II, III, V Modification / Renewal	$200,000 $150,000
UIC	Classes VI Individual Classes VI Modification	No Max No Max

R18-14-103. Initial Fees

~~**A.**~~ A person shall submit the applicable fee at the time a request for a water quality protection service is submitted to the Department.

~~**B.** For each water quality protection service subject to an hourly rate fee established under R18-14-102:~~

~~1. An applicant shall submit a $2,000 initial fee at the time a request is submitted to the Department for review.~~

~~2. If requested by an applicant, the Department may set a lower initial fee when the Department estimates a review fee that is less than the applicable initial fee.~~

~~**C.** The Department shall not review a request for a water quality protection service if the applicant or permittee has not paid any fee due under this Article, unless the applicant or permittee has an outstanding water quality protection service bill that is under appeal pursuant to R18-14-106.~~

R18-14-104. Annual Fees for Water Quality Protection Services Subject to Hourly Rate Fee

A. Annual Registration Fees. The annual registration fee required under A.R.S. § 49-242 is in Table 2, adjusted annually under subsection (E).

B. The Department shall assess an annual fee for an AZPDES-related water quality protection service subject to an hourly rate fee as listed in Table 3, adjusted annually under subsection (E).

C. The Department shall assess an annual fee of ~~$500~~ $714, adjusted annually under subsection (E), for an individual reclaimed water permit.

D. The Department shall assess an annual fee and an annual waste disposal fee as applicable to UIC regulated facilities, subject to an hourly rate fee, as listed in Tables 3.1 and 3.2, adjusted annually under subsection (E).

E. The Director shall adjust the annual fees listed in subsections (A), (B), (C), and (D) every August 1, to the nearest $10, beginning August 4, 2023, by multiplying the annual fee by the Consumer Price Index (CPI) for the most recent year, and then dividing by the CPI for the year 2023. The CPI for any year is the average of the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items published by the United States Department of Labor, as of the close of the 12-month period ending on June 30 of that year.

Table 2. APP Annual Registration Fees

Discharge or Influent per Day under the Individual APP or Notice of Disposal (in Gallons)	Annual Registration Fee	Annual Registration Fee if New Facility Under New APP Not Yet Constructed
3,000 to 9,999	~~$500~~ $714	~~$250~~ $357
10,000 to 99,999	~~$1,000~~ $1,427	~~$250~~ $357
100,000 to 999,999	~~$2,500~~ $3,568	~~$500~~ $714
1,000,000 to 9,999,999	~~$6,000~~ $8,562	~~$625~~ $892
10,000,000 or more	~~$8,500~~ $12,130	~~$750~~ $1,070

Table 3. AZPDES Annual Fees

Permit Type	Annual Fee	Annual Fee if New Facility Under New AZPDES Not Yet Constructed
Municipal separate storm sewer system	~~$10,000~~ $14,270	N/A
Wastewater treatment plant (based on gallons of discharge per day):		

▪ Less than 99,999	~~$250~~ $357	~~$250~~ $357
▪ 100,000 to 999,999	~~$500~~ $714	~~$500~~ $714
▪ 1,000,000 to 9,999,999	~~$2,500~~ $3,568	~~$625~~ $892
▪ 10,000,000 or more	~~$4,000~~ $5,708	~~$750~~ $1,070
Facility or activity that is not a wastewater treatment plant or municipal separate storm sewer and designated in the permit as either:		
Major	~~$2,500~~ $3,568	~~$625~~ $892
Minor	~~$500~~ $714	~~$500~~ $714
Pretreatment program	~~$3,000~~ $4,281	N/A
Consolidated individual permit for multiple AZPDES individual permits, as allowed under A.A.C. R18-9-B901(C)	Aggregate of the applicable annual fees of each individual permit	Aggregate of the applicable annual fees of each individual permit

Table 3.1. UIC Annual Fees

Permit Type	Annual Registration Fee	Annual Waste Disposal Fee
Area	$10,000 (and not subject to any other annual registration fee in Tables 3.1 and 3.2)	N/A
Class I	No Annual Registration Fee	$0.002/gallon. Minimum Fee: $10,000/year Maximum Fee: $25,000/year
Class II	See Table 3.2	N/A
Class III	See Table 3.2	N/A
Class V "Individual"	See Table 3.2	N/A
Class VI	No Annual Registration Fee	$0.08/ton Minimum Fee: $10,000/year

Table 3.2. UIC Annual Registration Fees

Design Injection Flow Rate in Gallons per day[1, 2]	Annual Registration Fee
3,000 to 9,999	$600
10,000 to 99,999	$1,200
100,000 to 999,999	$3,000
1,000,000 to 9,999,999	$7,000
10,000,000 or more	$10,000

[1] A Class II, III or V Individual UIC permittee with multiple wells or multiple permits may consolidate their same-class wells for the purpose of "design injection flow rate in gallons per day" under Table 3.2.
[2] An Area permit is not subject to Table 3.2.

R18-14-105. Fee Assessment and Collection

A. Billing. The Department shall bill an applicant for water quality protection services subject to an hourly rate no more than monthly, but at least quarterly. The following information shall be included in each bill:
1. The dates of the billing period;
2. The date and number of review hours itemized by employee name, position type and specifically describing:
   a. Each water quality protection service performed,
   b. Each facility involved and program component, and
   c. The hourly rate for each water quality protection service performed;
3. A description and amount of each review-related cost incurred for the project;
4. ~~The total fees paid to date, the~~ The total fees due for the billing period, and the date when the fees are due, which shall be at least 35 days after the date on the bill~~.~~. The total fees paid to date and the maximum fee for the project shall be provided upon request.

B. Final bill. After the Department makes a final determination whether to grant or deny a request for water quality protection services subject to an hourly rate fee, or when an applicant withdraws or closes the request, the Department shall prepare a final itemized bill of its review.

~~1. If the total fee exceeds the amount of the initial fee plus all invoicing, the Department shall issue a final itemized bill for the cost of the water quality protection services up to the applicable maximum fee established under R18-14-102.~~

~~2. If the total fee is less than the initial fee and all paid invoicing charges, the Department shall refund the difference to the applicant.~~

~~3.~~ 1. Fees for water quality protection services shall be paid in U.S. dollars by cash, check, cashier's check, money order, or any other method acceptable to the Department.

~~4.~~ 2. The Department shall not release the final permit or approval until the final itemized bill is paid in full.

R18-14-108. APP Water Quality Protection Services Flat Fees

A. The Department shall assess a flat fee for an APP water quality protection service listed in this Section.

B. Type 1 General Permits. No fee is required, except as stated in A.A.C. R18-9-A304(A)(2).

C. Fees for Type 2 and Type 3 General Permits and related water quality protection services are listed in Table 4, adjusted annually under subsection (E). For purposes of this Section, "complex" is defined in A.A.C. R18-1-501(9). "Standard" means any permit that does not meet the definition of complex.

Table 4. Type 2 and 3 General Permit Fees

Permit Description	Permit Fee	Renewal Fee
Standard Type 2: 2.01, 2.03, 2.04, 2.05, and 2.06	~~$1,500~~ $2,141	~~$500~~ $714
Complex Type 2: 2.02	~~$3,000~~ $4,281	~~$1,000~~ $1,427
Standard Type 3: 3.02, 3.03, 3.05, 3.06, and 3.07	~~$4,500~~ $6,422	~~$1,500~~ $2,141
Complex Type 3: 3.01 and 3.04	~~$7,500~~ $10,703	~~$2,500~~ $3,568
Amendment to Notice of Intent	Same as applicable renewal fee	N/A
Transfer of permit authorization	~~$50~~ $71	N/A
If a site contains more than one facility covered by the same Type 2 or Type 3 General Permit and each facility is substantially similar in design, construction, and operation, the first facility is paid at the full applicable fee, and each additional facility is:	Half the applicable fee	Half the applicable fee

D. Fees for Type 4 General Permits and related water quality protection services are listed in Table 5, adjusted annually under subsection (E).

Table 5. Type 4 General Permit Fees

Water Quality Protection Service	Description	Permit Fee
4.01 General Permit: Sewage Collection Systems	Under each Notice of Intent to Discharge, the fee is assessed on a per-component basis for the components listed below and is assessed cumulatively up to the maximum fee:	
	▪ Maximum fee	~~$25,000~~ $35,675
	▪ Force mains with design flow less than or equal to 10,000 gpd	~~$1,000~~ $1,427
	▪ Each additional increment of 50,000 gpd or less of force mains	~~$1,000~~ $1,427
	▪ Gravity sewer with design flow less than or equal to 10,000 gpd	~~$1,000~~ $1,427
	▪ Each additional increment of 50,000 gpd or less of gravity sewer	~~$1,000~~ $1,427
	▪ Each sewer lift station	~~$1,000~~ $1,427
	▪ Each depressed sewer	~~$1,000~~ $1,427
	▪ Realignment of existing sewer for a contiguous project that is less than 300 linear feet with no change in design flow or pipe size	~~$500~~ $714

4.01 General Permit courtesy review	If an applicant requests courtesy review, the Department shall approve or deny the request. When determining whether to approve a courtesy review request, the Department shall consider the complexity of the project and the Department's current work load	One-third applicable fee upon submittal, then balance of fee if Notice of Intent to Discharge is submitted with final documentation within 180 days of first submittal
4.23 General Permit: 3,000 to less than 24,000 Gallons per day Design Flow	▪ Onsite wastewater treatment facility with up to: • Three treatment technologies and disposal methods consisting of technologies or designs that are covered under other Type 4 general permits; and • Two onsite wastewater treatment facilities ▪ Maximum fee (cumulative) ▪ Each additional onsite wastewater treatment facility on same Notice of Intent to Discharge up to maximum fee ▪ Each additional treatment technology or disposal method consisting of technologies or designs that are covered under other Type 4 general permits on same Notice of Intent to Discharge up to maximum fee	~~$3,600~~ $5,137 ~~$7,500~~ $10,703 ~~$1,200~~ $1,712 ~~$500~~ $714
4.23 General Permit annual report	Annual report required under A.A.C. R18-9-E323(G)	~~$200~~ $285
Type 4 General Permits (4.02 through 4.22)	▪ Maximum fee ▪ First Type 4 general permit ▪ Each additional Type 4 general permit on same Notice of Intent to Discharge	~~$3,700~~ $5,280 ~~$1,200~~ $1,712 ~~$500~~ $714
Alternative Design under A.A.C. R18-9-A312(G)	A request for an alternative design, installation, or operational feature, per alternative design: ▪ Type 4.01 general permit ▪ All other Type 4 general permits	 ~~$750~~ $1,070 ~~$250~~ $357
Interceptor under A.A.C. R18-9-A315	A design requiring an interceptor (per interceptor)	~~$100~~ $143
Transfer	Transfer of discharge authorization	~~$50~~ $71
Priority Review	If an applicant requests priority review, the Department shall approve or deny the request. When determining whether to approve a priority review request, the Department shall consider the complexity of the project and the Department's current work load.	Double the Applicable Fee (including any applicable maximum fee)

E. The Director shall adjust the APP water quality protection services flat fees listed in subsections (C) and (D) every August 1, to the nearest $10, beginning August 4, 2023, by multiplying the APP water quality protection services flat fee by the Consumer Price Index (CPI) for the most recent year, and then dividing by the CPI for the year 2023. The CPI for any year is the average of the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items published by the United States Department of Labor, as of the close of the 12-month period ending on June 30 of that year.

R18-14-109. AZPDES Water Quality Protection Services Flat Fees

A. The Department shall assess a flat fee for an AZPDES water quality protection service, as described in Table 6, adjusted annually under subsection (D).

B. In addition to the requirements in A.A.C. R18-9-A907(B), a draft permit will state the category and fee assigned to the permit and the factors for establishing the fee, according to Table 6. Any person may comment on the fee category assignment as part of the public comment period described in A.A.C. R18-9-A908.

C. Annual Fee. The Department shall bill an annual fee, as described in Table 6, adjusted annually under subsection (D), to permittees who have not filed a notice of termination for an applicable general permit.

Table 6. AZPDES Water Quality Protection Services Flat Fees

Category	Factors for Establishing Fees	Initial Fee	Annual Fee
Municipal Separate Storm Sewer System General Permit	The fee is based on the population of the permitted area:		
	▪ Less than or equal to 10,000	~~$2,500~~ $3,568	~~$2,500~~ $3,568
	▪ Greater than 10,000 but less than or equal to 100,000	~~$5,000~~ $7,135	~~$5,000~~ $7,135
	▪ Greater than 100,000	~~$7,500~~ $10,703	~~$7,500~~ $10,703
	The fee for a non-traditional municipal separate storm sewer system, such as a hospital, college or military facility	~~$5,000~~ $7,135	~~$5,000~~ $7,135
Construction General Permit	The fee is based on the amount of acreage identified in the Notice of Intent:		
	▪ Less than or equal to 1 acre	~~$250~~ $357	~~$250~~ $357
	▪ Greater than 1 acre but less than or equal to 50 acres	~~$350~~ $499	~~$350~~ $499
	▪ Greater than 50 acres	~~$500~~ $714	~~$500~~ $714
	Pollution prevention plan review	~~$1,000~~ $1,427	N/A
	▪ Each additional submittal due to deficiency	~~$500~~ $714	N/A
	Waiver	~~$750~~ $1,070	N/A
	If more than one person must apply for general permit coverage of the same facility or discharge activity, each person pays:	Fee applicable to the amount of acreage each person controls	Fee applicable to the amount of acreage each person controls
Multi-Sector General Permit	The fee is based on the amount of acreage identified in the Notice of Intent:		
	▪ Less than or equal to 1 acre	~~$350~~ $499	~~$350~~ $499
	▪ Greater than 1 acre but less than or equal to 40 acres	~~$500~~ $714	~~$500~~ $714
	▪ Greater than 40 acres	~~$1,000~~ $1,427	~~$1,000~~ $1,427
	Pollution prevention plan review	~~$1,000~~ $1,427	N/A
	▪ Each additional submittal due to deficiency	~~$500~~ $714	N/A
	Certificate of No Exposure	~~$1,250~~ $1,784	N/A
	If more than one person must apply for general permit coverage of the same facility or discharge activity, each person pays:	Fee applicable to the amount of acreage each person controls	Fee applicable to the amount of acreage each person controls
General Permits for Non-Stormwater Discharges	The fee is based on the Department's total anticipated staff hours (including permit development, customer service, review of the notice of intent, and annual data review and inspections) divided by the total number of potential permittees over a five-year period:		
	▪ Level 1A	~~$250~~ $357	~~$250~~ $357
	• Staff hours: 1,500		
	• Number of potential permittees: 750		
	▪ Level 1B	~~$500~~ $714	~~$500~~ $714
	• Staff hours: 1,500		
	• Number of potential permittees: 375		
	▪ Level 2	~~$1,250~~ $1,784	~~$1,250~~ $1,784
	• Staff hours: 1,000		

	• Number of potential permittees: 100		
	▪ Level 3	~~$1,500~~ $2,141	~~$1,500~~ $2,141
	• Staff hours: 1,300		
	• Number of potential permittees: 100		
	▪ Level 4A	~~$2,000~~ $2,854	~~$2,000~~ $2,854
	• Staff hours: 1,600		
	• Number of potential permittees: 100		
	▪ Level 4B	~~$2,500~~ $3,568	~~$2,500~~ $3,568
	• Staff hours: 1,900		
	• Number of potential permittees: 100		
	Pollution prevention plan review	~~$1,000~~ $1,427	N/A
	▪ Each additional submittal due to deficiency	~~$500~~ $714	N/A
Emergency Discharge General Permit	Authorization for emergency discharge	~~$10,000~~ $14,270	N/A
Transfer	Authorization for permit transfer as allowed under A.A.C. R18-9-B905	~~$50~~ $71	N/A
Biosolids Land Applicators	Initial registration	~~$500~~ $714	N/A
	Registration amendment	~~$250~~ $357	N/A
	Annual report based on amount of dry metric tons applied		
	▪ Less than or equal to 7,500 dry metric tons	N/A	~~$2,500~~ $3,568
	▪ Greater than 7,500 dry metric tons but less than or equal to 15,000 dry metric tons	N/A	~~$3,000~~ $4,281
	▪ Greater than 15,000 dry metric tons	N/A	~~$4,500~~ $6,422

D. The Director shall adjust the AZPDES water quality protection services flat fees listed in subsections (C) and (D) every August 1, to the nearest $10, beginning August 4, 2023, by multiplying the AZPDES water quality protection services flat fee by the Consumer Price Index (CPI) for the most recent year, and then dividing by the CPI for the year 2023. The CPI for any year is the average of the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items published by the United States Department of Labor, as of the close of the 12-month period ending on June 30 of that year.

R18-14-110. Reclaimed Water Flat Fees

A. The Department shall assess a flat fee for a reclaimed water quality protection service as listed in Table 7, adjusted annually under subsection (B). For purposes of this Section, "complex" is defined in A.A.C. R18-1-501(9). "Standard" means any permit that does not meet the definition of complex.

Table 7. Reclaimed Water General Permit Fees

Permit Description	Permit Fee	Renewal Fee
Standard Type 2: Class A, A+, B, and B+	~~$600~~ $856	~~$450~~ $642
Complex Type 2: Class C	~~$750~~ $1,070	~~$575~~ $821
Standard Type 3: Reclaimed Water Agent, Reclaimed Water Blending Facility	~~$1,500~~ $2,141	~~$1,250~~ $1,784
Complex Type 3: Gray Water	~~$2,000~~ $2,854	~~$1,500~~ $2,141
Amendment to Notice of Intent	Same as applicable renewal fee	N/A
Transfer of permit authorization	~~$50~~ $71	N/A

B. The Director shall adjust the reclaimed water quality protection services flat fees listed in subsections (A) every August 1, to the nearest $10, beginning August 4, 2023, by multiplying the reclaimed water quality protection services flat fee by the Consumer Price Index (CPI) for the most recent year, and then dividing by the CPI for the year 2023. The CPI for any year is the average of the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items published by the United States Department of Labor, as of the close of the 12-month period ending on June 30 of that year.

R18-14-111. UIC Flat Fees

A. The Department shall assess a flat fee for the following UIC regulated facility services, adjusted annually under subsection (B):

1. Well installation in an Area Permit, $200 per well installation.
2. Class V authorization by rule, $200 per well inventory.
3. Class V authorization by rule, $100 per well transfer.

B. The Director shall adjust the UIC regulated facility services flat fees listed in subsections (A) every August 1, to the nearest $10, beginning August 4, 2023, by multiplying the UIC regulated facility services flat fee by the Consumer Price Index (CPI) for the most recent year, and then dividing by the CPI for the year 2023. The CPI for any year is the average of the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items published by the United States Department of Labor, as of the close of the 12-month period ending on June 30 of that year.

R18-14-112. Other Flat Fees

Flat fees. The Department shall assess a flat fee for the following water quality protection services:

~~1. Dry well registration, $100 per dry well until:~~
~~a. The fees in R18-14-111 are applicable, and~~
~~b. A.R.S Title 49, Chapter 2, Article 8 is removed.~~
~~2. Dry well transfer of registration, $50 per transfer:~~
~~a. The fees in R18-14-11 are applicable, and~~
~~b. A.R.S Title 49, Chapter 2, Article 8 is removed.~~
~~3.~~1. Certificate of Approval for Sanitary Facilities for Subdivisions.
   a. Subdivision with public sewerage system: ~~$800~~ $1,142, adjusted annually under subsection (2), for every increment of 150 lots or less;
   b. Subdivision with individual sewerage system:
      i. ~~$500~~ $714, adjusted annually under subsection (2), for less than 10 lots;
      ii. ~~$1,000~~ $1,427, adjusted annually under subsection (2), for greater than 10 lots but less than 50 lots;
      iii. ~~$1,000~~ $1,427, adjusted annually under subsection (2), for each additional increment of 50 lots or less.
   c. If water from a central system is not provided to the lot, the fee is one and one-half the applicable fee stated in subsection (3)(a) or (b).
   d. Condominium subdivision: ~~$1,000~~ $1,427, adjusted annually under subsection (2), for every increment of 150 units or less.

2. The Director shall adjust the water quality protection services flat fees listed in subsections (1) every August 1, to the nearest $10, beginning August 4, 2023, by multiplying the water quality protection services flat fee by the Consumer Price Index (CPI) for the most recent year, and then dividing by the CPI for the year 2023. The CPI for any year is the average of the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items published by the United States Department of Labor, as of the close of the 12-month period ending on June 30 of that year.

ARTICLE 2. PUBLIC WATER SYSTEM DESIGN REVIEW FEES

R18-14-202. Flat Rate Fees

A. The Department shall assess and collect a flat rate fee for design review services for public water systems.
B. Design criteria for public water systems are specified in 18 A.A.C. 4 and 18 A.A.C. 5.
C. An applicant shall submit public water system design review fees with an application for an Approval to Construct, as specified in 18 A.A.C. 5, Article 5.
D. The flat rate fees for a design review service:
   1. Are established in Table 1, adjusted annually under subsection (I), are assessed on a per-unit basis where applicable, and are cumulative unless otherwise specified in this Article;
   2. Shall be paid by cash, check, cashier's check, money order, or any other method acceptable to the Department; and
   3. Shall be paid in full before the Department issues approval of an application.

E. The Department shall refund 50 percent of the application fee paid by an applicant if, during the administrative completeness review time-frame period, the applicant:
1. Fails to respond in a reasonably timely manner, as set forth in A.A.C. R18-1-507, to a notice of administrative deficiencies requesting additional information under A.A.C. R18-1-503, and the Department denies the application; or
2. Withdraws the application.

F. If an application is denied under A.A.C. R18-1-507 after the end of the administrative completeness review time-frame, the Department shall retain the flat fee paid by the applicant.

G. If an applicant requests priority review, the Department shall approve or deny the request. When determining whether to approve a priority review request, the Department shall consider the complexity of the project and the Department's current work load. If priority review is approved by the Department, the applicant shall pay the priority review fee specified in Table 1, adjusted annually under subsection (I).

H. State agencies are exempt from all fees imposed under this Article pursuant to A.R.S. § 49-353(A)(2)(b).

I. The Director shall adjust the design review services fees listed in Table 1 every August 1, to the nearest $10, beginning August 4, 2023, by multiplying the design review services fee by the Consumer Price Index (CPI) for the most recent year, and then dividing by the CPI for the year 2023. The CPI for any year is the average of the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items published by the United States Department of Labor, as of the close of the 12-month period ending on June 30 of that year.

Table 1. Design Review Service Fees

Public Water System Design Review Application Types	**Fees[1, 2]**
Approval to Construct Public Water Supply Distribution System:	
• 150 or fewer service connections	~~$900~~ $1,284
• 151 to 300 service connections	~~$1,400~~ $1,998
• 301 to 450 service connections	~~$1,900~~ $2,711
• 451 to 600 service connections	~~$2,400~~ $3,425
• 601 to 750 service connections	~~$2,900~~ $4,138
• Each additional 150 service connections	Add ~~$500~~ $714
Water Treatment Plants and Blending Plans (including new source approval if applicable):	
• < 0.1 mgd	~~$1,500~~ $2,141
• ≥ 0.1 mgd and < 1 mgd	~~$2,000~~ $2,854
• ≥ 1 mgd and < 5 mgd	~~$3,000~~ $4,281
• ≥ 5 mgd	~~$5,000~~ $7,135
Well (including new source approval if applicable)	~~$1,250~~ $1,784
Storage Tank	~~$800~~ $1,142
Booster Pump	~~$800~~ $1,142
Main Line Extension	~~$250~~ $357
Chlorinators/Disinfection Devices	~~$250~~ $357
Extension of Time to Construct[3]	50% of the application fee, not to exceed ~~$500~~ $714
Priority Review Fee[4]	Double the Standard Fee

1 Fees are calculated on a per-unit basis; i.e., a separate fee is assessed for each separate storage tank, booster pump, disinfection device, or main line extension.

2 Fees for each application type are cumulative; an applicant must pay the total of all pertinent fees.

3 Extensions of time to construct are issued pursuant to A.A.C. R18-5-505(E); the Section states that an Approval to Construct becomes void if construction is not commenced or completed within a specified time period, unless the Department grants an extension of time.

4 Priority Review Projects require Department authorization prior to filing.

ARTICLE 3. CERTIFIED OPERATOR FEES

R18-14-301. Certified Operator Fees

A. Definition terms from A.A.C. R18-5-101 apply to this Article.

B. The Department shall assess and collect a flat rate fee for a certification or renewal under the operator certification program.

C. A person shall submit the applicable fee when requesting a certification or renewal under 18 A.A.C. 5, Article 1, as described below:

1. An applicant that seeks new certification shall submit a ~~$65~~ $87 fee, adjusted annually under subsection (D), per certification.
2. An operator that has not held a lower grade level for the required amount of time requests the Department's determination on experience and education in order to be admitted to a higher grade certification examination shall submit a fee of ~~$150~~ $201, adjusted annually under subsection (D), per application.
3. An applicant that requests a certificate based on reciprocity with another jurisdiction shall submit a fee of ~~$250~~ $334, adjusted annually under subsection (D), per application.
4. An operator submitting a certificate renewal shall submit a ~~$150~~ $201, adjusted annually under subsection (D), fee for each certificate. If the operator has multiple certificates, the first certificate is ~~$150~~ $201, adjusted annually under subsection (D), and each additional certificate with the same expiration date is ~~$50~~ $67, adjusted annually under subsection (D).

D. The Director shall adjust the certification or renewal fees listed in subsection (C) every August 1, to the nearest $10, beginning August 4, 2023, by multiplying the certification or renewal fee by the Consumer Price Index (CPI) for the most recent year, and then dividing by the CPI for the year 2023. The CPI for any year is the average of the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items published by the United States Department of Labor, as of the close of the 12-month period ending on June 30 of that year.

The economic, small business, and consumer impact statement

The following discussion addresses each of the elements required for an economic, small business and consumer impact statement under A.R.S. § 41-1055.

Identification of the rulemaking: 18 A.A.C. 14, Articles 1, 2, and 3, amending R18-14-101 through R18-14-105, R18-14-108 through R18-14-110, and R18-14-112; R18-14-202; and R18-14-301; and their respective tables. These rules are designed to collect fees for water quality protection programs, which will go into the water quality fee fund (WQFF) - not to change the conduct of any regulated entities. The hourly fees, flat fees, and maximum fees would be increased throughout the noted articles. When ADEQ originally set its permitting fees in 2011 and its Operator Certification fees in 2016, those fees were based on conservative assumptions, including costs associated with the minimum level of staffing that ADEQ believed was necessary to implement the permitting, compliance and enforcement programs, effectively, efficiently, and within licensing time-frames. Though using the best available information at the time, the actual costs of implementing the above programs is more than originally projected. The fees collected through the hourly and flat fees did not raise the revenue needed to properly conduct those programs, and outside funding had to be secured.

ADEQ's goal in this rulemaking is to establish water quality protection fees that will help sustain those programs while avoiding disproportionate impact on any one group of stakeholders. The amended fees included in this rulemaking are projected to raise about $2.8 million; however, these increased fees alone will be insufficient to cover the full cost of those programs. State leadership approved a bill that will help ADEQ close the gap for FY24. No new fees are being proposed in this rulemaking.

This rulemaking addresses the continued shortfall created by the elimination of the General Fund from ADEQ's budget in 2011 and the subsequent increase in program costs due to inflation, and includes increases to the following categories of fees:

- Hourly-based fees for individual permits or water quality protection services subject to variable review times;
- Flat fees for water quality protection services subject to predictable average times for review, such as for general permits;
- Annual fees to cover the costs of administering permit coverage; and
- Flat fees for operator certification.

Description of Water Quality Programs: ADEQ is responsible for developing permit programs for AZPDES, APP, UIC, and reclaimed water, as well as ensuring safe potable water for the public through (among other things) public water system design review and operator certification. *See* A.R.S. §§ 49-203(A)(2), (5), (6) and (7); and 49-351. These programs help protect human health and the environment by ensuring clean and safe water for consumption, recreational use, and agricultural use, among other things, through permitting, inspections, compliance, and enforcement of federal and state requirements. The permitting programs protect both surface water and groundwater through the issuance, management, and modification of permits that ensure pollutant limits are set at levels protective of human health and the environment. The safe drinking water program protects the drinking water for Arizonans, by conducting site inspections and monitoring for compliance. Complaints are investigated, and data involving compliance and/or noncompliance is compiled and tracked. Assistance for the regulated community is provided, and oversight is given when non-compliance events take place to ensure proper remediation.

Regulatory Universe: ADEQ's Water Quality Programs are responsible for protecting and enhancing public health and the environment by ensuring healthy drinking water in public water systems and by controlling current and future sources of surface and groundwater pollution. ADEQ's Certified Operator program establishes guidelines to ensure that only certified operators make decisions about process control or system integrity that affect public health. The program establishes minimum standards for certification and recertification of the operators of drinking water and wastewater systems.

ADEQ currently regulates more than 450 facilities with Individual Aquifer Protection Permits with approximately 150 of these facilities also requiring an Individual AZPDES permit to allow for a safe surface water discharge. As many as 4,000 facilities require a Type 2, 3, or 4 general permit for the APP or reclaimed water programs; these are generally for smaller discharge volumes or activities not requiring extensive Departmental review. ADEQ issues approximately 100 to 150 Certificates of Sanitary Facilities per year for new housing subdivisions. ADEQ's stormwater program accounts for approximately 11,000 to 30,000 permits (Construction, Multisector, and De Minimis) at any time. In addition to ADEQ's own permitting program, all 15 Arizona Counties and some cities have delegated programs for issuing and inspecting on permitted facilities in their jurisdictions.

Current Appropriation: The budget required for the FY24 Water Quality Program is approximately $19.2 million. The Program has operated at a deficit since the fees-related

rulemakings in 2011. Without a fee increase, the fees ADEQ generates through the permitting and operator certification processes will only be approximately $7.3 million. This rule is designed to help address the FY24 deficit, and allow for future, slower increases in fees through CPI. Again, while this fee rulemaking will not generate revenue sufficient to cover all necessary costs, an inflation adjusted fee increase is necessary and fair to all stakeholders.

Recent Implemented Efficiencies: ADEQ has continued to do more with fewer resources; despite the fact that ADEQ's budget is roughly $64.8 million less than it was in 2008 (in FY08 dollars). ADEQ has reduced the average time to obtain an environmentally protective permit by 76%, while decreasing its workforce by 36%. The AZPDES program permit backlog is one of the lowest in the country. Under our Safe Drinking Water Act programs, 66% fewer systems are delivering water that does not meet federal limits, and 99.8% of Arizonans are served healthy drinking water every day. While ADEQ continues to execute its mission with fewer resources, the current revenue flowing to the Water Quality Fee Fund is insufficient to maintain those advances.

Regulatory Objective: ADEQ preserves and protects human health and the environment by establishing and implementing controls for current and future sources of ground and surface water pollution, ensuring safe and clean drinking water is provided by public water systems, and certifying operators of public water systems. *See* A.R.S. §§ 49-203(A)(2) (AZPDES permit program); (A)(5) (APP permit program); (A)(6) (UIC permit program); (A)(7) (permit program for the direct reuse of reclaimed water); 49-351 (potable water systems); 49-352 and 49-361 (operator certification).

EPA requires states to adopt programs that are at least as stringent as the federal CWA and SDWA programs in in order to receive primary implementation and enforcement authority within its jurisdiction (primacy) for those programs. ADEQ must meet certain criteria and benchmarks to maintain primacy. If ADEQ is unable to adequately fund these programs, the EPA may step in and regain primary regulatory authority over these water quality programs. Most in the regulated community agree that ADEQ should implement the CWA and SDWA programs instead of EPA.

Resource Reduction Impacts: Without remedy, the WQFF deficit will impact ADEQ's long term ability to effectively implement state and federal water quality programs. For instance, this may impact ADEQ's inspection frequency as well as our ability to issue environmentally protective permits and maintain the improvements we have made in our permitting time frames all while protecting vital surface and groundwater sources of drinking water. Increasing fees for the water quality programs themselves will allow ADEQ to utilize previously reallocated funds to address other items, such as the Auditor General's findings, that included developing all required aquifer

water quality standards, conducting key ongoing groundwater monitoring of the State's aquifers, monitoring for agricultural pesticides in groundwater and surrounding soil, or reducing the number of impaired surface waters within the State. Additionally, failure to adequately fund the CWA and SDWA programs could cause ADEQ to lose primacy of these programs and corresponding grant funds. If the programs revert back to EPA, Arizona would lose control over enforcement and permitting decisions, and EPA would become the main regulatory body for those programs.

Least burden and cost; description of alternatives: A.R.S. § 41-1052(D)(3) requires ADEQ to demonstrate it has selected the alternative with the least burden and cost necessary to achieve the underlying regulatory objective. Similarly, A.R.S. § 49-104(B)(17) requires that fees be "fairly assessed and impose the least burden and cost to the parties subject to the fees" and be based on "the direct and indirect costs of the department's relevant duties … directly related to issuing licenses … and enforcing the requirements of the applicable regulatory program." For this rulemaking, ADEQ interprets those requirements to mean collecting fee amounts that will help the Department provide clean water resources to communities within the State, and meet the objectives of protecting all waters from pollution. *See* A.R.S. §§ 49-203(A)(2) (AZPDES permit program); (A)(5) (APP permit program); (A)(6) (UIC permit program); (A)(7) (permit program for the direct reuse of reclaimed water); 49-351 (potable water systems); 49-352 and 49-361 (operator certification). The Department believes the fees are "fairly assessed" because the fees are based on "the direct and indirect costs" of the applicable programs.

Alternatives: ADEQ has involved the regulated community in discussions regarding alternative fee increases. ADEQ considered a fee increase that would completely eliminate the annual deficit for the WQFF, but would cause stakeholders to internalize the full burden of the $11.9 million deficit. The current proposed fee increase will impact the parties subject to fees in a fair and proportional way, however, it will not completely bridge the gap necessary to meet the budget shortfall.

ADEQ's goal in this rulemaking is to establish water quality protection fees that will help sustain the programs while avoiding disproportionate impact on any one group of stakeholders.

ADEQ has aggressively pursued federal grant opportunities, and used EPA grants to develop and maintain its regulatory programs. Notwithstanding aggressive budget reductions that resulted in loss of staff through reductions in force and layoffs, fee increases are necessary to help cover the cost to implement and administer the programs.

ADEQ's ability to raise revenue is limited by the powers and duties granted it through statute, specifically A.R.S. §§ 49-104(C) and 49-203(A)(8). While ADEQ can impose civil and criminal penalties of up to $25,000 per day, both civil and criminal penalties obtained under an environmental enforcement action must be deposited in the General Fund (A.R.S. §§ 49-262(E) and 49-263(G)).

ADEQ considered the impact that a fee raise would have on the parties subject to the increases, and determined that the least amount of fees necessary to help the Department bridge the deficit would be fair and proportional to the parties impacted.

Cost/Benefit: The probable costs for this rule are the $2.8 million in increased fees necessary for ADEQ to close the $11.9 million deficit needed to maintain the water quality programs. These costs would be primarily incurred by permittees - ranging from private and public waste water treatment plants to mining companies - and certified operators.

The probable benefits are:

- Ability to address some of the issues raised in the '21 Auditor General's Report: As noted above, increasing fees for the water quality programs themselves will allow ADEQ to utilize previously reallocated funds to address other items, such as the Auditor General's findings.
- Maintain or improve our advances in providing drinking water that meets federal Standards: Under our Safe Drinking Water Act programs, 66% fewer systems are delivering water that does not meet federal limits, and 99.8% of Arizonans are served healthy drinking water every day. Increased revenue will allow us to maintain and improve this performance.
- Maintain or improve our ability to issue environmentally protective permits, quickly: ADEQ has reduced the average time to obtain an environmentally protective permit by 76%, while decreasing its workforce by 36%. This includes the individual permit in the Aquifer Protection Permitting Program, Reclaimed water and Arizona Pollution Discharge Elimination System Permits programs. Increased revenue will allow us to maintain and improve this efficiency.
- Ability of Arizona to implement the federal Clean Water Act program and federal Safe Drinking Water Act program: ADEQ obtained primacy for the AZPDES program in 2002, and primacy for safe drinking water systems in 1978, with federal approval for expansion of the initial programs in the years since. *See* 43 FR 38083; 67 FR 49916. If

EPA were to subsume these programs due to lack of ADEQ's financial ability to operate them, there could be a time lag with no oversight of these programs. EPA does not have the bandwidth to expeditiously begin running a program that ADEQ has run for several decades. ADEQ maintaining primacy means that there will not be a delay in either reviewing or issuing permits, or inspecting and ensuring that permittees follow local, state, and federal rules that benefit Arizonans.

- ADEQ maintains control over non-compliance events: The CWA and SDWA have reporting requirements that permittees must follow. Because Arizona has primacy over those federal programs, facilities and operators have to submit required information to ADEQ for transmittal to EPA. This allows ADEQ to maintain a positive working relationship with the regulatory community, and monitor and quickly respond if the information provided by permittees shows a facility is in non-compliance and negatively impacting human health and the environment. If ADEQ was unable to provide this compliance assistance service, EPA would have to step in, causing delay in problem solving.
- Rulemaking oversight: When EPA adopts a new regulation, Arizona has the authority to review that regulation and determine whether to adopt it and incorporate it into its rules with or without tailoring the requirements to our unique circumstances. If the CWA and SDWA programs are reverted back to the EPA, Arizona would lose the ability to implement the programs with tailored regulations for Arizona that align with federal regulations.
- Outreach to regulated community: Throughout the year, ADEQ staff participates in numerous conferences and training seminars with the goal of educating the regulated community about ADEQ's water quality requirements and policies. These include providing updates to the community on new rules, and helping ensure compliance with permits. It is unlikely that EPA would participate in such events in Arizona.

For these reasons, ADEQ believes that the benefits exceed the cost.

Rules More Stringent than Corresponding Federal Law. Not applicable. While the CWA and SDWA are applicable to some of ADEQ's water quality programs, these federal laws do not specify funding structures for the programs.

Probable Impact on Political Subdivisions of this State Directly Affected by this Rulemaking: Political subdivisions represent approximately 40 percent of the individual water quality

permitting universe and they will bear the greatest impact. This is because they own or operate facilities and/or conduct multiple activities requiring both APP and AZPDES permit coverage. Larger municipalities also typically own and operate multiple, more complex, and larger facilities. Smaller communities will likely be affected more so than large communities because they have a smaller population over which to spread the costs.

Many municipalities operate wastewater treatment facilities (WWTPs), which require various APP, AZPDES, and reclaimed water permits. Many municipalities also have reclaimed water permits. The typical municipality will also pay annual or renewal fees on most of these permits. For Articles 1 and 2 (water quality protection services and public water system design review, respectively), the fees will increase by a CPI adjustment of approximately 43%. For Article 3 (operator certification), the fees will increase by a CPI adjustment of approximately 34%. ADEQ has classified the increases as moderate for all parties impacted. The proposed fee increases do not fully fund the programs, but help ADEQ minimize the deficit. While a less than CPI adjusted increase would likely result in a minimal impact, the funds raised would also be insufficient to meet the needs of the programs. A greater than CPI increase might more fully fund the programs, but would have caused a substantial impact to all those affected.

Examples of the impact of the fee increases can be best shown by the impact on different classes of customers. A large municipality might have multiple wastewater treatment plants requiring an individual APP and, sometimes an individual AZPDES. In this example we will assume that the plant in question has a discharge volume of ten million gallons or more. That municipality would currently pay $8,500 per year for the APP discharge and $4,000 year for the AZPDES discharge, for a total of $12,500 per year. Under the fee model proposed in this rulemaking, that municipality would pay $12,130 per year for the APP discharge and $5,708 for the AZPDES discharge, for a total of $17,838. ADEQ considers this a moderate increase in cost for a large municipality that may have multiple plans for which it is responsible. The same holds true for any municipality regardless of size; since fees are tied to discharge volume, smaller municipalities will have correspondingly smaller annual fee burdens. By way of an example, the table below demonstrates the change to individual AZPDES annual fees, as is described above:

Permitted Discharge Volume (GPD) or Minor/Major Industrial	**Current Annual Fee**	**New Annual Fee**
Less than 99,999	$250	$357

100,000 to 999,999	$500	$714
1,000,000 to 9,999,999	$2,500	$3568
10,000,000 or more	$4,000	$5,708
Minor	$500	$714
Major	$2,500	$3,568

The CPI increase that applies to ADEQ Operator Certification will be approximately 34%. Municipalities or private companies may, and often do, reimburse employees for these expenses. ADEQ recognizes, however, that many operators in smaller communities are financially responsible for their own certifications. The increase of 34% reflects an adjustment that will aid the administration of the program. Operators have to renew their certification every three years. Currently, an operator with four certificates, the highest number available, pays $300 every three years. The increase of 34% would require that an operator with all four certifications pay $402 every three years. Under the new fee model, the cost for renewing the highest number of certifications is moderate. The table below demonstrates the comparison between current fees and new fees for operator certifications:

Description	**Current Fee**	**New Fee**
New certification	$65	$87
An operator that has not held a lower grade level for the required amount of time requests the Departments determination on experience and education in order to be admitted to a higher grade certification examination	$150	$201
An applicant that requests a certificate based on reciprocity with another jurisdiction	$250	$344
An operator submitting a certificate renewable shall submit a fee for each certificate		

(see below)		
If the operator has multiple certificates; the first certificate	$150	$201
Each additional certificate with the same expiration date	$50	$67

Reduction of Impact on Small Businesses: A.R.S. § 41-1035 requires state agencies to reduce the impact of a rulemaking on small businesses, if any of the following methods are legal and feasible in meeting the statutory objectives which are the basis of the rule making:

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 listed methods are not generally relevant to a rule establishing fees. *See* A.R.S. § 49-104(B)(17) (requiring fees be "fairly assessed" and based on "direct and indirect costs.")

Probable Impact on Small Businesses: Small businesses with facilities that require APP or AZPDES permit coverage include small construction companies, truck stops and gas stations, and mobile home and recreational vehicle parks. Generally, these types of small businesses do not operate facilities requiring reclaimed water permits, although a small golf course could have a reclaimed water general permit for use of treated effluent for irrigation. Truck stops and gas stations likely have general APP permits for drywells and will also be assessed the increased APP fees. Small businesses tend to have a smaller customer base over which to spread the costs of the increased fees.

Truck stops, gas stations, and mobile home and recreational vehicle parks that are not within incorporated communities served by centralized sewer, would likely require on-site wastewater

treatment. The APP Type 4.23 general permit is for larger on-site facilities (up to 24,000 gallons per day).

Water and wastewater operators in Arizona who are certified, who seek to become certified, or seek additional certifications bear the costs of paying the fees for renewals, examinations, reciprocity, or early examination. ADEQ's Operator Certification program has approximately 6,800 certified operators who hold approximately 12,000 certificates. About 3,800 operators hold multiple certifications; about 1,500 operators hold all four certifications.

An operator certified in Arizona can have a maximum of four certificates, meaning they are certified in each of the four classes of facilities: water treatment plants, water distribution systems, wastewater treatment plants, or wastewater collection systems. An operator with four certificates could pay a maximum renewal fee of $402 every three years.

These rules do not make any changes to current costs for examination or professional development hours (PDHs). An operator will still be responsible for costs or fees paid to the examination contractor or for PDHs. The current cost to sit for an exam at Gateway is $89, which is paid to Gateway. Generally, the fee can be up to $109 for examinations held off-site from Gateway. The exam fee covers costs for Gateway and ABC operator certification examinations; ADEQ does not receive any part of this examination fee.

It is likely that most small businesses that require permitting or operator certification will be smaller waste water treatment plants or smaller municipalities, and to the extent that the small businesses reimburse operators, the increased fees will moderately impact them – as compared to the minimal impact of a less than CPI increase, or the significant impact of a greater than CPI increase.

Identification of Persons Directly Affected by the Rule Making: Applicants and permittees of the drinking water, APP, UIC, reclaimed water, and AZPDES permitting programs will be affected by these rules, as well as individuals certified by our Operator Certification program. Permittees include businesses, individuals, political subdivisions, federal agencies, and non-profit organizations. Other entities that may be indirectly impacted by the rules include customers of permittees. This rulemaking does not directly impact the fees of ADEQ's delegated government entities. A.A.C. R18-14-107 establishes authority for counties or other local governments to set independent fees for implementing ADEQ delegated water protection programs.

ADEQ anticipates that this rulemaking will affect 17,000 to nearly 38,000 permitted facilities or activities, as well as an unknown number of facilities or activities in the future. ADEQ anticipates

the increased fees will have a moderate impact on these persons – as compared to the minimal impact of a less than CPI increase, or the significant impact of a greater than CPI increase.

Probable Effect on State Revenues: ADEQ estimates that fees from this rulemaking will directly affect state revenues by increasing revenues to the WQFF Fund by $2.8 million annually.

Gmail

David Lelsz <lelsz.david@azdeq.gov>

Support Water Quality

1 message

Steve Griffin <steveg@innovaquartz.com> Mon, May 15, 2023 at 9:29 AM
To: "Lelsz.David@azdeq.gov" <Lelsz.David@azdeq.gov>

An increasing population as well as newly emergent challenges regularly confront our State's scientists and technicians charged with maintaining our water quality, from trace prescription drug residues in wastewater to perfluorinated alkyl substances (PFAS) in our surface and groundwaters. While nobody likes paying higher fees for government services, absent some billionaire's largess in bequeath of an adequate trust, ADEQ really needs our support for fee increases AND for legislation that provides additional funding from other sources.

Stephen Griffin, PhD

Founder & CTO

InnovaQuartz LLC

& SilicaPhysics LLC

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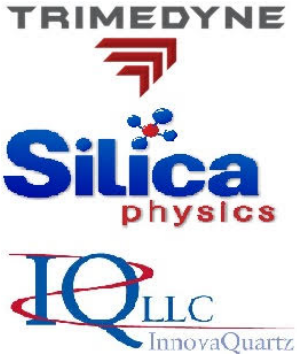
TRIMEDYNE
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David Lelsz <lelsz.david@azdeq.gov>

ADEQ fee rule comment

1 message

Catherine L Evilsizor <azcland@gmail.com> Mon, May 15, 2023
To: Lelsz.David@azdeq.gov

Hello,
ADEQ should absolutely charge and/or receive funding via the legislature adequate to operate.
Water quality is essential to all life.
I am in favor of raising fees to cover the cost of the important work of ADEQ for our state.
--
Catherine
--
Build the world you want to live in.
¡Ahora es cuando!
The most common way people give up their power is by thinking they don't have any. Alice Walker

Catherine Land Evilsizor
Tucson, AZ
520-261-1628 (Calls/text messages)

City of Phoenix
OFFICE OF ENVIRONMENTAL PROGRAMS

May 30, 2023

David Lelsz, Ph.D.
Arizona Department of Environmental Quality
Water Quality Division
1110 W. Washington Street
Phoenix, AZ 85007

Re: Water Quality Division Fee Rule Update - Proposed Rule

Dr. Lelsz:

The City of Phoenix ("City") appreciates the opportunity to provide the Arizona Department of Environmental Quality ("ADEQ") with comments on the Water Quality Division Fee Rule Update published in the Arizona Administrative Register on April 28, 2023.

While the City supports many of the changes ADEQ is proposing from the informal draft fees previously provided to the public, including the retention of maximum fees (cap) for individual permit amendments and modifications, the City provides the following comments:

1. ADEQ Water Quality Funding Sources

The City strongly supports ADEQ's efforts to obtain a reliable annual funding source to support the water quality goals of Arizona, rather than relying solely on permittee fees. To this end, the City supports Senate Bill (SB) 1391 which would allocate $9,060,000 to the Water Quality Fee Fund, in addition to the one-time $9,500,000 appropriation from state general funds for Fiscal Year 2023-2024.

If SB 1391 fails to pass, the City urges ADEQ to continue to investigate and pursue reliable, sustainable funding for the protection of public health and the environment rather than return to a fully fee-based approach, especially considering the increased state-wide program activities ADEQ will need to fund based on the Auditor General's report. Permittees already pay for the cost of getting a permit and for any of the unfunded conditions required by permits. Adding increased permit fees that are not directly related to the cost of obtaining a permit unfairly places the burden of ADEQ's water quality division on those already paying to mitigate and minimize their own impacts on water quality. Instead, permittees should only be charged for the direct cost of permitting (fee-for-service). Placing the sole responsibility for funding ADEQ's water

quality program on permittees would place an unreasonable and non-justifiable burden on a few entities and would not provide a reliable and consistent funding source.

2. Operator Certification Fees

The City does not support ADEQ's proposal to increase the fees annually for the Operator Certification program. ADEQ has not provided sufficient justification for the proposed increases. No additional functions or efficiencies were identified by ADEQ that would be added to the Operator Certification program as a result of operator certification fee increases. An annual adjustment using the CPI would result in a significant and continually growing burden on operators.

For example, over the course of three years, the cost for an operator with two certifications would rise by $36. Many operators have three or even four different certifications they keep up to date. This reflects just the first three years. With the proposed annual CPI adjustment, these fees will continue to rise over time and become increasingly burdensome for individual operators and for companies that reimburse employees for these expenses. This is one of the most significant financial implications to the City from these fee increases, due to the sheer number of operators we employ.

The City is also concerned the increased fees could result in operator workforce depletion. The water and wastewater industry are currently experiencing a workforce crisis, struggling to recruit, train, and retain employees, and approximately one-third of the water sector workforce will be eligible to retire within the next several years. This fee increase will further exacerbate the workforce crisis, leaving the state with less certified operators available to operate water and wastewater systems. The City believes that this increase will disincentivize an individual obtaining multiple types of operator certifications and that this additional financial burden on the individual operators, as consumers, would further jeopardize the public health and the environment.

3. AZPDES Multi Sector General Permit ("MSGP")

The proposed fee increase will be magnified when passed along by multiple MSGP permit holders across Arizona to others involved in an AZPDES Sector (for example, in Sector S Air Transportation fueling, hangar, air service, airport, etc.) or between AZPDES Sectors (for example, Air Transportation, Land Transportation, Warehousing, Manufacturing, etc.).

Increasing fees will cause the biggest impact to small businesses. Permit fees are a barrier to business entry and endanger small business sustainability. Fees based solely on acreage do not work for all small businesses/co-permittees. For example, mobile providers have no leasehold or location/storage area and are only working in small areas but are expected to pay an amount based on acreage. For a mobile provider operating at all three Phoenix airport locations, this is an increase of from $1,050 to $1,497 annually based on the increase from $350 to $499 annually for sites that are <=1 acre.

The City requests that ADEQ consider the following:

- Fee waivers for the following small business partners: mobile mechanics and wash service providers.
- De minimus fees for mobile providers based on the business rather than the facility acreage. For example: If located at one to three facilities $100 annual fee; If located at four to six facilities $200 annual fee. This would lower the cost barrier to business entry into the field.
- Phase in fee increases over multiple years to reduce impacts to small businesses or assess a lower annual fee, as noted in the bullet above.
- If ADEQ retains the 5-year No Exposure Certificate ("NEC"), the fee should be prorated and refunded if the business closes during that 5-year period or provide the option of either paying for a 5-year NEC up front or paying an annual fee (similar to vehicle registrations).

The cost burden for a No Exposure Certificate ("NEC") holder is excessive, particularly considering that the owner is certifying there is no potential for contaminates to be discharged to stormwater infrastructure and when compared to a site that has filed a Notice of Intent ("NOI"), especially considering a site with a filed NEC has already taken certain active measures and Best Management Practices to not expose activities to stormwater, and because an NEC only requires a review from ADEQ once every five years. The City requests ADEQ evaluate the ideas for NEC fee adjustments as noted in the bulleted list above.

Thank you for the opportunity to provide comment. If you have any questions or need additional information, please contact Tricia Balluff, Environmental Programs Coordinator, at tricia.balluff@phoenix.gov or 602-534-1775.

Sincerely,

Nancy Allen

Nancy Allen
Environmental Programs Administrator

cc: Tricia Balluff, Office of Environmental Programs
David Benton, Law Department
Jennifer Calles, Water Services Department
Jordan Feld, Aviation Department

ARIZONA MINING ASSOCIATION
916 W Adams Street Suite 2
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(602) 266-4416

May 30, 2022

Via Email (lelsz.david@azdeq.gov)
David Lelsz, Ph.D.
Arizona Department of Environmental Quality
Surface Water Quality Section
1110 W. Washington
Phoenix, AZ 85007

Re: Arizona Mining Association Comments on Proposed Revisions to ADEQ's Water Quality Protection Fees Rule (29 Ariz. Admin. Reg. 955-972 (April 28, 2023))

Dear Dr. Lelsz:

The Arizona Mining Association ("AMA") appreciates this opportunity to submit comments in support of the Arizona Department of Environmental Quality's ("ADEQ") proposed water quality protection fees rule as published in the Arizona Administrative Register on April 28, 2023 (29 Ariz. Admin. Reg. 955-972).

The AMA is a non-profit corporation comprised of entities engaged in mining and mineral processing in Arizona. In 2022, AMA member companies produced approximately 74% of the nation's newly-mined copper, along with significant amounts of associated valuable co-products (e.g., gold, silver, selenium, tellurium and molybdenum). Arizona's hard rock mining industry employs approximately 13,645 people directly which supported an additional 47,262 indirectly and has an estimated direct and indirect impact on the Arizona economy of nearly $14.2 billion. The AMA is the unified voice of responsible, sustainable and safe mining in Arizona. Through our advocacy, we help Arizona continue to be a premier location for mining investment in the U.S.

AMA members actively apply for and obtain various water quality permits and other authorizations and approvals from ADEQ. Consequently, the proposed water quality protection fees rule will directly impact AMA and its members.

As a general matter, AMA supports an adequately funded Water Quality Division. The Division does important work that benefits all Arizonans, not just AMA members. This past legislative session, AMA supported ADEQ receiving additional funds outside of permit fees to support its non-permitting activities, and we anticipate doing the same in future years. Such non-permit sources of funding are important because, as explained below, statutory limits exist on the types of expenses that ADEQ may recover through permit fees in some of its key water quality programs.

With respect to the current proposed rule, AMA supports ADEQ's proposal to increase its fees for water quality protection services and public water system design reviews by approximately 43%, and certified operator fees by approximately 34%. These increases allow the agency to keep up with the significant inflation that has occurred since the fees were last adjusted. AMA also supports the proposed annual Consumer Price Index ("CPI") adjustments for the various water quality fees.

In particular, AMA appreciates ADEQ's recent successful efforts to streamline the process for reviewing and then issuing environmentally protective permits. These commendable efforts make it more palatable for the regulated community to support an increase in permitting fees. As part of the planned increase in fees, we encourage ADEQ to continue moving forward with and improving on its permit streamlining efforts.

Although AMA supports the proposed fee increases, it is important to note that the statutes for both the aquifer protection permit ("APP") program and the Arizona Pollutant Discharge Elimination System ("AZPDES") permit program place limits on the fees that ADEQ can charge for processing permits. A.R.S. § 49-241.02(A) gives ADEQ authority to establish fees by rule but only "to pay the expenses incurred in implementing the [APP] program." The APP program is found in A.R.S. Chapter 49, Chapter 2, Article 3. Similarly, A.R.S. § 49-255.01(J) only authorizes ADEQ to establish fees (including maximum fees) by rule "to pay expenses incurred in implementing the AZPDES program." The AZPDES program is found in A.R.S. Title 49, Chapter 2, Article 3.1. Other programs such as ambient monitoring, adopting water quality standards, identifying impaired waters, establishing total maximum daily loads ("TMDLs"), and implementing voluntary nonpoint source measures are found in separate articles and are not part of the statutorily defined APP and AZPDES programs. Based on these statutory limits, ADEQ should ensure the fees it is proposing for APP and AZPDES water quality services are not used to support or fund activities outside of the permitting programs.

AMA finally requests that ADEQ remove all references to needing funds to implement the findings of the 2021 Auditor General's Report of ADEQ's Water Quality Division in the preamble to the final version of this rule. Setting aside any questions about the accuracy or legitimacy of many of the findings in the 2021 Report, all of the findings relate to ancillary activities that are outside the scope of the main permit programs administered by ADEQ. For the reasons described above, addressing the findings should not be paid for by the fees collected under ADEQ's water quality protection fees rule.

Sincerely,

Steve Trussell
Executive Director, Arizona Mining Association

cc: Trevor Baggiore, ADEQ Water Quality Division Director (baggiore.trevor@azdeq.gov)

Arizona Administrative CODE
www.azsos.gov
Office of the Secretary of State
ADMINISTRATIVE RULES DIVISION

TITLE 18. ENVIRONMENTAL QUALITY

CHAPTER 14. DEPARTMENT OF ENVIRONMENTAL QUALITY - PERMIT AND COMPLIANCE FEES

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
July 1, 2022 through September 30, 2022

Questions about these rules? Contact:

Department:	Arizona Department of Environmental Quality Water Quality Division
Address:	1110 W. Washington St. Phoenix, AZ 85007
Website:	https://azdeq.gov/UIC
Name:	Jon Rezabek
Telephone:	(602) 771-8219
Email:	rezabek.jon@azdeq.gov

The release of this Chapter in Supp. 22-3 replaces Supp. 15-4, 1-9 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. § 41-5505.

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.

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TITLE 18. ENVIRONMENTAL QUALITY

CHAPTER 14. DEPARTMENT OF ENVIRONMENTAL QUALITY - PERMIT AND COMPLIANCE FEES

Authority: A.R.S. §§ 49-203(A)(6), 49-203(A)(9), 49-104(C)(1)

Supp. 22-3

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ARTICLE 1. WATER QUALITY PROTECTION FEES

R18-14-101. Definitions

In addition to the definitions in A.R.S. §§ 49-201, 49-241.02, 49-255, 49-331, and A.A.C. R18-9-101, A.A.C. R18-9-701, and A.A.C. R18-9-A901, the following terms apply to this Article:

1. "APP" means an Aquifer Protection Permit.
2. "Complex modification" means:
   a. A revision of an individual Aquifer Protection Permit for a facility within a mining sector as defined in A.R.S. § 49-241.02(F)(1); and
   b. A revision of an individual Aquifer Protection Permit for a facility within a non-mining sector due to any of the following:
      i. An expansion of an existing pollutant management area requiring a new or relocated point of compliance;
      ii. A new subsurface disposal including injection or recharge, or new wetlands construction;
      iii. Submission of data indicating contamination, or identification of a discharging facility or pollutants not included in previous applications that requires reevaluation of BADCT; or
      iv. Closure of a facility that cannot meet the clean closure requirements of A.R.S. § 49-252 and requires post-closure care, monitoring, or remediation.
3. "Courtesy review" means a design review service that the Department performs within 30 days from the date of receiving the submittals, of the 60 percent completion specifications, design report, and construction drawings for a sewage collection system.
4. "Priority review" means a design review service for an APP Type 4 permit application that the Department completes using not more than 50 percent of the total review time-frame for the applicable Type 4 permit application as specified in 18 A.A.C. 1, Table 10.
5. "Request" means a written application, notice, letter, or memorandum submitted by an applicant to the Department for water quality protection services. The Department considers a request made on the date it is received by the Department.
6. "Review hours" means the hours or portions of hours that the Department's staff spends on a request for a water quality protection service. Review hours include the time spent by the project manager and technical review team members, and if requested by the applicant, the supervisor or unit manager.
7. "Review-related costs" means any of the following costs applicable to a specific request for water quality protection service:
   a. Presiding officer services for public hearings on a permitting decision,
   b. Court reporter services for public hearings on a permitting decision,
   c. Facility rentals for public hearings on a permitting decision,
   d. Charges for laboratory analyses performed during the review, and
   e. Other reasonable and necessary review-related expenses documented in writing by the Department and agreed to by an applicant.
8. "Standard modification" means an amendment to an individual Aquifer Protection Permit that is not a complex modification.
9. "UIC" means Arizona's Underground Injection Control Program.
10. "Water quality protection service" means:
    a. Reviewing a request for an APP determination of applicability;
    b. Issuing, renewing, amending, modifying, transferring, or denying an aquifer protection permit, an AZPDES permit, a UIC permit, a UIC application for an aquifer exemption or an injection depth waiver or a reclaimed water permit;
    c. Reviewing supplemental information required by a permit condition, including closure for an APP;
    d. Performing an APP clean closure plan review;
    e. Issuing or denying a Certificate of Approval for Sanitary Facilities for a Subdivision;
    f. Registering or transferring registration of a dry well;
    g. Conducting a site visit;
    h. Reviewing proprietary and other reviewed products under A.A.C. R18-9-A309(E);
    i. Reviewing, processing, and managing documentation related to an AZPDES general permit, including a notice of intent, notice of termination, certificate of no exposure, and waiver;
    j. Registering and reporting land application of biosolids; or
    k. Pretreatment program review, inspection, or audit.

Historical Note

Adopted effective November 15, 1996 (Supp. 96-4). Amended by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1). Amended by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2). Amended by final rulemaking at 28 A.A.R. 1811 (July 29, 2022), effective September 6, 2022 (Supp. 22-3).

R18-14-102. Hourly Rate and Maximum Fees for Water Quality Protection Services

A. The Department shall assess and collect an hourly rate fee for a water quality protection service, except for APP minor permit amendments specified under A.A.C. R18-9-A211(C)(1), (2) and (3) and A.A.C. R18-9-B906(B), unless a flat fee is other-wise designated in this Article, and UIC minor modifications specified under A.A.C. R18-9-C633(A).

B. Hourly rate fees. The Department shall calculate the fee using an hourly rate of $122 except for the UIC program, where the Department shall calculate the fee using an hourly rate of $145. These rates shall then be multiplied by the number of review hours to provide a water quality protection service, plus any applicable review-related costs, up to the maximum fee specified in subsection (C). The Department shall not charge an applicant for the first 60 minutes of Department preapplication consultation time costs for the project manager.

C. Maximum fees for a water quality protection service assessed at an hourly rate in Table 1.

Historical Note

Adopted effective November 15, 1996 (Supp. 96-4). Amended by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1). Amended by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2). Amended by final rulemaking at 28 A.A.R. 1811 (July 29, 2022), effective September 6, 2022 (Supp. 22-3).

Table 1. Maximum Fees

Program Area	Permit Type	Maximum Fee
APP	Individual or area-wide	$200,000
APP	Complex modification to individual or area-wide	$150,000
APP	Clean closure of facility	$50,000
APP	Standard modification to individual or area-wide (per modification up to the maximum fee, and modification can be reassigned under A.A.C. R18-1-516): ▪ Maximum fee (cumulative per submittal) ▪ Modification under A.A.C. R18-9-A211(C)(1) through (3) ▪ Modification under A.A.C. R18-9-A211(C)(4) through (6) ▪ Modification under A.A.C. R18-9-A211(C)(7), (D)(2)(b) through (i), and (k) through (l) ▪ Modification under A.A.C. R18-9-A211(D)(2)(a) and (j) ▪ Modification under A.A.C. R18-9-A211(B) that is not classified as complex modification under R18-14-101(2)	 $150,000 No fee $5,000 $15,000 $25,000 $25,000
APP	For an APP issued before July 1, 2011, the fee for a submittal required by a compliance schedule is assessed per submittal and cumulative up to the maximum fee. The applicable maximum fee for all compliance schedule submissions shall be according to one of the three maximum fee categories listed below. The maximum fee is for the lifetime of the APP unless a new compliance schedule is established in the APP due to a modification that is classified as both a significant amendment under A.A.C. R18-9-A211(B) and a complex modification under R18-14-101(2) ▪ For a permit with a compliance schedule where one or more submissions require a permit modification that requires a determination or reevaluation of BADCT, the fee is assessed as described above for each standard modification, with a maximum fee for the permit's entire compliance schedule of: ▪ For a permit with a compliance schedule where one or more submissions require a permit modification, but no determination or reevaluation of BADCT is required, the fee is assessed as described above for each standard modification, with a maximum fee for the permit's entire compliance schedule of: ▪ For a permit with a compliance schedule requiring one or more submissions that require ADEQ review but do not require a permit modification, the maximum fee for the permit's entire compliance schedule is:	 $150,000 $100,000 $100,000
APP	For an APP issued on or after July 1, 2011, the fee for a submittal required by a compliance schedule is assessed per submittal and cumulative up to the maximum fee for the lifetime of the APP	$100,000
APP	Determination of applicability	$15,000
APP	Reviewing proprietary and other reviewed products under A.A.C. R18-9-A309(E)	$15,000
AZPDES	Individual permit for municipal separate storm sewer system	$40,000
AZPDES	Individual permit for wastewater treatment plant (based on gallons of discharge per day) ▪ 3,000 to 99,999 ▪ 100,000 to 999,999 ▪ 1,000,000 to 9,999,999 ▪ 10,000,000 or more	 $15,000 $20,000 $30,000 $50,000
AZPDES	Individual permit for a facility or activity that is not a wastewater treatment plant or a municipal separate storm sewer	$30,000
AZPDES	Amendment to an individual permit	$12,500
AZPDES	Approval of a new or revised pretreatment program under AZPDES	$10,000
AZPDES	Consolidated individual permit for multiple AZPDES individual permits, as allowed under A.A.C. R18-9-B901(C)	Aggregate of the applicable maximum fees
Reclaimed	Reclaimed water individual permit	$32,000
UIC	Area Area Modification / Renewal	$200,000 $150,000
UIC	Classes I, II, III, V Individual Classes I, II, III, V Modification / Renewal	$200,000 $150,000
UIC	Classes VI Individual Classes VI Modification	No Max No Max

Historical Note

Table 1 adopted by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1). Table 1 repealed; new Table 1 adopted by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2). Amended by final rulemaking at 28 A.A.R. 1811 (July 29, 2022), effective September 6, 2022 (Supp. 22-3).

R18-14-103. Initial Fees

A. A person shall submit the applicable fee at the time a request for a water quality protection service is submitted to the Department.

B. For each water quality protection service subject to an hourly rate fee established under R18-14-102:

1. An applicant shall submit a $2,000 initial fee at the time a request is submitted to the Department for review.
2. If requested by an applicant, the Department may set a lower initial fee when the Department estimates a review fee that is less than the applicable initial fee.

C. The Department shall not review a request for a water quality protection service if the applicant or permittee has not paid any fee due under this Article, unless the applicant or permittee has an outstanding water quality protection service bill that is under appeal pursuant to R18-14-106.

Historical Note

Adopted effective November 15, 1996 (Supp. 96-4). Amended by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1). Amended by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

R18-14-104. Annual Fees for Water Quality Protection Services Subject to Hourly Rate Fee

A. Annual Registration Fees. The annual registration fee required under A.R.S. § 49-242 is in Table 2.

B. The Department shall assess an annual fee for an AZPDES-related water quality protection service subject to an hourly rate fee as listed in Table 3.

C. The Department shall assess an annual fee of $500 for an individual reclaimed water permit.

D. The Department shall assess an annual fee and an annual waste disposal fee as applicable to UIC regulated facilities, subject to an hourly rate fee, as listed in Tables 3.1 and 3.2.

Historical Note

Adopted effective November 15, 1996 (Supp. 96-4). Amended by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1). Amended by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2). Tables 2 and 3 removed from this Section to conform with the A.A.C. codification scheme; amended by final rulemaking at 28 A.A.R. 1811 (July 29, 2022), effective September 6, 2022 (Supp. 22-3).

Table 2. APP Annual Registration Fees

Discharge or Influent per Day under the Individual APP or Notice of Disposal (in Gallons)	Annual Registration Fee	Annual Registration Fee if New Facility Under New APP Not Yet Constructed
3,000 to 9,999	$500	$250
10,000 to 99,999	$1,000	$250
100,000 to 999,999	$2,500	$500
1,000,000 to 9,999,999	$6,000	$625
10,000,000 or more	$8,500	$750

Historical Note

Table 2 made by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

Table 3. AZPDES Annual Fees

Permit Type	Annual Fee	Annual Fee if New Facility Under New AZPDES Not Yet Constructed
Municipal separate storm sewer system	$10,000	N/A
Wastewater treatment plant (based on gallons of discharge per day):		
▪ Less than 99,999	$250	$250
▪ 100,000 to 999,999	$500	$500
▪ 1,000,000 to 9,999,999	$2,500	$625
▪ 10,000,000 or more	$4,000	$750
Facility or activity that is not a wastewater treatment plant or municipal separate storm sewer and designated in the permit as either:		
Major	$2,500	$625
Minor	$500	$500
Pretreatment program	$3,000	N/A
Consolidated individual permit for multiple AZPDES individual permits, as allowed under A.A.C. R18-9-B901(C)	Aggregate of the applicable annual fees of each individual permit	Aggregate of the applicable annual fees of each individual permit

Historical Note

Table 3 made by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

Table 3.1. UIC Annual Fees

Permit Type	Annual Registration Fee	Annual Waste Disposal Fee
Area	$10,000 (and not subject to any other annual registration fee in Tables 3.1 and 3.2)	N/A
Class I	No Annual Registration Fee	$0.002/gallon. Minimum Fee: $10,000/year Maximum Fee: $25,000/year

Class II	See Table 3.2	N/A
Class III	See Table 3.2	N/A
Class V "Individual"	See Table 3.2	N/A
Class VI	No Annual Registration Fee	$0.08/ton Minimum Fee: $10,000/year

Historical Note

Table 3.1 made by final rulemaking at 28 A.A.R. 1811 (July 29, 2022), effective September 6, 2022 (Supp. 22-3).

Table 3.2. UIC Annual Registration Fees

Design Injection Flow Rate in Gallons per day[1, 2]	Annual Registration Fee
3,000 to 9,999	$600
10,000 to 99,999	$1,200
100,000 to 999,999	$3,000
1,000,000 to 9,999,999	$7,000
10,000,000 or more	$10,000

[1] A Class II, III or V Individual UIC permittee with multiple wells or multiple permits may consolidate their same-class wells for the purpose of "design injection flow rate in gallons per day" under Table 3.2.
[2] An Area permit is not subject to Table 3.2.

Historical Note

Table 3.2 made by final rulemaking at 28 A.A.R. 1811 (July 29, 2022), effective September 6, 2022 (Supp. 22-3).

Schedule A. Repealed

Historical Note

Schedule A adopted effective November 15, 1996 (Supp. 96-4). Schedule repealed by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1).

Schedule B. Repealed

Historical Note

Schedule B adopted effective November 15, 1996 (Supp. 96-4). Schedule repealed by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1).

Schedule C. Repealed

Historical Note

Schedule C adopted effective November 15, 1996 (Supp. 96-4). Schedule repealed by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1).

Schedule D. Repealed

Historical Note

Schedule D adopted effective November 15, 1996 (Supp. 96-4). Schedule repealed by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1).

R18-14-105. Fee Assessment and Collection

A. Billing. The Department shall bill an applicant for water quality protection services subject to an hourly rate no more than monthly, but at least quarterly. The following information shall be included in each bill:
1. The dates of the billing period;
2. The date and number of review hours itemized by employee name, position type and specifically describing:
   a. Each water quality protection service performed,
   b. Each facility involved and program component, and
   c. The hourly rate for each water quality protection service performed;
3. A description and amount of each review-related cost incurred for the project;
4. The total fees paid to date, the total fees due for the billing period, the date when the fees are due, which shall be at least 35 days after the date on the bill, and the maximum fee for the project.

B. Final bill. After the Department makes a final determination whether to grant or deny a request for water quality protection services subject to an hourly rate fee, or when an applicant withdraws or closes the request, the Department shall prepare a final itemized bill of its review.
1. If the total fee exceeds the amount of the initial fee plus all invoicing, the Department shall issue a final itemized bill for the cost of the water quality protection services up to the applicable maximum fee established under R18-14-102.
2. If the total fee is less than the initial fee and all paid invoicing charges, the Department shall refund the difference to the applicant.
3. Fees for water quality protection services shall be paid in U.S. dollars by cash, check, cashier's check, money order, or any other method acceptable to the Department.
4. The Department shall not release the final permit or approval until the final itemized bill is paid in full.

Historical Note

Adopted effective November 15, 1996 (Supp. 96-4). Amended by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1). Amended by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

R18-14-106. Reconsideration of a Bill; Appeal Process

A. A person may seek review of a bill by filing a written request for reconsideration with the Director.
1. The request shall specify, in detail, why the bill is in dispute and shall include any supporting documentation.
2. The written request for reconsideration shall be delivered to the Director in person, by mail, or by facsimile on or before the payment due date or within 35 days of the invoice print date, whichever is greater.

B. The Director shall make a final decision on the request for reconsideration of the bill and mail a final written decision to the person within 20 working days after the date the Director receives the written request.

Historical Note
Adopted effective November 15, 1996 (Supp. 96-4).
Amended by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1).

R18-14-107. Effect on County Fees
Nothing in this Chapter affects the authority of county or other local governments to charge fees for implementing delegated Department water quality protection programs in accordance with statutory authority.

Historical Note
Adopted effective November 15, 1996 (Supp. 96-4).
Amended by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1).

R18-14-108. APP Water Quality Protection Services Flat Fees
A. The Department shall assess a flat fee for an APP water quality protection service listed in this Section.
B. Type 1 General Permits. No fee is required, except as stated in A.A.C. R18-9-A304(A)(2).
C. Fees for Type 2 and Type 3 General Permits and related water quality protection services are listed in Table 4. For purposes of this Section, "complex" is defined in A.A.C. R18-1-501(9). "Standard" means any permit that does not meet the definition of complex.

Table 4. Type 2 and 3 General Permit Fees

Permit Description	Permit Fee	Renewal Fee
Standard Type 2	$1,500	$500
Complex Type 2	$3,000	$1,000
Standard Type 3	$4,500	$1,500
Complex Type 3	$7,500	$2,500
Amendment to Notice of Intent	Same as applicable renewal fee	N/A
Transfer of permit authorization	$50	N/A
If a site contains more than one facility covered by the same Type 2 or Type 3 General Permit and each facility is substantially similar in design, construction, and operation, the first facility is paid at the full applicable fee, and each additional facility is:	Half the applicable fee	Half the applicable fee

D. Fees for Type 4 General Permits and related water quality protection services are listed in Table 5.

Table 5. Type 4 General Permit Fees

Water Quality Protection Service	Description	Permit Fee
4.01 General Permit: Sewage Collection Systems	Under each Notice of Intent to Discharge, the fee is assessed on a per-component basis for the components listed below and is assessed cumulatively up to the maximum fee:	
	▪ Maximum fee	$25,000
	▪ Force mains with design flow less than or equal to 10,000 gpd	$1,000
	▪ Each additional increment of 50,000 gpd or less of force mains	$1,000
	▪ Gravity sewer with design flow less than or equal to 10,000 gpd	$1,000
	▪ Each additional increment of 50,000 gpd or less of gravity sewer	$1,000
	▪ Each sewer lift station	$1,000
	▪ Each depressed sewer	$1,000
	▪ Realignment of existing sewer for a contiguous project that is less than 300 linear feet with no change in design flow or pipe size	$500
4.01 General Permit courtesy review	If an applicant requests courtesy review, the Department shall approve or deny the request. When determining whether to approve a courtesy review request, the Department shall consider the complexity of the project and the Department's current work load	One-third applicable fee upon submittal, then balance of fee if Notice of Intent to Discharge is submitted with final documentation within 180 days of first submittal
4.23 General Permit: 3,000 to less than 24,000 Gallons per day Design Flow	▪ Onsite wastewater treatment facility with up to: • Three treatment technologies and disposal methods consisting of technologies or designs that are covered under other Type 4 general permits; and • Two onsite wastewater treatment facilities	$3,600
	▪ Maximum fee (cumulative)	$7,500
	▪ Each additional onsite wastewater treatment facility on same Notice of Intent to Discharge up to maximum fee	$1,200
	▪ Each additional treatment technology or disposal method consisting of technologies or designs that are covered under other Type 4 general permits on same Notice of Intent to Discharge up to maximum fee	$500
4.23 General Permit annual report	Annual report required under A.A.C. R18-9-E323(G)	$200

Water Quality Protection Service	**Description**	**Permit Fee**
Type 4 General Permits (4.02 through 4.22)	▪ Maximum fee	$3,700
	▪ First Type 4 general permit	$1,200
	▪ Each additional Type 4 general permit on same Notice of Intent to Discharge	$500
Alternative Design under A.A.C. R18-9-A312(G)	A request for an alternative design, installation, or operational feature, per alternative design:	
	▪ Type 4.01 general permit	$750
	▪ All other Type 4 general permits	$250
Interceptor under A.A.C. R18-9-A315	A design requiring an interceptor (per interceptor)	$100
Transfer	Transfer of discharge authorization	$50
Priority Review	If an applicant requests priority review, the Department shall approve or deny the request. When determining whether to approve a priority review request, the Department shall consider the complexity of the project and the Department's current work load.	Double the Applicable Fee (including any applicable maximum fee)

Historical Note

Adopted effective November 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1). New Section made by exempt rulemaking at 16 A.A.R. 851, effective July 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1505, effective July 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

R18-14-109. AZPDES Water Quality Protection Services Flat Fees

A. The Department shall assess a flat fee for an AZPDES water quality protection service, as described in Table 6.

B. In addition to the requirements in A.A.C. R18-9-A907(B), a draft permit will state the category and fee assigned to the permit and the factors for establishing the fee, according to Table 6. Any person may comment on the fee category assignment as part of the public comment period described in A.A.C. R18-9-A908.

C. Annual Fee. The Department shall bill an annual fee to permittees who have not filed a notice of termination for an applicable general permit.

Table 6. AZPDES Water Quality Protection Services Flat Fees

Category	**Factors for Establishing Fees**	**Initial Fee**	**Annual Fee**
Municipal Separate Storm Sewer System General Permit	The fee is based on the population of the permitted area:		
	▪ Less than or equal to 10,000	$2,500	$2,500
	▪ Greater than 10,000 but less than or equal to 100,000	$5,000	$5,000
	▪ Greater than 100,000	$7,500	$7,500
	The fee for a non-traditional municipal separate storm sewer system, such as a hospital, college or military facility	$5,000	$5,000
Construction General Permit	The fee is based on the amount of acreage identified in the Notice of Intent:		
	▪ Less than or equal to 1 acre	$250	$250
	▪ Greater than 1 acre but less than or equal to 50 acres	$350	$350
	▪ Greater than 50 acres	$500	$500
	Pollution prevention plan review	$1,000	N/A
	▪ Each additional submittal due to deficiency	$500	N/A
	Waiver	$750	N/A
	If more than one person must apply for general permit coverage of the same facility or discharge activity, each person pays:	Fee applicable to the amount of acreage each person controls	Fee applicable to the amount of acreage each person controls
Multi-Sector General Permit	The fee is based on the amount of acreage identified in the Notice of Intent:		
	▪ Less than or equal to 1 acre	$350	$350
	▪ Greater than 1 acre but less than or equal to 40 acres	$500	$500
	▪ Greater than 40 acres	$1,000	$1,000
	Pollution prevention plan review	$1,000	N/A
	▪ Each additional submittal due to deficiency	$500	N/A
	Certificate of No Exposure	$1,250	N/A
	If more than one person must apply for general permit coverage of the same facility or discharge activity, each person pays:	Fee applicable to the amount of acreage each person controls	Fee applicable to the amount of acreage each person controls

Category	Factors for Establishing Fees		Initial Fee	Annual Fee
General Permits for Non-Stormwater Discharges	The fee is based on the Department's total anticipated staff hours (including permit development, customer service, review of the notice of intent, and annual data review and inspections) divided by the total number of potential permittees over a five-year period:			
	▪ Level 1A		$250	$250
	• Staff hours:	1,500		
	• Number of potential permittees:	750		
	▪ Level 1B		$500	$500
	• Staff hours:	1,500		
	• Number of potential permittees:	375		
	▪ Level 2		$1,250	$1,250
	• Staff hours:	1,000		
	• Number of potential permittees:	100		
	▪ Level 3		$1,500	$1,500
	• Staff hours:	1,300		
	• Number of potential permittees:	100		
	▪ Level 4A		$2,000	$2,000
	• Staff hours:	1,600		
	• Number of potential permittees:	100		
	▪ Level 4B		$2,500	$2,500
	• Staff hours:	1,900		
	• Number of potential permittees:	100		
	Pollution prevention plan review		$1,000	N/A
	▪ Each additional submittal due to deficiency		$500	N/A
Emergency Discharge General Permit	Authorization for emergency discharge		$10,000	N/A
Transfer	Authorization for permit transfer as allowed under A.A.C. R18-9-B905		$50	N/A
Biosolids Land Applicators	Initial registration		$500	N/A
	Registration amendment		$250	N/A
	Annual report based on amount of dry metric tons applied			
	▪ Less than or equal to 7,500 dry metric tons		N/A	$2,500
	▪ Greater than 7,500 dry metric tons but less than or equal to 15,000 dry metric tons		N/A	$3,000
	▪ Greater than 15,000 dry metric tons		N/A	$4,500

Historical Note
New Section made by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

R18-14-110. Reclaimed Water Flat Fees
The Department shall assess a flat fee for a reclaimed water quality protection service as listed in Table 7. For purposes of this Section, "complex" is defined in A.A.C. R18-1-501(9). "Standard" means any permit that does not meet the definition of complex.

Historical Note
New Section made by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

Table 7. Reclaimed Water General Permit Fees

Permit Description	Permit Fee	Renewal Fee
Standard Type 2	$600	$450
Complex Type 2	$750	$575
Standard Type 3	$1,500	$1,250
Complex Type 3	$2,000	$1,500
Amendment to Notice of Intent	Same as applicable renewal fee	N/A
Transfer of permit authorization	$50	N/A

Historical Note
New Table 7 made by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

R18-14-111. UIC Flat Fees
The Department shall assess a flat fee for the following UIC regulated facility services:
1. Well installation in an Area Permit, $200 per well installation.
2. Class V authorization by rule, $200 per well inventory.
3. Class V authorization by rule, $100 per well transfer.

Historical Note
New Section made by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2). Section R18-14-111 renumbered to R18-14-112; new R18-14-111 made by final rulemaking at 28 A.A.R. 1811 (July 29, 2022), effective September 6, 2022 (Supp. 22-3).

R18-14-112. Other Flat Fees
Flat fees. The Department shall assess a flat fee for the following water quality protection services:
1. Dry well registration, $100 per dry well until:
   a. The fees in R18-14-111 are applicable, and
   b. A.R.S Title 49, Chapter 2, Article 8 is removed.
2. Dry well transfer of registration, $50 per transfer until:
   a. The fees in R18-14-111 are applicable, and
   b. A.R.S Title 49, Chapter 2, Article 8 is removed.

3. Certificate of Approval for Sanitary Facilities for Subdivisions.
   a. Subdivision with public sewerage system: $800 for every increment of 150 lots or less;
   b. Subdivision with individual sewerage system:
      i. $500 for less than 10 lots;
      ii. $1,000 for greater than 10 lots but less than 50 lots;
      iii. $1,000 for each additional increment of 50 lots or less.
   c. If water from a central system is not provided to the lot, the fee is one and one-half the applicable fee stated in subsection (3)(a) or (b).

d. Condominium subdivision: $1,000 for every increment of 150 units or less.

Historical Note

New Section made by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2). Section R18-14-112 renumbered to R18-14-113; new R18-14-112 renumbered from R18-14-111 and amended by final rulemaking at 28 A.A.R. 1811 (July 29, 2022), effective September 6, 2022 (Supp. 22-3).

R18-14-113. Implementation

The fees in this Article apply on July 1, 2011. For fees related to the AZPDES program:

1. A person shall submit the applicable fee when requesting a water quality protection service as specified in an AZPDES General Permit or in 18 A.A.C. 9, Article 9; and
2. A person is responsible for paying the annual fee for an AZPDES general permit, even if the person filed for coverage before the effective date of these rules.

Historical Note

New Section made by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2). Section R18-14-113 renumbered to R18-14-114; new R18-14-113 renumbered from R18-14-112 by final rulemaking at 28 A.A.R. 1811 (July 29, 2022), effective September 6, 2022 (Supp. 22-3).

R18-14-114. Annual Report

By December 1 of each year, the Department shall publish an accounting of Water Quality Fee Fund revenue and expenditure activity for the prior fiscal year.

Historical Note

New Section R18-14-114 renumbered from R18-14-113 by final rulemaking at 28 A.A.R. 1811 (July 29, 2022), effective September 6, 2022 (Supp. 22-3).

R18-14-115. UIC Fees Review

The Department shall review the revenues derived from the implementation of the UIC program from the date of primacy through June 30, 2025. By September 30, 2025, the Department shall determine the adequacy of the fees in comparison to the relevant data from the time period. The Department shall repeat the review every three years based on the initial review date of June 30, 2025.

Historical Note

New Section R18-14-115 made by final rulemaking at 28 A.A.R. 1811 (July 29, 2022), effective September 6, 2022 (Supp. 22-3).

ARTICLE 2. PUBLIC WATER SYSTEM - DESIGN REVIEW FEES

R18-14-201. Definitions

In addition to the definitions in A.A.C. R18-1-501, and 18 A.A.C. 4, the following terms apply to this Article:

"Design review" means the process for reviewing an application for an Approval to Construct as prescribed in A.A.C. R18-5-505(B).

"Design review service" means all activities related to processing an application for an Approval to Construct, including reviewing, approving, or denying an application, conducting a pre-application meeting or site visit, or other activity required to review an Approval to Construct application.

"Distribution system" has the same meaning prescribed in A.A.C. R18-5-101.

"Priority Review" means a design review service where a license application is reviewed using not more than 50% of the total review time-frame for an Approval to Construct license application.

"Public water system" has the same meaning prescribed in A.R.S. § 49-352(B).

"Licensing time-frame" means a period of time described and defined in A.R.S. Title 41, Chapter 6, Article 7.1, and 18 A.A.C. 1, Article 5.

"Water treatment plant" has the same meaning prescribed in A.A.C. R18-5-101.

Historical Note

Section made by final rulemaking at 14 A.A.R. 4102, effective December 6, 2008 (Supp. 08-4).

R18-14-202. Flat Rate Fees

A. The Department shall assess and collect a flat rate fee for design review services for public water systems.

B. Design criteria for public water systems are specified in 18 A.A.C. 4 and 18 A.A.C. 5.

C. An applicant shall submit public water system design review fees with an application for an Approval to Construct, as specified in 18 A.A.C. 5, Article 5.

D. The flat rate fees for a design review service:
   1. Are established in Table 1, are assessed on a per-unit basis where applicable, and are cumulative unless otherwise specified in this Article;
   2. Shall be paid by cash, check, cashier's check, money order, or any other method acceptable to the Department; and
   3. Shall be paid in full before the Department issues approval of an application.

E. The Department shall refund 50 percent of the application fee paid by an applicant if, during the administrative completeness review time-frame period, the applicant:
   1. Fails to respond in a reasonably timely manner, as set forth in A.A.C. R18-1-507, to a notice of administrative deficiencies requesting additional information under A.A.C. R18-1-503, and the Department denies the application; or
   2. Withdraws the application.

F. If an application is denied under A.A.C. R18-1-507 after the end of the administrative completeness review time-frame, the Department shall retain the flat fee paid by the applicant.

G. If an applicant requests priority review, the Department shall approve or deny the request. When determining whether to approve a priority review request, the Department shall consider the complexity of the project and the Department's current work load. If priority review is approved by the Department, the applicant shall pay the priority review fee specified in Table 1.

H. State agencies are exempt from all fees imposed under this Article pursuant to A.R.S. § 49-353(A)(2)(b).

Historical Note
Section made by final rulemaking at 14 A.A.R. 4102, effective December 6, 2008 (Supp. 08-4).

Table 1. Design Review Service Fees

Public Water System Design Review Application Types	Fees[1, 2]
Approval to Construct Public Water Supply Distribution System:	
• 150 or fewer service connections	$900
• 151 to 300 service connections	$1,400
• 301 to 450 service connections	$1,900
• 451 to 600 service connections	$2,400
• 601 to 750 service connections	$2,900
• Each additional 150 service connections	Add $500
Water Treatment Plants and Blending Plans (including new source approval if applicable):	
• < 0.1 mgd	$1,500
• ≥ 0.1 mgd and < 1 mgd	$2,000
• ≥ 1 mgd and < 5 mgd	$3,000
• ≥ 5 mgd	$5,000
Well (including new source approval if applicable)	$1,250
Storage Tank	$800
Booster Pump	$800
Main Line Extension	$250
Chlorinators/Disinfection Devices	$250
Extension of Time to Construct[3]	50% of the application fee, not to exceed $500
Priority Review Fee[4]	Double the Standard Fee

[1] Fees are calculated on a per-unit basis; i.e., a separate fee is assessed for each separate storage tank, booster pump, disinfection device, or main line extension.
[2] Fees for each application type are cumulative; an applicant must pay the total of all pertinent fees.
[3] Extensions of time to construct are issued pursuant to A.A.C. R18-5-505(E); the Section states that an Approval to Construct becomes void if construction is not commenced or completed within a specified time period, unless the Department grants an extension of time.
[4] Priority Review Projects require Department authorization prior to filing.

Historical Note
Table 1, Design Review Service Fees, made by final rulemaking at 14 A.A.R. 4102, effective December 6, 2008 (Supp. 08-4).

ARTICLE 3. CERTIFIED OPERATOR FEES

R18-14-301. Certified Operator Fees

A. Definition terms from A.A.C. R18-5-101 apply to this Article.

B. The Department shall assess and collect a flat rate fee for a certification or renewal under the operator certification program.

C. A person shall submit the applicable fee when requesting a certification or renewal under 18 A.A.C. 5, Article 1, as described below:

1. An applicant that seeks new certification shall submit a $65 fee per certification.
2. An operator that has not held a lower grade level for the required amount of time requests the Department's determination on experience and education in order to be admitted to a higher grade certification examination shall submit a fee of $150 per application.
3. An applicant that requests a certificate based on reciprocity with another jurisdiction shall submit a fee of $250 per application.
4. An operator submitting a certificate renewal shall submit a $150 fee for each certificate. If the operator has multiple certificates, the first certificate is $150, and each additional certificate with the same expiration date is $50.

Historical Note
New Section made by final rulemaking at 21 A.A.R. 2597, effective July 1, 2016 (Supp. 15-4).

R18-14-302. Fee Assessment and Collection

A. Fees for certification or renewal shall be paid in U.S. dollars by cash, check, cashier's check, money order, or any other method acceptable to the Department.

B. The Department shall not accept a request for a certification or renewal without the appropriate fee.

C. If the Department does not accept an operator certificate renewal form, required according to A.A.C. R18-5-107(B), the certificate expires for failure to renew according to A.A.C. R18-5-108.

Historical Note
New Section made by final rulemaking at 21 A.A.R. 2597, effective July 1, 2016 (Supp. 15-4).

R18-14-303. Implementation

The fees in this Article apply to any application for a certification or renewal that is submitted on or after July 1, 2016.

Historical Note

New Section made by final rulemaking at 21 A.A.R. 2597, effective July 1, 2016 (Supp. 15-4).

49-104. Powers and duties of the department and director

A. The department shall:

1. Formulate policies, plans and programs to implement this title to protect the environment.

2. Stimulate and encourage all local, state, regional and federal governmental agencies and all private persons and enterprises that have similar and related objectives and purposes, cooperate with those agencies, persons and enterprises and correlate department plans, programs and operations with those of the agencies, persons and enterprises.

3. Conduct research on its own initiative or at the request of the governor, the legislature or state or local agencies pertaining to any department objectives.

4. Provide information and advice on request of any local, state or federal agencies and private persons and business enterprises on matters within the scope of the department.

5. Consult with and make recommendations to the governor and the legislature on all matters concerning department objectives.

6. Promote and coordinate the management of air resources to ensure their protection, enhancement and balanced utilization consistent with the environmental policy of this state.

7. Promote and coordinate the protection and enhancement of the quality of water resources consistent with the environmental policy of this state.

8. Encourage industrial, commercial, residential and community development that maximizes environmental benefits and minimizes the effects of less desirable environmental conditions.

9. Ensure the preservation and enhancement of natural beauty and man-made scenic qualities.

10. Provide for the prevention and abatement of all water and air pollution including that related to particulates, gases, dust, vapors, noise, radiation, odor, nutrients and heated liquids in accordance with article 3 of this chapter and chapters 2 and 3 of this title.

11. Promote and recommend methods for the recovery, recycling and reuse or, if recycling is not possible, the disposal of solid wastes consistent with sound health, scenic and environmental quality policies. The department shall report annually on its revenues and expenditures relating to the solid and hazardous waste programs overseen or administered by the department.

12. Prevent pollution through the regulation of the storage, handling and transportation of solids, liquids and gases that may cause or contribute to pollution.

13. Promote the restoration and reclamation of degraded or despoiled areas and natural resources.

14. Participate in the state civil defense program and develop the necessary organization and facilities to meet wartime or other disasters.

15. 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.

16. Unless specifically authorized by the legislature, ensure that state laws, rules, standards, permits, variances and orders are adopted and construed to be consistent with and no more stringent than the corresponding federal law that addresses the same subject matter. This paragraph does not adversely affect standards adopted by an Indian tribe under federal law.

17. Provide administrative and staff support for the oil and gas conservation commission.

B. The department, through the director, shall:

1. Contract for the services of outside advisers, consultants and aides reasonably necessary or desirable to enable the department to adequately perform its duties.

2. Contract and incur obligations reasonably necessary or desirable within the general scope of department activities and operations to enable the department to adequately perform its duties.

3. Utilize any medium of communication, publication and exhibition when disseminating information, advertising and publicity in any field of its purposes, objectives or duties.

4. Adopt procedural rules that are necessary to implement the authority granted under this title, but that are not inconsistent with other provisions of this title.

5. Contract with other agencies, including laboratories, in furthering any department program.

6. Use monies, facilities or services to provide matching contributions under federal or other programs that further the objectives and programs of the department.

7. Accept gifts, grants, matching monies or direct payments from public or private agencies or private persons and enterprises for department services and publications and to conduct programs that are consistent with the general purposes and objectives of this chapter. Monies received pursuant to this paragraph shall be deposited in the department fund corresponding to the service, publication or program provided.

8. Provide for the examination of any premises if the director has reasonable cause to believe that a violation of any environmental law or rule exists or is being committed on the premises. The director shall give the owner or operator the opportunity for its representative to accompany the director on an examination of those premises. Within forty-five days after the date of the examination, the department shall provide to the owner or operator a copy of any report produced as a result of any examination of the premises.

9. Supervise sanitary engineering facilities and projects in this state, authority for which is vested in the department, and own or lease land on which sanitary engineering facilities are located, and operate the facilities, if the director determines that owning, leasing or operating is necessary for the public health, safety or welfare.

10. Adopt and enforce rules relating to approving design documents for constructing, improving and operating sanitary engineering and other facilities for disposing of solid, liquid or gaseous deleterious matter.

11. Define and prescribe reasonably necessary rules regarding the water supply, sewage disposal and garbage collection and disposal for subdivisions. The rules shall:

(a) Provide for minimum sanitary facilities to be installed in the subdivision and may require that water systems plan for future needs and be of adequate size and capacity to deliver specified minimum quantities of drinking water and to treat all sewage.

(b) Provide that the design documents showing or describing the water supply, sewage disposal and garbage collection facilities be submitted with a fee to the department for review and that no lots in any subdivision be offered for sale before compliance with the standards and rules has been demonstrated by approval of the design documents by the department.

12. Prescribe reasonably necessary measures to prevent pollution of water used in public or semipublic swimming pools and bathing places and to prevent deleterious conditions at those places. The rules shall prescribe minimum standards for the design of and for sanitary conditions at any public or semipublic swimming pool or bathing place and provide for abatement as public nuisances of 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 health services and shall be consistent with the rules adopted by the director of the department of health services pursuant to section 36-136, subsection I, paragraph 10.

13. Prescribe reasonable rules regarding sewage collection, treatment, disposal and reclamation systems to prevent the transmission of sewage borne or insect borne diseases. The rules shall:

(a) Prescribe minimum standards for the design of sewage collection systems and treatment, disposal and reclamation systems and for operating the systems.

(b) Provide for inspecting the premises, systems and installations and for abating as a public nuisance any collection system, process, treatment plant, disposal system or reclamation system that does not comply with the minimum standards.

(c) Require that design documents for all sewage collection systems, sewage collection system extensions, treatment plants, processes, devices, equipment, disposal systems, on-site wastewater treatment facilities and reclamation systems be submitted with a fee for review to the department and may require that the design documents anticipate and provide for future sewage treatment needs.

(d) Require that construction, reconstruction, installation or initiation of any sewage collection system, sewage collection system extension, treatment plant, process, device, equipment, disposal system, on-site wastewater treatment facility or reclamation system conform with applicable requirements.

14. Prescribe reasonably necessary rules regarding excreta storage, handling, treatment, transportation and disposal. The rules may:

(a) Prescribe minimum standards for human excreta storage, handling, treatment, transportation and disposal and shall provide for inspection of premises, processes and vehicles and for abating as public nuisances any premises, processes or vehicles that do not comply with the minimum standards.

(b) Provide that vehicles transporting human excreta from privies, septic tanks, cesspools and other treatment processes shall be licensed by the department subject to compliance with the rules. The department may require payment of a fee as a condition of licensure. The department may establish by rule a fee as a condition of licensure, including a maximum fee. As part of the rulemaking process, there must be public notice and comment and a review of the rule by the joint legislative budget committee. The department shall not increase that fee by rule without specific statutory authority for the increase. The fees shall be deposited, pursuant to sections 35-146 and 35-147, in the solid waste fee fund established by section 49-881.

15. Perform the responsibilities of implementing and maintaining a data automation management system to support the reporting requirements of title III of the superfund amendments and reauthorization act of 1986 (P.L. 99-499) and article 2 of this chapter.

16. Approve remediation levels pursuant to article 4 of this chapter.

17. Establish or revise fees by rule pursuant to the authority granted under title 44, chapter 9, article 8 and chapters 4 and 5 of this title for the department to adequately perform its duties. All fees shall be fairly assessed and impose the least burden and cost to the parties subject to the fees. In establishing or revising fees, the department shall base the fees on:

(a) The direct and indirect costs of the department's relevant duties, including employee salaries and benefits, professional and outside services, equipment, in-state travel and other necessary operational expenses directly

related to issuing licenses as defined in title 41, chapter 6 and enforcing the requirements of the applicable regulatory program.

(b) The availability of other funds for the duties performed.

(c) The impact of the fees on the parties subject to the fees.

(d) The fees charged for similar duties performed by the department, other agencies and the private sector.

18. Appoint a person with a background in oil and gas conservation to act on behalf of the oil and gas conservation commission and administer and enforce the applicable provisions of title 27, chapter 4 relating to the oil and gas conservation commission.

C. The department may:

1. Charge fees to cover the costs of all permits and inspections it performs to ensure compliance with rules adopted under section 49-203, except that state agencies are exempt from paying those fees that are not associated with the dredge and fill permit program established pursuant to chapter 2, article 3.2 of this title. For services provided under the dredge and fill permit program, a state agency shall pay either:

(a) The fees established by the department under the dredge and fill permit program.

(b) The reasonable cost of services provided by the department pursuant to an interagency service agreement.

2. Monies collected pursuant to this subsection shall be deposited, pursuant to sections 35-146 and 35-147, in the water quality fee fund established by section 49-210.

3. Contract with private consultants for the purposes of assisting the department in reviewing applications for licenses, permits or other authorizations to determine whether an applicant meets the criteria for issuance of the license, permit or other authorization. If the department contracts with a consultant under this paragraph, an applicant may request that the department expedite the application review by requesting that the department use the services of the consultant and by agreeing to pay the department the costs of the consultant's services. Notwithstanding any other law, monies paid by applicants for expedited reviews pursuant to this paragraph are appropriated to the department for use in paying consultants for services.

D. The director may:

1. If the director has reasonable cause to believe that a violation of any environmental law or rule exists or is being committed, inspect any person or property in transit through this state and any vehicle in which the person or property is being transported and detain or disinfect the person, property or vehicle as reasonably necessary to protect the environment if a violation exists.

2. Authorize in writing any qualified officer or employee in the department to perform any act that the director is authorized or required to do by law.

49-210. Water quality fee fund; appropriation; exemption; monies held in trust

A. The water quality fee fund is established consisting of monies appropriated by the legislature and fees received pursuant to sections 49-104, 49-203, 49-211, 49-241, 49-241.02, 49-242, 49-255.01, 49-352, 49-353 and 49-361. The director shall administer the fund.

B. Monies in the fund are subject to annual legislative appropriation to the department for water quality programs. Monies in the fund are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

C. On notice from the director, the state treasurer shall invest and divest monies in the fund as provided by section 35-313, and monies earned from investment shall be credited to the fund.

D. Monies in the water quality fee fund shall be used for activities required to implement this chapter, except for articles 1.1 and 5 of this chapter, and to implement section 49-104, subsection B, paragraphs 9 through 13 and subsection C.

E. Any fee, assessment or other levy that is authorized by law or administrative rule and that is collected and deposited in the water quality fee fund shall be held in trust. The monies in the fund may be used only for the purposes prescribed by statute and shall not be appropriated or transferred by the legislature to fund the general operations of this state or to otherwise meet the obligations of the general fund of this state. This subsection does not apply to any taxes or other levies that are imposed pursuant to title 42 or 43.

49-241. Permit required to discharge

A. Unless otherwise provided by this article, any person who discharges or who owns or operates a facility that discharges shall obtain an aquifer protection permit from the director.

B. Unless exempted under section 49-250, or unless the director determines that the facility will be designed, constructed and operated so that there will be no migration of pollutants directly to the aquifer or to the vadose zone, the following are considered to be discharging facilities and shall be operated pursuant to either an individual permit or a general permit, including agricultural general permits, under this article:

1. Surface impoundments, including holding, storage settling, treatment or disposal pits, ponds and lagoons.

2. Solid waste disposal facilities except for mining overburden and wall rock that has not been and will not be subject to mine leaching operations.

3. Injection wells.

4. Land treatment facilities.

5. Facilities that add a pollutant to a salt dome formation, salt bed formation, dry well or underground cave or mine.

6. Mine tailings piles and ponds.

7. Mine leaching operations.

8. Underground water storage facilities.

9. Sewage treatment facilities, including on-site wastewater treatment facilities.

10. Wetlands designed and constructed to treat municipal and domestic wastewater for underground storage.

C. The director shall provide public notice and an opportunity for public comment on any request for a determination from the director under subsection B of this section that there will be no migration of pollutants from a facility. A public hearing may be held at the discretion of the director if sufficient public comment warrants a hearing. The director may inspect and may require reasonable conditions and appropriate monitoring and reporting requirements for a facility managing pollutants that are determined not to migrate under subsection B of this section. The director may identify types of facilities, available technologies and technical criteria for facilities that will qualify for a determination. The director's determination may be revoked on evidence that pollutants have migrated from the facility. The director may impose a review fee for a determination under subsection B of this section. Any issuance, denial or revocation of a determination may be appealed pursuant to section 49-323.

D. The director shall annually make the fee schedule for aquifer protection permit applications available to the public on request and on the department's website, and a list of the names and locations of the facilities that have filed applications for aquifer protection permits, with a description of the status of each application, is available to the public on request.

E. The director shall prescribe the procedures for aquifer protection permit applications and fee collection under this section. The director shall deposit, pursuant to sections 35-146 and 35-147, all monies collected under this section in the water quality fee fund established by section 49-210 and may authorize expenditures from the fund, subject to legislative appropriation, to pay reasonable and necessary costs of processing and issuing permits and administering the registration program.

49-242. Procedural requirements for individual permits; annual registration of permittees; fee

A. The director shall prescribe by rule requirements for issuing, denying, suspending or modifying individual permits, including requirements for submitting notices, permit applications and any additional information necessary to determine whether an individual permit should be issued, and shall prescribe conditions and requirements for individual permits.

B. Each owner of an injection well, a land treatment facility, a dry well, an on-site wastewater treatment facility with a capacity of more than three thousand gallons per day, a recharge facility or a facility that discharges to protected surface waters to whom an individual or area-wide permit is issued shall register the permit with the director each year and pay an annual registration fee for each permit based on the total daily discharge of pollutants pursuant to subsection E of this section.

C. Each owner of a surface impoundment, a facility that adds a pollutant to a salt dome formation, salt bed formation, underground cave or mine, a mine tailings pile or pond, a mine leaching operation, a sewage or sludge pond or a wastewater treatment facility to whom an individual or area-wide permit is issued shall register the permit with the director each year and pay an annual registration fee for each permit based on the total daily influent of pollutants pursuant to subsection E of this section.

D. Pending the issuance of individual or area-wide aquifer protection permits, each owner of a facility that is prescribed in subsection B or C of this section that is operating on September 27, 1990 pursuant to the filing of a notice of disposal or a groundwater quality protection permit issued under title 36 shall register the notice of disposal or the permit with the director each year and shall pay an annual registration fee for each notice of disposal or permit based on the total daily influent or discharge of pollutants pursuant to subsection E of this section.

E. The director shall establish by rule an annual registration fee for facilities prescribed by subsections B, C and D of this section. The fee shall be measured in part by the amount of discharge or influent per day from the facility.

F. For a site with more than one permit subject to the requirements of this section, the owner or operator of the facility at that site shall pay the annual registration fee prescribed pursuant to subsection E of this section based on the permit that covers the greatest gallons of discharge or influent per day plus one-half of the annual registration fee for gallons of discharge or influent for each additional permit.

G. The director shall prescribe the procedures to register the notice of disposal or permit and collect the fee under this section. The director shall deposit, pursuant to sections 35-146 and 35-147, all monies collected under this section in the water quality fee fund established by section 49-210 and may authorize expenditures from the fund to pay the reasonable and necessary costs of administering the registration program.

49-211. Direct potable reuse of treated wastewater; fees; rules

A. On or before December 31, 2024, the director shall establish by rule permit fees sufficient to administer a direct potable reuse of treated wastewater program. Monies collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the water quality fee fund established by section 49-210.

B. On or before December 31, 2024, the director shall adopt all rules necessary to establish and implement a direct potable reuse of treated wastewater program, including rules establishing permitting standards and a permit application process.

49-241.02. Aquifer protection permit program fees

A. The department shall adopt by rule fees to pay the expenses incurred in implementing the aquifer protection permit program. Monies collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the water quality fee fund established by section 49-210.

B. If the department contracts with a consultant under section 49-203, an applicant may request that the department expedite the application review by requesting that the department use the services of the consultant and agreeing to pay to the department the costs of the consultant's services regardless of the other provisions of this section.

49-242. Procedural requirements for individual permits; annual registration of permittees; fee

A. The director shall prescribe by rule requirements for issuing, denying, suspending or modifying individual permits, including requirements for submitting notices, permit applications and any additional information necessary to determine whether an individual permit should be issued, and shall prescribe conditions and requirements for individual permits.

B. Each owner of an injection well, a land treatment facility, a dry well, an on-site wastewater treatment facility with a capacity of more than three thousand gallons per day, a recharge facility or a facility that discharges to protected surface waters to whom an individual or area-wide permit is issued shall register the permit with the director each year and pay an annual registration fee for each permit based on the total daily discharge of pollutants pursuant to subsection E of this section.

C. Each owner of a surface impoundment, a facility that adds a pollutant to a salt dome formation, salt bed formation, underground cave or mine, a mine tailings pile or pond, a mine leaching operation, a sewage or sludge pond or a wastewater treatment facility to whom an individual or area-wide permit is issued shall register the permit with the director each year and pay an annual registration fee for each permit based on the total daily influent of pollutants pursuant to subsection E of this section.

D. Pending the issuance of individual or area-wide aquifer protection permits, each owner of a facility that is prescribed in subsection B or C of this section that is operating on September 27, 1990 pursuant to the filing of a notice of disposal or a groundwater quality protection permit issued under title 36 shall register the notice of disposal or the permit with the director each year and shall pay an annual registration fee for each notice of disposal or permit based on the total daily influent or discharge of pollutants pursuant to subsection E of this section.

E. The director shall establish by rule an annual registration fee for facilities prescribed by subsections B, C and D of this section. The fee shall be measured in part by the amount of discharge or influent per day from the facility.

F. For a site with more than one permit subject to the requirements of this section, the owner or operator of the facility at that site shall pay the annual registration fee prescribed pursuant to subsection E of this section based on the permit that covers the greatest gallons of discharge or influent per day plus one-half of the annual registration fee for gallons of discharge or influent for each additional permit.

G. The director shall prescribe the procedures to register the notice of disposal or permit and collect the fee under this section. The director shall deposit, pursuant to sections 35-146 and 35-147, all monies collected under this section in the water quality fee fund established by section 49-210 and may authorize expenditures from the fund to pay the reasonable and necessary costs of administering the registration program.

49-255.01. Arizona pollutant discharge elimination system program; rules and standards; affirmative defense; fees; general permit

A. A person shall not discharge except under either of the following conditions:

1. In conformance with a permit that is issued or authorized under this article or rules authorized under section 49-203, subsection A, paragraph 2.

2. Pursuant to a permit that is issued or authorized by the United States environmental protection agency until a permit that is issued or authorized under this article takes effect.

B. The director shall adopt rules to establish an AZPDES permit program for discharges to WOTUS consistent with the requirements of sections 402(b) and 402(p) of the clean water act. This program shall include requirements to ensure compliance with section 307 and requirements for the control of discharges consistent with sections 318 and 405(a) of the clean water act. The director shall not adopt any requirement for WOTUS that is more stringent than any requirement of the clean water act. The director shall not adopt any requirement that conflicts with any requirement of the clean water act. The director may adopt federal rules pursuant to section 41-1028 or may adopt rules to reflect local environmental conditions to the extent that the rules are consistent with and not more stringent than the clean water act and this article.

C. The rules adopted by the director under subsection B of this section shall provide for:

1. Issuing, authorizing, denying, modifying, suspending or revoking individual or general permits.

2. Establishing permit conditions, discharge limitations and standards of performance as prescribed by section 49-203, subsection A, paragraph 8 including case-by-case effluent limitations that are developed in a manner consistent with 40 Code of Federal Regulations section 125.3(c).

3. Modifications and variances as allowed by the clean water act.

4. Other provisions necessary for maintaining state program authority under section 402(b) of the clean water act.

D. This article does not affect the validity of any existing rules that are adopted by the director and that are equivalent to and consistent with the national pollutant discharge elimination system program authorized under section 402 of the clean water act until new rules for AZPDES discharges are adopted pursuant to this article.

E. An upset constitutes an affirmative defense to any administrative, civil or criminal enforcement action brought for noncompliance with technology-based permit discharge limitations if the permittee complies with all of the following:

1. The permittee demonstrates through properly signed contemporaneous operating logs or other relevant evidence that:

(a) An upset occurred and that the permittee can identify the specific cause of the upset.

(b) The permitted facility was being properly operated at the time of the upset.

(c) If the upset causes the discharge to exceed any discharge limitation in the permit, the permittee submitted notice to the department within twenty-four hours after the upset.

(d) The permittee has taken appropriate remedial measures including all reasonable steps to minimize or prevent any discharge or sewage sludge use or disposal that is in violation of the permit and that has a reasonable likelihood of adversely affecting human health or the environment.

2. In any administrative, civil or criminal enforcement action, the permittee shall prove, by a preponderance of the evidence, the occurrence of an upset condition.

F. Compliance with a permit issued pursuant to this article shall be deemed compliance with both of the following:

1. All requirements in this article or rules adopted pursuant to this article relating to state implementation of sections 301, 302, 306 and 307 of the clean water act, except for any standard that is imposed under section 307 of the clean water act for a toxic pollutant that is injurious to human health.

2. Limitations for pollutants in WOTUS adopted pursuant to sections 49-221 and 49-222, if the discharge of the pollutant is specifically limited in a permit issued pursuant to this article or the pollutant was specifically identified as present or potentially present in facility discharges during the application process for the permit.

G. Notwithstanding section 49-203, subsection D, permits that are issued under this article shall not be combined with permits issued under article 3 of this chapter.

H. The decision of the director to issue or modify a permit takes effect on issuance if there were no changes requested in comments that were submitted on the draft permit unless a later effective date is specified in the decision. In all other cases, the decision of the director to issue, deny, modify, suspend or revoke a permit takes effect thirty days after the decision is served on the permit applicant, unless either of the following applies:

1. Within the thirty-day period, an appeal is filed with the water quality appeals board pursuant to section 49-323.

2. A later effective date is specified in the decision.

I. In addition to other reservations of rights provided by this chapter, this article does not impair or affect rights or the exercise of rights to water claimed, recognized, permitted, certificated, adjudicated or decreed pursuant to state or other law.

J. The director shall establish by rule fees, including maximum fees, to pay expenses incurred in implementing the AZPDES program. Monies collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the water quality fee fund established by section 49-210.

K. Any permit conditions concerning threatened or endangered species shall be limited to those required by the endangered species act.

L. When developing a general permit for discharges of storm water from construction activity, the director shall provide for reduced control measures at sites that retain storm water in a manner that eliminates discharges from the site, except for the occurrence of an extreme event. Reduced control measures shall be available if all of the following conditions are met:

1. The nearest downstream receiving water is ephemeral and the construction site is a sufficient distance from a water warranting additional protection as described in the general permit.

2. The construction activity occurs on a site designed so that all storm water generated by disturbed areas of the site exclusive of public rights-of-way is directed to one or more retention basins that are designed to retain the runoff from an extreme event. For the purposes of this subsection, "extreme event" means a rainfall event that meets or exceeds the local one hundred-year, two-hour storm event as calculated by an Arizona registered professional engineer using industry practices.

3. The owner or operator complies with good housekeeping measures included in the general permit.

4. The owner or operator maintains the capacity of the retention basins.

5. Construction conforms to the standards prescribed by this section.

M. If the director commences proceedings for the renewal of a general permit issued pursuant to this article, the existing general permit shall not expire and coverage may continue to be obtained by new dischargers until the proceedings have resulted in a final determination by the director. If the proceedings result in a decision not to renew the general permit, the existing general permit shall continue in effect until the last day for filing for review of the decision of the director not to renew the permit or until any later date that is fixed by court order.

49-352. Classifying systems and certifying personnel; limitation

A. The department shall establish and enforce rules for the classification of systems for potable water and certifying operating personnel according to the skill, knowledge and experience necessary within the classification. The rules shall also provide that operating personnel may be certified on the basis of training and supervision at the place of employment. The department may assess and collect reasonable certification fees to reimburse the cost of certification services, which shall be deposited in the water quality fee fund established by section 49-210. Such rules apply to all public water systems involved in the collection, storage, treatment or distribution of potable water. The rules do not apply to systems that are not public water systems, including irrigation, industrial or similar systems where the water is used for nonpotable purposes.

B. For the purposes of this article:

1. A public water system is a water system that:

(a) Provides water for human consumption through pipes or other constructed conveyances.

(b) Has at least fifteen service connections or regularly serves an average of at least twenty-five persons daily for at least sixty days a year.

2. A public water system as described in paragraph 1, subdivisions (a) and (b) of this subsection includes any collection, treatment, storage and distribution facilities that are under the control of the operator of a public water system and that are used primarily in connection with the system and any collection or pretreatment storage facilities that are not under the control of the operator of a public water system and that are used primarily in connection with a public water system.

3. A service connection does not include a connection to a system that delivers water by a constructed conveyance other than a pipe, if any of the following applies:

(a) The water is used exclusively for purposes other than residential uses consisting of drinking, cooking or bathing or other similar uses.

(b) The department determines that alternative water is provided for residential or similar uses for drinking and cooking and that the water achieves a level of public health protection that is equivalent to the applicable national primary drinking water regulations.

(c) The department determines that the water that is provided for residential or similar uses for drinking, cooking and bathing is centrally treated or is treated at the point of entry by the water provider, a pass-through entity or the user to achieve the level of public health protection that is equivalent to the applicable national primary drinking water regulations.

4. An irrigation district in existence before May 18, 1994 and that provides primarily agricultural service through a piped water system with only incidental residential or similar use is not a public water system if the system or the residential or other similar users of the system comply with paragraph 3, subdivision (b) or (c) of this subsection.

5. Persons who receive water through connections that are not service connections pursuant to paragraph 3 of this subsection are not included in the computation of the number of persons prescribed by paragraph 1, subdivision (b) of this subsection.

49-353. Duties of director; rules; prohibited lead use

A. The director shall:

1. Exercise general supervision over all matters related to water quality control of public water systems throughout this state.

2. Prescribe rules regarding the production, treatment, distribution and testing of potable water by public water systems, except that such rules shall not apply to irrigation, industrial or similar systems where the water is used for nonpotable purposes. The rules shall comply with at least the following:

(a) The requirements established by the United States environmental protection agency for state primary enforcement responsibility of the safe drinking water act, including the requirements of 40 Code of Federal Regulations parts 141 and 142.

(b) Require that the plans and specifications for all public water systems, including water treatment plants, distribution systems, distribution system extensions, water treatment methods and devices and all appurtenances and devices for sale to be used in water supplies and public water systems be submitted with a fee for review to the department. 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. Monies collected from the fees shall be deposited in the water quality fee fund established by section 49-210. The director may require that plans and specifications for public water systems include programs to meet future needs for drinking water and to supply specified minimum quantities of drinking water. The director shall:

(i) Require that a new public water system demonstrate that the system possesses adequate managerial and financial capacity to operate in compliance with this article and the rules adopted pursuant to this article.

(ii) Accept adequate findings of other public authorities regarding the adequate managerial and financial capacity of a public water system to operate in compliance with this article and the rules adopted pursuant to this article.

(c) Provide that no public water system, including a water treatment plant, distribution system, distribution system extension, water treatment method or device, appurtenance and device used in water supplies or public water systems be constructed, reconstructed, installed or initiated before compliance with the standards and rules has been demonstrated by approval of the plans and specifications by the department. The rules shall prescribe minimum standards for the bacteriological, physical and chemical quality of water distributed through public water systems. The director of environmental quality may consult with the director of the department of health services in developing these standards.

(d) Provide for a simplified administrative procedure for approving structural revisions, additions, extensions or modifications to existing small public water systems for potable water serving a population of three thousand three hundred or fewer persons.

(e) Exempt from the plan review requirements of this paragraph, including any requirements for approval to construct or approval of construction, any structural revisions, additions, extensions or modifications to public water systems which are in compliance with the department's rules applicable to those systems or which are making satisfactory progress towards compliance under a schedule approved by the department if either of the following conditions is satisfied:

(i) The revision, addition, extension or modification has a project cost of twelve thousand five hundred dollars or less.

(ii) The revision, addition, extension or modification is made to a water line which is not for a subdivision requiring plat approval by a city, town or county, and has a project cost of more than twelve thousand five

hundred dollars but less than fifty thousand dollars, the design of which is sealed by a professional engineer registered in this state and the construction of which is reviewed for conformance with the design by a professional engineer.

(f) Require a notice of compliance with the conditions for exemption on the completion of any revisions, additions, extensions or modifications completed in accordance with subdivision (e) of this paragraph.

(g) Provide for the submission of samples at stated intervals.

(h) Provide for inspection and certification of such water supplies.

(i) Provide for the abatement as public nuisances of any premises, equipment, process or device, or public water system that does not comply with the minimum standards and rules.

(j) Provide for records regarding water quality to be kept by owners and operators of the public water systems and that reports regarding water quality be filed with the department.

(k) Provide for appropriate actions to be taken if a water supply does not meet the standards established by the department.

(l) Require a public water system to implement a specified program to control contamination from backflow, backsiphonage or cross connection. All such programs shall be consistent with section 37-1388.

(m) Require that public water systems identify and provide notice to persons that may be affected by lead contamination of their drinking water where such contamination results from either or both of the following:

(i) The lead content in the construction materials of the public water distribution system.

(ii) Corrosivity of the water supply sufficient to cause leaching of lead.

(n) Provide for relief from water testing and monitoring requirements for public water systems qualifying under the federal safe drinking water act (P.L. 93-523; 88 Stat. 1661; P.L. 95-190; 91 Stat. 1393; P.L. 104-182; 110 Stat. 1613), as amended in 1996.

3. Develop and implement strategies to assist public water systems in acquiring and maintaining the technical, managerial and financial capacity to operate in compliance with this article and the rules adopted pursuant to this article. Assistance may be provided based on the needs of the water system.

B. Pipes, pipe fittings and plumbing fittings and fixtures having a lead content in excess of a weighted average of one-quarter of one percent lead when used with respect to the wetted surfaces and solders and flux having a lead content in excess of two-tenths of one percent shall not be used in the installation or repair of public water systems or of any plumbing in residential or nonresidential facilities providing water for human consumption. The weighted average lead content of a pipe, pipe fitting or plumbing fitting or fixture shall be calculated as follows:

1. For each wetted component, the percentage of lead in the component shall be multiplied by the ratio of the wetted surface area of that component to the total wetted surface area of the entire product to arrive at the weighted percentage of lead of the component.

2. The weighted percentage of lead of each wetted component shall be added together, and the sum of these weighted percentages shall constitute the weighted average lead content of the product.

3. The lead content of the material used to produce a wetted component shall be used to determine compliance with this subsection.

4. For lead content of materials that are provided as a range, the maximum content of that range shall be used.

C. Subsection B of this section does not apply to:

1. Leaded joints necessary for the repair of cast iron pipes.

2. Pipes, pipe fittings and plumbing fittings and fixtures, including backflow preventers, that are used exclusively for nonpotable water services such as manufacturing, industrial processing, irrigation, outdoor watering or any other uses where the water is not anticipated to be used for human consumption.

3. Toilets, bidets, urinals, fill valves, flushometer valves, tub fillers, shower valves or service saddles or water distribution main gate valves that are two inches in diameter or larger.

D. Notwithstanding subsection A, paragraph 2, subdivision (c) of this section, a public water system may construct, reconstruct, install, extend or initiate a water supply system, water treatment plant, distribution system, water treatment method or device, or appurtenance that is used in water supply or in a public water system when the system is out of compliance with standards and rules adopted pursuant to this article only if the construction is necessary to correct the system's noncompliance.

E. This section and the rules adopted pursuant to this section apply to public water systems as described by section 49-352, subsection B.

49-361. Sewage treatment plants; operator certification

The department shall adopt and enforce rules to classify sewage collection systems and treatment plants and to certify operating personnel according to the skill, knowledge and experience necessary within the classification. The rules shall provide that operating personnel may be certified on the basis of training and supervision at the place of employment. The department may assess and collect reasonable certification fees to reimburse the cost of certification services, and the fees shall be deposited, pursuant to sections 35-146 and 35-147, in the water quality fee fund established by section 49-210. The rules apply to all sewage treatment plants that receive and treat wastes from common collection sewers and industrial plants but do not apply to septic tanks, to devices that serve a single home or to industrial treatment devices that are used to perform or allow recycling or impounding wastes within the boundaries of the industry's property.

b. The Department's proposed action and effective date for that action;
c. The location where relevant, nonconfidential documents may be obtained and reviewed during normal business hours;
d. The name, address and telephone number of a person within the Department who may be contacted for further information;
e. The location where public comments may be addressed, and the date and time by which comments shall be received.

B. In addition to meeting the requirements in subsection (A), a notice for a general public hearing shall include the following information:
1. The time and location of the general public hearing;
2. A statement to the effect that any person may appear at the hearing and present views, either orally or in writing;
3. The time by which a decision shall be reached;
4. The exact nature of the action or issues to be discussed.

C. The notice for a general public hearing described in this Section shall be published at least 30 days prior to the date of the hearing unless otherwise prescribed by statute or rule.

Historical Note
Adopted effective July 7, 1988 (Supp. 88-3).

R18-1-402. General Public Hearing Procedures

A. If a general public hearing is required by statute or by rule, the hearing shall be noticed as required in R18-1-401.

B. The Department shall maximize the opportunity for public participation at a general public hearing and shall consider all of the following when scheduling the general public hearing:
1. A location in or near the geographical area of the issue addressed in the hearing, and easily accessible to a majority of the affected public;
2. A time which can facilitate public attendance;
3. Other hearings concerning the public, in the same geographical area, which may be scheduled for the same time and location.

C. The Department may schedule persons wishing to speak, and Department personnel knowledgeable about the issue shall be present to provide information.

D. A general public hearing shall be conducted so as to do both of the following:
1. Inform the public of the exact nature of the action or issue, and
2. Allow time for persons to make statements and submit written comments.

E. The person presiding at a general public hearing shall maintain order and may allot equitable time periods for oral comment by participants.

F. A general public hearing shall be recorded by means of an electronic device or stenographically.

G. The record of a general public hearing shall be maintained by the Department and made available for public inspection, during normal business hours, at the location specified in the public notice. The record of the hearing shall include the agenda, written comments submitted before the close of record, and the tape or transcript of the hearing.

Historical Note
Adopted effective July 7, 1988 (Supp. 88-3).

ARTICLE 5. LICENSING TIME-FRAMES

R18-1-501. Definitions

In addition to the definitions provided in A.R.S. § 41-1001, § 41-1072, and R18-1-101, the following definitions apply to this Article:

1. "Administrative completeness" or "administratively complete" means Department receipt of all application components required by statute or rule and necessary to enable the Department to issue a notice of administrative completeness under A.R.S. § 41-1074 and thereby end the administrative completeness review time-frame and start the substantive review time-frame.
2. "Administrative completeness review" means the process of clerical verification by the Department to determine whether the submitted application components meet the requirements of administrative completeness.
3. "Applicant" means a person who requests the Department to issue a license.
4. "Applicant response" means a written response from the applicant to a Department notice that complies with all the following:
   a. The response identifies the applicant.
   b. The response identifies the Department notice.
   c. The response is addressed to the Department employee identified in the Department notice as the designated recipient of the notice.
   d. The response contains the required information identified in the Department notice or the response contains a notice under R18-1-520 to rely on the application components as submitted.
5. "Application" means a request to the Department to issue a license to the requestor when that request is in writing and complies with R18-1-502 and R18-1-503(A).
6. "Application clerk" means a Department employee with authority to receive applications for a specific license or an application component or applicant response.
7. "Application component" means a document, other written information, or fee required by statute or rule and submitted to the Department in support of an application.
8. "Companion category" means one of an association of two or more consecutive categories, shown on the license tables with paired license names, and containing a distinction between "standard" and "complex", between "without a public hearing" and "with a public hearing", or "without a public meeting" and "with a public meeting".
9. "Complex" means an application category that requires significantly more Department resources to review the application than applications processed in a companion standard category due to the size, novelty, complexity, or technical difficulty expressed in the application.
10. "Comprehensive request for additional information" means a Department notification made after the administrative completeness review time-frame that:
    a. Contains a list of information required by statute or rule and necessary before the Department may grant the license; and
    b. Suspends the running of days within the time-frames.
11. "Day" means business day and excludes Saturdays, Sundays, and state holidays.
12. "Department notification" or "Department notice" means written communication by the Department to an applicant in person or at the mailing or electronic address identified on the application. The Department may notify the applicant at the applicant's electronic address only if the appli-

ARTICLE 5. MINIMUM DESIGN CRITERIA

Article 5, consisting of R18-5-501 through R18-5-509, recodified from 18 A.A.C. 4, Article 5 at 10 A.A.R. 585, effective January 30, 2004 (Supp. 04-1).

ARTICLE 1. CLASSIFICATION OF WATER AND WASTEWATER FACILITIES AND CERTIFICATION OF OPERATORS

R18-5-101. Definitions

The terms in this Article have the following meanings:

"Certified operator" or "operator" means an individual who holds a current certificate issued by the Department in the field of water or wastewater treatment, water distribution, or wastewater collection.

"Collection system" means a pipeline or conduit, a pumping station, a force main, or any other device or appurtenance used to collect and conduct wastewater to a central point for treatment and disposal.

"Department" means the Department of Environmental Quality or its designated representative.

"Director" means the Director of the Department of Environmental Quality or the Director's designated representative.

"Direct responsible charge" means day-to-day decision making responsibility for a facility or a major portion of a facility.

"Distribution system" means a pipeline, appurtenance, or device of a public water system that conducts water from a water source or treatment plant to consumers for domestic or potable use.

"Facility" means a water treatment plant, wastewater treatment plant, distribution system, or collection system.

"Industrial waste" means the liquid, gaseous, or solid waste produced at an industrial operation.

"Onsite operator" means an operator who visits a facility at least daily to ensure that the facility is operating properly.

"Onsite representative" means an individual located at a facility who monitors the daily operation at the facility and maintains contact with the remote operator regarding the facility.

"Operator" has the same meaning as certified operator, as defined in this Section.

"PDH" means professional development hour, as defined in this Section.

"Population equivalent" means the population that would contribute an equal amount of biochemical oxygen demand (BOD) computed on the basis of 0.17 pounds of five-day, 20-degree centigrade BOD per capita per day.

"Professional development hour" or "PDH" means one hour of participation in an organized educational activity related to engineering, biological or chemical sciences, a closely related technical or scientific discipline, or operations management.

"Public water system" has the same meaning prescribed in A.R.S. § 49-352.

"Qualifying discipline" means engineering, biology, chemistry, or a closely related technical or scientific discipline.

"Qualifying experience" means experience, skill, or knowledge obtained through employment that is applicable to the technical or operational control of all or part of a facility.

"Remote operator" means an operator who is not an onsite operator.

"Validated examination" means an examination that is approved by the Department after being reviewed to ensure that the examination is based on the class and grade of a system or facility.

"Wastewater" means sewage, industrial waste, and all other waterborne waste that may pollute any lands or waters of the state.

"Wastewater treatment plant" means a process, device, or structure used to treat or stabilize wastewater or industrial waste and dispose of the effluent.

"Water treatment plant" means a process, device, or structure used to improve the physical, chemical, or biological quality of the water in a public water system.

Historical Note

Former Section R9-20-504 repealed, new Section R9-20-504 adopted effective November 1, 1979 (Supp. 79-6). Former Section R9-20-504 amended, renumbered as Section R9-20-501, then renumbered as Section R18-4-101 effective October 23, 1987 (Supp. 87-4). R18-5-101 recodified from R18-4-101 (Supp. 95-2). Amended by final rulemaking at 7 A.A.R. 1171, effective February 16, 2001 (Supp. 01-1). Amended by final rulemaking at 7 A.A.R. 5079, effective October 16, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 998, effective April 2, 2005 (Supp. 05-1).

R18-5-102. Applicability

A. The rules in this Article apply to owners and operators of facilities in Arizona.

B. The following facilities are exempt from the requirements of this Article:

1. A public water system that meets the nonapplicability criteria in R18-4-102.
2. A septic tank or collection system that discharges to a septic tank.
3. A collection system that serves 2,500 or fewer persons and discharges into a facility that is operated by a certified operator.

ADEQ's Water Quality Program Fee Update – Supplemental Information

- In collaboration with the Arizona Commerce Authority (ACA), five "competitor" states were identified for a benchmarking survey conducted in 2021 to understand the funding structure of certain environmental protection and permitting programs related to water quality; WQD has used the same states for this new fee comparison.
- According to ACA these states typically compete against Arizona for business expansions and relocations.
- The benchmarking survey, attached, provides the information that GRRC requested and provides a summary of the relative subsidization of the relevant water quality programs, not the fees charged by the programs.
- All competitor States subsidize environmental protection programs; the true cost of those programs is not necessarily reflected in the fees they charge.
- At the request of GRRC, ADEQ compiled the table below, which directly compares the fees in the competitive states. ADEQ excluded Georgia as they do not charge permit fees.
- While the fees from competitor states do not align perfectly with the Arizona rule, a relevant comparison may be made.
- As shown in the table, Arizona permitting rates are competitive with other states.

Additional Notes for GRRC Consideration

- GRRC approved the UIC fee rules and they became effective in the Arizona Administrative Code on Sept. 7, 2022; the proposed rule only adds an annual inflation adjustment.
- The increases in fees in the proposed rules are only designed to address the relative increases in costs due to inflation since the last time the rules were approved by GRRC.
- The legislative appropriation for fiscal year 2024 anticipated ADEQ increasing fees for inflation to ensure sufficient funding for the Water Quality Division.
- The cost of a permit is not likely to contribute significantly to the total cost of the project.
- Stakeholders support the approach reflected in this proposed fee rule.

	Hourly rates		Annual Fees						
	Underground Injection Control (UIC) UIC fees are already in rule	All others	Drinking water treatment plants	Wastewater Discharge (Groundwater/Aquifer Protection Permit Program)	NPDES or state surface water	Municipal Separate Storm Sewer Systems Permits	Construction fees	Multi Sector General Permit or Equivalent GP or Individual Permit (IP)	UIC (Arizona UIC fees set in 2022, proposed rules adjust CPI annually)
Arizona (new proposed fees)	**$145**	**$174**	**No fee in rule**	**Range: $714-$12,130 2 mgd $8,562 5 mgd $8,562 10 mgd $12,130**	**Range: $357-$5,708 100,000 up to 999,999 gpd - $714**	**Range: $3,568-$10,000**	**Range: $357 to $714**	**Range: $499 to $1,427**	**$600 to $10,000 based on design injection flow Or a waste disposal fee of $0.002/ gallon (Class 1) Or a waste disposal fee of $0.08/ ton (Class 6)**
Colorado	NA	flat fees	$695-$1000	Range: $750-$30,622 2 mgd $7,881 5 mgd $15,907 10 mgd $24,132	Range: $555-$2,269 600,000 up to 999,999 gpd - $2,269	Range: $8,093 to $13,754	Range: $165 to $540	Range: $475-$604, $10,014 for an IP	NA
Nevada	flat fees	flat fees	$703-$1,406	Range $1,055-$56,263 10 mgd $28,132	NA	Range: $1200-$2000	Range: $300 to $1,250	$1,500	$1,875 to $40,000/year
Texas	flat fees	flat fees	No fee in rule	Range: $1,250 to $131,603	Range: $1,250 to $131,603	No fee in rule	$100	Range: $100 to $800	Flat fees $250 to $500
Utah	$110	$115	No fee in rule	Range: $443-$14,122	Range: $633- $11,500	Range: $750-$4,000	$150	$250	No fee in rule

NOTE: In accordance with statutory authority, ADEQ is not "charg[ing] or receiv[ing] a fee or mak[ing] a rule establishing a fee unless the fee for the specific activity is expressly authorized by statute…" A.R.S. § 41-1008(A)(1). Further, A.R.S. § 49-104(B)(17) requires that fees be "fairly assessed and impose the least burden and cost to the parties subject to the fees" and be based on "the direct and indirect costs of the department's relevant duties … directly related to issuing licenses … and enforcing the requirements of the applicable regulatory program."

To: **David Lelsz, Ph.D., ADEQ**
From: **Richard Merritt, Elliott D. Pollack & Company**
Daniel Court, Elliott D. Pollack & Company
Re: **Permit Fee Structure Analysis for the Water Quality Division of ADEQ: A Six State Benchmarking Comparison**
Date: **April 19,2022**

Executive Summary

The Department of Environmental Quality is currently experiencing an annual budgetary shortfall of revenue for its Water Quality Division (WQD). The current fee policy assumes that WQD's permitting and permit support programs would be self-sustaining through permit fees. However, WQD annually requires an influx of revenue from non-fee income to cover its cost; no general fund dollars are allocated to the Division. In addition, the WQD has many other program responsibilities that don't fit into the fee-for-service model. Even with the influx of non-fee income, the WQD does not have sufficient income to meet all federal and state obligations. The Division has estimated a $13 million gap for FY 24. In order to evaluate Arizona's WQD funding policy, a benchmarking survey was undertaken by the Division. ADEQ contracted with an external consultant, Elliott D. Pollack & Company, to assist with the benchmarking survey.

In collaboration with the Arizona Commerce Authority (ACA), five "competitor" states were identified for a benchmarking survey to understand the funding structure of certain environmental protection and permitting programs related to water quality. These states typically compete against Arizona for business expansions and relocations according to ACA; they include Colorado, Georgia, Nevada, Texas, and Utah. All have very strong, growing economies and, except for Nevada, are among the 12 states in the country that as of February 2022 have recovered more jobs than were lost during the pandemic.

The following chart outlines the bottom-line comparison of funding sources among competitor states and Arizona. The primary findings of the survey are:

- Arizona stands alone among competitor states with its policy of allocating no general fund dollars to water quality programs. Nevada is the only other state that is most closely aligned with this policy.

- The use of general fund dollars for water quality programs is the norm among the competitive states at an average of 16% of total funds although some states are higher than the average.
- The average percentage of program funding from permit fees among the competitive states, excluding Georgia which is the sole outlier, is 53%. Arizona is below the average; only 36% of its water quality program funding comes from fees.

Summary of Percentage of Funding Sources - Competitor States
Water Quality Programs

State	Fees	Gen Fund	Grants & Other Funds	Total
Colorado	49.4%	33.1%	17.4%	100.0%
Georgia	0.0%	43.4%	56.6%	100.0%
Nevada	65.1%	0.3%	34.5%	100.0%
Texas TCEQ & RCT UIC Budget	78.4%	6.6%	15.0%	100.0%
Utah	18.3%	24.7%	57.0%	100.0%
Average Percentage - Competitor States Excluding Georgia	52.8%	16.2%	31.0%	100.0%
Arizona	36.2%	0.0%	63.8%	100.0%

Purpose of Study

The Department of Environmental Quality is currently experiencing an annual budgetary shortfall of revenue for its Water Quality Division (WQD). The current fee policy, originally established in 2011, is that WQD would be self-sustaining through permit fees. That policy has proven unworkable; WQD annually requires an influx of revenue from non-fee income to cover its cost. No general fund dollars are allocated to the Water Quality Division as noted in the FY 2022 Spending Plan. In addition, the WQD has many other program responsibilities that don't fit into the fee-for-service model. Even with the influx of non-fee income, the WQD does not have sufficient income to meet all federal and state obligations. The Division has estimated a $13 million gap for FY 24.

In order to address the shortfall of programs funds, ADEQ contracted with an external consultant, Elliott D. Pollack & Company, to conduct a benchmarking study of competitor peer states to understand the funding structure of certain environmental protection and permitting programs related to water quality. The funding of the water quality programs in these states will be compared to the Arizona fee-for-service/federal grant supported model to determine its viability

and consistency with competitor states. The outcome of the analysis could lead to a potential increase in fees charged to customers or support from other sources of revenue. Any future rulemaking on fees will include a public outreach process with impacted stakeholders.

Benchmarking Process

In collaboration with the Arizona Commerce Authority (ACA), five "competitor" states were identified for benchmarking. These states are ones that Arizona typically competes against for business expansions and relocations and all exhibit strong economic fundamentals. The competitor states subject to benchmarking include, in no particular order, Colorado, Georgia, Nevada, Texas, and Utah.

Through established contacts with the environmental quality agencies in other states, email requests for assistance were sent to the competitor states. Those requests were followed up with phone calls to establish times for conference calls. A benchmarking survey was sent to each agency and an agenda was prepared by Dr. David Lelsz of ADEQ (see Appendix) which (1) focused on the purpose of the benchmarking study, (2) provided a definition of ADEQ programs that could then be compared to competitor state programs, and (3) provided the questions that needed to be answered regarding the water quality program funding structures for each competitor state. The Arizona team offered that the results of the benchmarking study would be sent to each state who contributed to the study. Each conference call was moderated by Dr. Lelsz and at least one representative from Elliott D. Pollack & Company was on each of the conference calls.

As part of the benchmarking survey, definitions were provided for the various ADEQ fee funded programs (in **bold** below**)**. Non-fee funded activities are in *italics.* The definition section of the survey was designed to provide comparison between the terminology of ADEQ programs and the various competitor state programs. The definitions are:

1. Administrative Costs (AC) - State costs not associated with program costs in definitions 2-5, excluding program costs for other environmental protection activities
2. Groundwater Protection Program (GPP)-Permitting program that regulates a discharge to the aquifer or vadose zone; **includes permittee/permit/facility monitoring, compliance assistance, inspection, and enforcement.** Groundwater protection also includes some non-customer-oriented programs like *ambient groundwater monitoring and standards development.*
3. Surface Water Protection Program (SWPP)-Permitting program that regulates a discharge to a water of the United States or other surface water; includes **permittee/permit/facility monitoring, compliance assistance, inspection, and enforcement. Includes stormwater permitting and NPDES permitting.**

4. Surface Water Monitoring and Improvement Program (SWMIP) - *a non-permitting program that undertakes TMDL, standards development and non-permit related monitoring*
5. Drinking Water Protection Program (DWP)-**Permitting and/or engineering review program; includes permittee/permit/facility monitoring, compliance assistance, inspection, and enforcement.** Drinking Water Protection also includes some non-customer-oriented programs like *technical assistance to systems.*
6. Fee Funded-**Any program where a fee is required of a customer that covers all or part of the agencies cost to administer**
7. Non-Fee Funded-Any program where a fee is NOT required; for ADEQ, those programs are;
    - *GPP-Ambient groundwater monitoring and groundwater standards development.*
    - *SWMIP-TMDL, standards development and non-permit related monitoring*
    - *DWP-Technical assistance to systems.*

Outreach Results

The outreach effort to competitor states was successful with funding data provided by most involved in water quality. The detail and depth of the data, however, varied from state to state. Some states provided detailed data by program while others could offer only high level department summaries. Data from some states was also dated, but we understand that funding policies had not changed over time. We recognize the significant effort on the part of the personnel of the assisting states to provide this information to ADEQ; their cooperation was vital to the preparation of this report.

Following is a summary of the information provided from each state.

Colorado

The Colorado Water Quality Control Division within the Colorado Department of Public Health and Environment provided budget information for fiscal year 2015-16 for six programs. Those programs are:

- SWPP and SWMIP
    - Commerce and Industry (equivalent to Individual and General Permits for AZDES – industrial only)
    - Construction (largely equivalent to ADEQ Construction General Permit)
    - MS4 (Municipal Separate Stormwater System)
    - Pesticide
    - WQ Certification (401 certifications for USACE 404 permits)

- SWPP and GWP
    - Public/Private Utilities (sewage treatment only)

Colorado does not have a GW program. Funding for drinking water programs has not been received from the Division.

The amount of user permit fees that are used to support the water quality programs vary by program. Typically permit fees account for less than 50% of revenue for the individual programs. However, approximately 80% of the Construction program budget comes from permit fees. **In total, 49.4% of the Colorado Water Quality Control Division revenue is generated by user fees followed by General Fund dollars at 33.1%. Grants account for the remaining 17.4% of revenue.** The results of the data from Colorado are shown on the following chart.

Colorado Department of Public Health and Environment
Water Quality Control Division

FY 2015-16 Actual Revenues

Program	Fees	Gen Fund	Grants & Other Funds	Total
SWPP & SWMIP				
Commerce & Industry	$1,000,120	$997,062	$607,926	$2,605,108
Construction	$1,424,096	$291,751	$57,168	$1,773,015
MS4	$144,465	$122,965	$88,207	$355,637
Pesticides	$61,621	$140,591	$0	$202,212
WQ Certification	$0	$151,017	$10,291	$161,308
SWPP & GWP				
Public/Private Utilities	$2,198,037	$1,533,888	$939,288	$4,671,213
Totals	**$4,828,339**	**$3,237,274**	**$1,702,880**	**$9,768,493**

Percent of Revenue

Program	Fees	Gen Fund	Grants & Other Funds	Total
SWPP & SWMIP				
Commerce & Industry	38.4%	38.3%	23.3%	100.0%
Construction	80.3%	16.5%	3.2%	100.0%
MS4	40.6%	34.6%	24.8%	100.0%
Pesticides	30.5%	69.5%	0.0%	100.0%
WQ Certification	0.0%	93.6%	6.4%	100.0%
SWPP & GWP				
Public/Private Utilities	47.1%	32.8%	20.1%	100.0%
Totals	**49.4%**	**33.1%**	**17.4%**	**100.0%**

Note: Percentages may not add to 100% due to rounding.

Source: Colorado Water Quality Control Division

Georgia

Georgia Department of Natural Resources' Environmental Protection Division (EDP) provided written information regarding funding sources and a generalized summary for the Water Quality Branch. Essentially, except in one instance, funds for all programs come from the state's general fund and grants. Following is a summary by program.

- GPP: No permit fees are collected. Funding sources to support the program are state general funds and federal grants.
- SWPP: No fees are collected except for construction stormwater fees for land disturbing activities. However, those fees are not retained by the Department but are sent to the Treasury to the credit of the General Fund. All other SWPP funding sources to support the program are state general funds and federal grants.
- SWMIP: No permit fees are collected. Funding sources to support the program are state general funds and federal grants.
- DWP: No permit fees are collected. Funding sources to support the program are state general funds and federal grants. However, laboratory testing fees for drinking water analyses are collected. The fees do not cover the entire cost of the DW lab operations. The optional fee for service program at the EPD laboratory makes compliance monitoring and laboratory testing available to all public water systems at a reasonable cost.

The results of the data from Georgia are shown on the following chart. Georgia programs are covered in their entirety by the General Fund from the State and federal grants.

Georgia Department of Natural Resources
Environmental Protection Division

FY 2021 Actual Expenditures

Program	Fees	Gen Fund	Grants & Other Funds	Total
Water Quality Branch	$0	$25,248,184	$32,931,408	$58,179,592
Percent of Total	0.0%	43.4%	56.6%	100.0%

Source: Georgia Department of Natural Resources' Environmental Protection Division

Nevada

The Nevada Division of Environmental Protection has four programs devoted to water quality.

- The Bureau of Safe Drinking Water (SDW) implements the Public Water System Supervision Program (PWSSP) and the Laboratory Certification Program (LCP). State implementation of the PWSSP ensures Nevada's public water systems comply with state and federal drinking water standards by enforcing the sampling, monitoring and National

Primary Drinking Water standards, including requirements for water quality, surface water treatment and corrosion control. The Bureau primarily depends on grants for funding. General fund dollars do not support the program.

- The Bureau of Water Pollution Control (WPC) ensures compliance with water pollution control laws by issuing permits to discharge to surface and/or groundwater, inspect facilities to ensure compliance and enforcement actions are taken when necessary, and review the design of wastewater treatment plants and infrastructure to ensure subdivisions have adequate systems/infrastructures in place to treat wastewater. This budget account is primarily (91%) funded by fees and the remainder by federal grants (no general fund dollars).
- The Bureau of Water Quality Planning (WQP) is responsible for implementing programs to meet requirements of the Clean Water Act and Nevada water quality statutes and regulations that protect and/or improve the chemical, physical and biological integrity of the waters of Nevada. This budget account is fully funded by federal grants.
- The Mining Regulation and Reclamation Agency to ensure that Nevada's surface and groundwaters are not degraded by mining operations and that the lands disturbed by mining operations are reclaimed to safe and stable conditions to ensure a productive post-mining land use. Funding comes from permits.

The following table summarizes funding sources for Nevada. Data for the WPC and WQP bureaus was provided from Nevada staff through the Benchmarking Survey. Funding for SDW and Mining was collected from FY 2022 and 2023 budget documents.

Nevada Department of Conservation and Natural Resources				
FY 2022 Budget Revenues				
Program	**Fees**	**Gen Fund**	**Grants & Other Funds**	**Total**
Bureau of Safe Drinking Water	$465,126	$0	$4,632,102	$5,097,228
Water Pollution Control	$7,862,841	$0	$762,665	$8,625,506
Water Quality Planning	$0	$0	$2,146,821	$2,146,821
Mining Regulation/Reclamation	$5,897,863	$70,171	$0	$5,968,034
Totals	**$14,225,830**	**$70,171**	**$7,541,588**	**$21,837,589**
Percent of Revenue				
Program	**Fees**	**Gen Fund**	**Grants & Other Funds**	**Total**
Bureau of Safe Drinking Water	9.1%	0.0%	90.9%	100.0%
Water Pollution Control	91.2%	0.0%	8.8%	100.0%
Water Quality Planning	0.0%	0.0%	100.0%	100.0%
Mining Regulation/Reclamation	98.8%	1.2%	0.0%	100.0%
Totals	**65.1%**	**0.3%**	**34.5%**	**100.0%**
Source: Nevada Department of Conservation & Natural Resources				

Overall, permit fees comprise 65.1% of total funding for water quality programs. However, WPC and Mining rely on near 100% funding from permits. The opposite is true for Safe Drinking Water and Water Quality Planning. There are essentially no general funds provided to the water quality programs.

Texas

The staff of the Texas Commission of Environmental Quality (TCEQ) was able to supply detail on funding policies for water quality programs. Information was also received from the Railroad Commission of Texas (RCT) which administers the UIC Program. The overall distribution of funding for TCEQ and RCT is shown below with permitting providing approximately 39% of funding. Overall, only 15.5% of program funding comes from the general fund. The percentage of funding among the various programs varies widely. SWPP has the highest level of fee funding at 77% followed by GPP at 67%. Drinking water and UIC have the lowest levels of permit fee funding.

Texas Commission of Environmental Quality & Railroad Commission of Texas - UIC Program				
FY 2022 Budget				
Program	**Fees**	**Gen Fund**	**Grants & Other Funds**	**Total**
Drinking Water (TCEQ)	$2,710,105	$8,130,315	$16,260,629	$27,101,049
SWPP (TCEQ)	$5,613,914	$0	$1,676,883	$7,290,797
GPP (TCEQ)	$6,710,050	$0	$3,304,950	$10,015,000
SWMIP (TCEQ)	$10,720,299	$872,582	$9,182,892	$20,775,773
UIC (Railroad Commission)	$350,400	$1,436,200	$452,900	$2,239,500
Total TCEQ + UIC Budget	**$26,104,767**	**$10,439,097**	**$30,878,254**	**$67,422,119**
Percent of Revenue				
Program	**Fees**	**Gen Fund**	**Grants & Other Funds**	**Total**
Drinking Water (TCEQ)	10.0%	30.0%	60.0%	100.0%
SWPP (TCEQ)	77.0%	0.0%	23.0%	100.0%
GPP (TCEQ)	67.0%	0.0%	33.0%	100.0%
SWMIP (TCEQ)	51.6%	4.2%	44.2%	100.0%
UIC (Railroad Commission)	15.6%	64.1%	20.2%	100.0%
Total TCEQ + UIC Budget	**38.7%**	**15.5%**	**45.8%**	**100.0%**
Note: Percentages may not add to 100% due to rounding.				
Source: Texas Commission of Environmental Quality & Railroad Commission of Texas				

Overall, except for Drinking Water and UIC, the Texas water quality programs rely little on general fund dollars, focusing more on permit fees and grants. For the TCEQ and RCT budgets, only 15.5% of funding comes from general funds.

Utah

The Utah Department of Environmental Quality, Division of Water Quality (UDWQ) responded with a variety of information on funding sources for various programs.

- GPP: The UDWQ's groundwater program charges annual permit fees and an hourly fee for permit modifications and/or renewals. This includes the Underground Injection Control (UIC) program. Fees are only a portion of the revenue required for program support.
- SWPP: UDWQ charges annual permit fees. Fees are only a portion of the revenue required for program support. UDWQ does not charge a fee for monitoring.
- SWMIP: UDWQ does not charge a fee for Standards, TMDL or monitoring related services and/or programs.

- DWP: UDWG does not oversee any drinking water programs. The Utah Division of Drinking Water is responsible for the program.

A summary of funding sources for water quality programs is provided below. **General fund dollars account for 25% of total funds with about 18% coming from fees. SWPP relies primarily on fees with remaining support coming from grants.**

Utah Department of Environmental Quality
Division of Water Quality

Program	Fees	Gen Fund	Grants & Other Funds	Total
GPP	$323,200	$212,800	$75,900	$611,900
SWPP	$1,628,600	$0	$911,300	$2,539,900
Compliance & Enforcement (GPP/SWPP)	$154,400	$74,200	$403,300	$631,900
SWMIP	$0	$569,900	$3,198,800	$3,768,700
Drinking Water	$743,300	$2,983,700	$4,277,700	$8,004,700
Totals	**$2,849,500**	**$3,840,600**	**$8,867,000**	**$15,557,100**

Program	Fees	Gen Fund	Grants & Other Funds	Total
GPP	52.8%	34.8%	12.4%	100.0%
SWPP	64.1%	0.0%	35.9%	100.0%
Compliance & Enforcement (GPP/SWPP)	24.4%	11.7%	63.8%	100.0%
SWMIP	0.0%	15.1%	84.9%	100.0%
Drinking Water	9.3%	37.3%	53.4%	100.0%
Totals	**18.3%**	**24.7%**	**57.0%**	**100.0%**

Source: Utah Department of Environmental Quality

Summary

The following chart outlines the bottom-line comparison of funding sources among competitor states and Arizona. Georgia has been excluded from the summary percentages below because it is the outlier since it does not charge any permit fees. Findings of the benchmarking survey are:

- Arizona stands alone among competitor states with its policy of allocating no general fund dollars to water quality programs. Nevada is the only other state that is most closely aligned with this policy.
- The use of general fund dollars for water quality programs is the norm at an average of 16% of total funds (excluding Georgia).
- The average percentage of program funding from permit fees among the competitive states is 53% (excluding Georgia). Arizona is below the average; only 36% of its water quality program funding comes from fees.

- Georgia is the sole competitor state that does not charge any permit fees, instead relying on a significant general fund allocation for water quality programs.

Summary of Percentage of Funding Sources - Competitor States Water Quality Programs				
State	Fees	Gen Fund	Grants & Other Funds	Total
Colorado	49.4%	33.1%	17.4%	100.0%
Georgia	0.0%	43.4%	56.6%	100.0%
Nevada	65.1%	0.3%	34.5%	100.0%
Texas TCEQ & RCT UIC Budget	78.4%	6.6%	15.0%	100.0%
Utah	18.3%	24.7%	57.0%	100.0%
Average Percentage - Competitor States Excluding Georgia	52.8%	16.2%	31.0%	100.0%
Arizona	36.2%	0.0%	63.8%	100.0%

Appendix

Benchmarking Survey

Background

ADEQ has contracted with an external consultant (Elliott D. Pollack & Company) to conduct a benchmarking of peer states to examine the funding structure of certain environmental protection and permitting programs related to water quality in order to examine the viability of supplementing Arizona's fee for service/Federal grant supported model. This could include the potential to increase the fees charged to customers or other sources of revenue from State or customers sources.

Definitions

*For clarity, ADEQ fee funded programs are in **bold** and non-fee funded activities are in italics*

1. Administrative Costs (AC) - State costs not associated with program costs in definitions 2-5, excluding program costs for other environmental protection activities
2. Groundwater Protection Program[1] (GPP)-Permitting program that regulates a discharge to the aquifer or vadose zone; **includes permittee/permit/facility monitoring, compliance assistance, inspection, and enforcement.** Groundwater protection also includes some non-customer oriented programs like *ambient groundwater monitoring and standards development.*
3. Surface Water Protection Program (SWPP)-Permitting program that regulates a discharge to a water of the United States or other surface water; includes **permittee/permit/facility monitoring, compliance assistance, inspection, and enforcement. Includes stormwater permitting and NPDES permitting.**
4. Surface Water Monitoring and Improvement Program (SWMIP) - *a non-permitting program that undertakes TMDL, standards development and non-permit related monitoring*
5. Drinking Water Protection Program (DWP)-**Permitting and/or engineering review program; includes permittee/permit/facility monitoring, compliance assistance, inspection, and enforcement.** Drinking Water Protection also includes some non-customer oriented programs like *technical assistance to systems.*
6. Fee Funded-**Any program where a fee is required of a customer that covers all or part of the agencies cost to administer**
7. Non-Fee Funded-Any program where a fee is NOT required; for ADEQ, those programs are;
    - *GPP-Ambient groundwater monitoring and groundwater standards development.*
    - *SWMIP-TMDL, standards development and non-permit related monitoring*
    - *DWP-Technical assistance to systems.*

[1] ADEQ's Groundwater Programs also include reclaimed water and water reuse programs

Questions

1. Do you have fees that cover all or part of the cost of your programs?[2] If so, do those fees reliably cover the cost of that program as defined in definitions 2-5? Do they cover the same, similar fee funded elements as described in definitions 2-5?
    - GPP
    - SWPP
    - SWMIP
    - DWP
2. Regardless of the availability of fee revenue, does your State subsidize the cost of these programs in other ways? If so, how?[3]
    - GPP
    - SWPP
    - SWMIP
    - DWP
3. Do fees or these other sources of revenue cover the entire cost of your programs? If not, how do you fund those programs?
    - GPP
    - SWPP
    - SWMIP
    - DWP
4. Are revenue and cost estimates for the next # fiscal years available?
5. Can you supply links to your fee schedules/administrative code/statute for your GPP, SWPP, SWMIP, and DWP programs?
6. Can you supply data on the number of permits issued, by type and revenue?
7. Can you supply data on federal grants, transfer, or State general fund allocations, or any other form of income for your GPP, SWPP, SWMIP, and DWP programs?
8. Can you supply data on the costs of your GPP, SWPP, SWMIP, and DWP programs? Total budget?
9. Is the State considering adding or amending your fee funded program?

[2] Does another unit/section/division/department of the State government administer that program?

[3] For example; State budget allocation, transfer, Federal Grant, etc.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
Title 9, Chapter 22, Article 19

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

MEETING DATE: **Aug 1, 2023**

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

FROM: Council Staff

DATE: **July 6, 2023**

SUBJECT: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**
Title 9, Chapter 22, Article 19

Summary

This Five Year Review Report (5YRR) from Arizona Health Care Cost Containment System (AHCCCS) or (Administration), covers sixteen (16) rules in Title 9, Chapter 22, Article 19. AHCCCS, is Arizona's Medicaid program designed to deliver quality health care under managed care. The Freedom to Work program is a program that provides health coverage to working people with disabilities in Arizona who are not otherwise eligible for AHCCCS. People in the Freedom to Work program get full AHCCCS coverage in exchange for a monthly premium. The program pays for the same services that standard AHCCCS covers, including visits to the doctor, hospital stays, medical equipment, home care services, and mental health services.

Proposed Action

The Administration has initiated the rulemaking process to fix all of the issues outlined in this report and to bring the language of the rules into alignment with policy. An exception to the Moratorium was received from the Governor's Office on May 23, 2023

1. **Has the agency analyzed whether the rules are authorized by statute?**

The Administration cites both general and specific statutory authority for these rules.

2. **Summary of the agency's economic impact comparison and identification of stakeholders:**

The Administration states that the economic impact of this chapter remains the same as the prior five-year review. The Administration also indicates that none of the proposed changes in the review have any effect on the economic impact of this chapter. In a prior EIS the Administration identifies stakeholders as the Administration, applicants and taxpayers.

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 Administration indicates that the proposed changes in the five-year review are meant for clarifying purposes and do not impose any additional burdens or cost on regulated persons. In addition, the Administration states that they impose the least burden and cost to achieve the same benefits as the Article currently provides regulated person.

4. **Has the agency received any written criticisms of the rules over the last five years?**

The Administration states they have not received any written criticisms of the rules in the last five years.

5. **Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Administration indicates that the rules are not clear, concise, or understandable for reasons such as incorrect cross references, incorrect statute references, and incorrect terminology used in the rules.

6. **Has the agency analyzed the rules' consistency with other rules and statutes?**

The Administration indicates that the rules are not consistent with other rules and statutes for reasons such as incorrect cross references, incorrect statute references, and incorrect terminology used in the rules.

7. **Has the agency analyzed the rules' effectiveness in achieving its objectives?**

The Administration indicates that the rules are not effective in achieving its objectives for reasons such as incorrect cross references, incorrect statute references, and incorrect terminology used in the rules.

8. **Has the agency analyzed the current enforcement status of the rules?**

The Administration indicates that the rules are not enforced as written for reasons such as incorrect statute references and incorrect terminology used in the rules.

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 Administration states that 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?**

The Administration states that this section is not applicable.

11. **Conclusion**

As indicated above, the rules are not clear, concise, or understandable and are not effective in achieving their objectives. The Administration has initiated the rulemaking process by requesting and receiving approval from the Governor's Office from the rulemaking moratorium. The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Council staff recommends approval.

AHCCCS
Arizona Health Care Cost Containment System

Katie Hobbs, Governor
Carmen Heredia, Director

May 30, 2023

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 19;

Dear Ms. Sornsin:

Please find enclosed AHCCCS's Five-Year Review Report for Title 9, Chapter 22, Article 19 due on May 30, 2023.

AHCCCS hereby certifies compliance with A.R.S. § 41-1091.

For questions about this report, please contact me or Sladjana Kuzmanovic at 602-417-4116 or sladjana.kuzmanovic@azahcccs.gov.

Sincerely,

Nicole Fries
Deputy General Counsel
Office of the General Counsel

Attachments

Arizona Health Care Cost Containment System

(AHCCCS)

5 YEAR REVIEW REPORT

A.A.C. Title 9, Chapter 22, Article 19

May 2023

1. Authorization of the rule by existing statutes

General Statutory Authority: A.R.S. § 36-2903.01.

Specific Statutory Authority: A.R.S. § 36-2929.

2. The objective of each rule:

Rule	Objective
R9-22-1901	Provides general requirements for the Freedom to Work (FTW) program.
R9-22-1902	Provides the general administrative requirements regarding confidentiality.
R9-22-1903	Describes the application process to apply for the FTW program.
R9-22-1904	Describes the required notification in writing regarding the determination of eligibility for the FTW program.
R9-22-1905	References R9-22-1501(H) as the changes a member must report.
R9-22-1906	Describes when eligibility for FTW can change or be affected.
R9-22-1907	Describes when the Administration may notify a member of an action.
R9-22-1908	Provides the option for a member to request a hearing.
R9-22-1909	Describes conditions that must be met to be eligible for the FTW program.
R9-22-1910	Provides prior quarter coverage under the FTW program.
R9-22-1913	Describes the premium requirement that a member must pay when qualified for FTW.
R9-22-1915	Describes the exclusions from eligibility for certain institutionalized persons.
R9-22-1918	Describes additional eligibility criteria for the Basic Coverage Group.
R9-22-1919	Describes additional eligibility criteria for the Medically Improved Group.
R9-22-1921	Describes the enrollment requirements for a member.
R9-22-1922	Describes when a redetermination of eligibility for FTW must be conducted.

3. Are the rules effective in achieving their objectives? **Yes** __ **No** X

Rule	Explanation
R9-22-1903	Cross reference to R9-22-1406 in Subsection C should be changed to R9-22-302 since the relevant information in the rule was moved.
R9-22-1904	Cross reference to R9-22-1501(G) should be changed to R9-22-307 since the relevant information in the rule was moved.

R9-22-1905	Cross reference to R9-22-1501(H) should be changed to R9-22-306 since the relevant information in the rule was moved.
R9-22-1907	Cross reference to R9-22-1501(K) should be changed to R9-22-312 since the relevant information in the rule was moved.
R9-22-1909	Cross reference to R9-22-1502 should be changed to R9-22-306 since the relevant information in the rule was moved.
R9-22-1913	Update Subsection B to read: The Administration shall process premiums under 9 A.A.C. 31, Articles 1409 – 1419.
R9-22-1915	Update Subsection 2 to read: Age 22 through age 64 and is residing in an ICF/IID except when allowed under the Administration's Section 1115 IMD waiver or allowed under a managed care contract approved by CMS.
R9-22-1919	Update Subsection 3 to read: Continues to have a severe medically determinable impairment, as determined under 42 U.S.C. 1396d(v)(1).
R9-22-1922	Update Subsection B to read: Change in circumstance. The Administration shall complete a redetermination of eligibility if there is a change in the member's circumstances, including a change in disability or employment that may affect eligibility.

4. Are the rules consistent with other rules and statutes? **Yes ___** **No X**

Rule	Explanation
R9-22-1901	Remove federal citation because all of the provisions of the cited statute are included in the text of the rules, incorporation by reference is not needed.
R9-22-1903	Cross reference to R9-22-1406 in Subsection C should be changed to R9-22-302 since the relevant information in the rule was moved.
R9-22-1904	Cross reference to R9-22-1501(G) should be changed to R9-22-307 since the relevant information in the rule was moved.
R9-22-1905	Cross reference to R9-22-1501(H) should be changed to R9-22-306 since the relevant information in the rule was moved.
R9-22-1907	Cross reference to R9-22-1501(K) should be changed to R9-22-312 since the relevant information in the rule was moved.
R9-22-1909	Cross reference to R9-22-1502 should be changed to R9-22-306 since the relevant information in the rule was moved.
R9-22-1913	Update Subsection B to read:

	The Administration shall process premiums under 9 A.A.C. 31, Articles 1409 – 1419.
R9-22-1915	Update Subsection 2 to read: Age 22 through age 64 and is residing in an ICF/IID except when allowed under the Administration's Section 1115 IMD waiver or allowed under a managed care contract approved by CMS.
R9-22-1919	Update Subsection 3 to read: Continues to have a severe medically determinable impairment, as determined under 42 U.S.C. 1396d(v)(1).
R9-22-1922	Update Subsection B to read: Change in circumstance. The Administration shall complete a redetermination of eligibility if there is a change in the member's circumstances, including a change in disability or employment that may affect eligibility.

5. Are the rules enforced as written? **Yes ___** **No X**

Rule	Explanation
R9-22-1913	Update Subsection B to read: The Administration shall process premiums under 9 A.A.C. 31, Articles 1409 – 1419.
R9-22-1915	Update Subsection 2 to read: Age 22 through age 64 and is residing in an ICF/IID except when allowed under the Administration's Section 1115 IMD waiver or allowed under a managed care contract approved by CMS.
R9-22-1919	Update Subsection 3 to read: Continues to have a severe medically determinable impairment, as determined under 42 U.S.C. 1396d(v)(1).
R9-22-1922	Update Subsection B to read: Change in circumstance. The Administration shall complete a redetermination of eligibility if there is a change in the member's circumstances, including a change in disability or employment that may affect eligibility.

6. Are the rules clear, concise, and understandable? **Yes __** **No X**

Rule	Explanation
R9-22-1901	Remove federal citation because all of the provisions of the cited statute are included in the text of the rules, incorporation by reference is not needed.
R9-22-1903	Cross reference to R9-22-1406 in Subsection C should be changed to R9-22-302 since the relevant information in the rule was moved.

R9-22-1904	Cross reference to R9-22-1501(G) should be changed to R9-22-307 since the relevant information in the rule was moved.
R9-22-1905	Cross reference to R9-22-1501(H) should be changed to R9-22-306 since the relevant information in the rule was moved.
R9-22-1907	Cross reference to R9-22-1501(K) should be changed to R9-22-312 since the relevant information in the rule was moved.
R9-22-1909	Cross reference to R9-22-1502 should be changed to R9-22-306 since the relevant information in the rule was moved.
R9-22-1913	Update Subsection B to read: The Administration shall process premiums under 9 A.A.C. 31, Articles 1409 – 1419.
R9-22-1915	Update Subsection 2 to read: Age 22 through age 64 and is residing in an ICF/IID except when allowed under the Administration's Section 1115 IMD waiver or allowed under a managed care contract approved by CMS.
R9-22-1919	Update Subsection 3 to read: Continues to have a severe medically determinable impairment, as determined under 42 U.S.C. 1396d(v)(1).
R9-22-1922	Update Subsection B to read: Change in circumstance. The Administration shall complete a redetermination of eligibility if there is a change in the member's circumstances, including a change in disability or employment that may affect eligibility. This change is required because the Administration is bound to re-determine eligibility if certain factors call into question a member's possibility of being in the FTW program.

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:

None of the changes proposed in this 5YRR have any effect on the economic impact of this chapter. Substantive and procedural rights of members are not affected, nor are any of the programs of the Administration. These proposed changes are merely clarifying; therefore the economic impact of this chapter remains the same as the prior 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?

The Administration has requested an exemption from the statutory rulemaking moratorium, and it was approved by the Governor's office on May 23, 2023. AHCCCS is currently drafting the Notice of Proposed Rulemaking and will submit it to the Secretary of State's office for publication as soon as possible. The Administration anticipates being able to supplement this filing with the filed Notice of Proposed Rulemaking in advance of the Council's Study Session.

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 changes that are proposed in this 5YRR are meant for clarifying purposes and do not impose any additional burdens or costs on regulated persons. In addition, they are they impost the least burden and cost to achieve the same benefits as the Article currently provides to regulated persons.

12. Are the rules more stringent than corresponding federal laws? Yes ___ No X

The rules are not more stringent than 42 U.S.C. 1396, 42 U.S.C. 1382a and 20 C.F.R. Parts 416, 435.1009, 431.231.

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 Administration has initiated making all of the changes outlined in this report in the Notice of Proposed Rulemaking to bring the language of the rules into alignment with policy, as well as improving clarity and conciseness. As noted above, the Administration anticipates being able to supplement this filing with the filed Notice of Proposed Rulemaking in advance of the Council's Study Session.

ARTICLE 18. RESERVED

ARTICLE 19. FREEDOM TO WORK

Article 19, consisting of Sections R9-22-1901 through R9-22-1922, made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1901. General Freedom to Work Requirements

Under 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI), the Administration shall determine eligibility for AHCCCS medical services, under Article 2 of this Chapter, using the eligibility criteria and requirements under this Article for an applicant or member who is:

1. At least 16 years of age, but less than 65 years of age,
2. Employed, and
3. Not income eligible under A.R.S. § 36-2901(6)(a).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1902. General Administration Requirements

The Administration shall comply with the confidentiality rule under R9-22-512(C).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1903. Application for Coverage

A. A person may apply by submitting an application to an Administration office.

B. The application date is the date the application is received at an Administration office or outstation location approved by the Director as described under R9-22-1406(A).

C. The provisions in R9-22-1406(B) and (D) apply to this Section.

D. The applicant or representative who files the application may withdraw the application for coverage either orally or in writing. An applicant withdrawing an application shall receive a denial notice under R9-22-1904.

E. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 45 days.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1904. Notice of Approval or Denial

The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the action, and:

1. If approved, the notice shall contain:
   a. The effective date of eligibility,
   b. The amount the person shall pay, and
   c. An explanation of the person's hearing rights specified in 9 A.A.C. 34.
2. If denied, R9-22-1501(G)(3) applies.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1905. Reporting and Verifying Changes

An applicant or member shall report and verify changes, as described under R9-22-1501(H), to the Administration.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1906. Actions that Result from a Redetermination or Change

The processing of a redetermination or change shall result in one of the following actions:

1. No change in eligibility or premium,
2. Discontinuance of eligibility if a condition of eligibility is no longer met,
3. A change in premium amount, or
4. A change in the coverage group under which a person receives AHCCCS medical coverage.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1907. Notice of Adverse Action Requirements

A. The requirements under R9-22-1501(K)(1) apply.

B. Advance notice of a change in eligibility or premium amount. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (C), advance notice shall be issued whenever an adverse action is taken to discontinue eligibility, or increase the premium amount.

C. Exceptions from advance notice. A notice shall be issued to the member to discontinue eligibility no later than the effective date of action if:

1. A member provides a clearly written statement, signed by that member, that services are no longer wanted.
2. A member provides information that requires termination of eligibility or reduction of services, indicates that the member understands that this must be the result of supplying that information, and the member signs a written statement waiving advance notice;
3. A member cannot be located and mail sent to the member's last known address has been returned as undeliverable subject to reinstatement of discontinued services under 42 CFR 431.231(d);
4. A member has been admitted to a public institution where a person is ineligible for coverage;
5. A member has been approved for Medicaid in another state; or
6. The Administration receives information confirming the death of a member.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1908. Request for Hearing

An applicant or member may request a hearing under 9 A.A.C. 34.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1909. Conditions of Eligibility

An applicant or member shall meet the following conditions to qualify for the Freedom to Work program:

1. Furnish a valid Social Security Number (SSN);
2. Be a resident of Arizona;
3. Be a citizen of the United States, or meet requirements for a qualified alien under A.R.S. § 36-2903.03(B);
4. Be at least 16 years of age, but less than 65 years of age;
5. Have countable income that does not exceed 250 percent of FPL. The Administration shall count the income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K with the following exceptions:
   a. The unearned income of the applicant or member shall be disregarded,
   b. The income of a spouse or other family member shall be disregarded, and
   c. The deduction for a minor child shall not apply;
6. Comply with the member responsibility provisions under R9-22-1502(D) and (F).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Section repealed; new Section made by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1910. Prior Quarter Eligibility

A person may be made eligible during a prior quarter period when applying for the Freedom to Work program, as described under Article 3.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). New Section made by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

R9-22-1911. Repealed

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1912. Repealed

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1913. Premium Requirements

A. As a condition of eligibility, an applicant or member shall:
   1. Pay the premium required under subsection (B).
   2. Not have any unpaid premiums for more than one month's premium amount.

B. The Administration shall process premiums under 9 A.A.C. 31, Article 14 with the following exceptions:
   1. A member who has countable income:
      a. Under $500, the monthly premium payment shall be $0.
      b. Over $500 but not greater than $750, the monthly premium payment shall be $10.
   2. The premium for a member shall be increased by $5 for each $250 increase in countable income above $750.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1914. Repealed

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1915. Institutionalized Person

A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution if federal financial participation (FFP) is not available, or
2. Age 21 through age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except when allowed under the Administration's Section 1115 IMD waiver or allowed under a managed care contract approved by CMS.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1916. Repealed

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1917. Repealed

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1918. Additional Eligibility Criteria for the Basic Coverage Group

An applicant or member shall meet the following eligibility criteria:

1. Disabled. As a condition of eligibility, an applicant or member shall be disabled. Disabled means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E), except employment activity, earnings, and substantial gainful activity shall not be considered in determining whether the individual meets the definition of disability.
2. Employed. As a condition of eligibility, an applicant or member shall be employed. Employed means that an applicant or member is paid for working and Social Security or Medicare taxes are paid on the applicant or member's work.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1919. Additional Eligibility Criteria for the Medically Improved Group

As a condition of eligibility for the Medically Improved Group, a member shall:

1. Be employed. Under this Section, employed means an individual who:
   a. Earns at least the minimum wage and works at least 40 hours per month, or
   b. Has gross monthly earnings at least equal to those earned by an individual who is earning the minimum wage working 40 hours per month.
2. Cease to be eligible for medical coverage under R9-22-1918 or a similar Basic Coverage Group program administered by another state because the member, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be disabled; and
3. Continues to have a severe medically determinable impairment, as determined under Social Security Act section 1902(a)(10)(A)(ii)(XVI).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1920. Repealed

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1921. Enrollment

The Administration shall enroll members under Article 17 of this Chapter. If a member has not paid a required premium, the Administration shall not grant a guaranteed enrollment period.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1922. Redetermination of Eligibility

A. Redetermination. Except as provided in subsection (B), the Administration shall complete a redetermination of eligibility at least once a year.

B. Change in circumstance. The Administration may complete a redetermination of eligibility if there is a change in the member's circumstances, including a change in disability or employment that may affect eligibility.

C. Medical Improvement. If a member is no longer disabled under R9-22-1918, the Administration shall determine if the member is eligible under other coverage groups including the medically improved group.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

ARTICLE 20. BREAST AND CERVICAL CANCER TREATMENT PROGRAM

R9-22-2001. Breast and Cervical Cancer Treatment Program Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meaning unless the context explicitly requires another meaning:

"AZ-NBCCEDP" means the Arizona programs of the National Breast and Cervical Cancer Early Detection Program. AZ-NBCCEDP provides breast and cervical cancer screening and diagnosis in Arizona.

"Cryotherapy" means the destruction of abnormal tissue using an extremely cold temperature.

"LEEP" means the loop electrosurgical excision procedure that passes an electric current through a thin wire loop.

"Peer-reviewed study" means that, prior to publication, a medical study has been subjected to the review of medical experts who:

Have expertise in the subject matter of the study,
Evaluate the science and methodology of the study,
Are selected by the editorial staff of the publication, and
Review the study without knowledge of the identity or qualifications of the author.

"WWHP" means the Well Women Healthcheck Program administered by the Arizona Department of Health Services. The WWHP is one of the programs within AZ-NBCCEDP that provides breast and cervical cancer screening and diagnosis.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2002. General Requirements

A. Confidentiality. The Administration shall maintain the confidentiality of a woman's records and shall not disclose a woman's financial, medical, or other confidential information except as allowed under R9-22-512.

B. Covered services. A woman who is eligible under this Article receives all medically necessary services under Articles 2 and 12 of this Chapter.

C. Choice of health plan. A woman who is eligible under this Article shall be enrolled with a contractor under Article 17 of this Chapter.

D. A Native American woman who receives services through Indian Health Service (IHS) or through a tribal health program qualifies for services provided under this Article if all eligibility requirements are met.

E. A woman qualified under this Article shall pay co-pays as described in R9-22-711.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2003. Eligibility Criteria

A. General. To be eligible under this Article, a woman shall meet the requirements of this Article and:

1. Be screened for breast and cervical cancer through AZ-NBCCEDP;
2. Be less than 65 years of age;
3. Be ineligible for Title XIX under Articles 14 and 15 in this Chapter;
4. Receive a positive screen under subsection (A)(1), a confirmed diagnosis through AZ-NBCCEDP, and need treatment for breast cancer or cervical cancer, including a precancerous cervical lesion, as specified in R9-22-2004;
5. Not be covered under creditable coverage as specified in Section 2701(c) of the Public Health Services Act, 42 U.S.C. 300gg(c). For purposes of this Article, IHS or Tribal health coverage is not considered creditable coverage as specified in 42 U.S.C. 1396a(a)(10)(A)(ii), as amended by the Native American Breast and Cervical

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 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.

36-2929. Services to persons with disabilities; eligibility; premiums

A. Subject to the approval of the centers for medicare and medicaid services, beginning on January 1, 2002, the Arizona health care cost containment system administration shall provide services pursuant to this article to any person with a disability who is defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (g), who meets the income requirements of subsection B of this section and who has too much income to qualify for the system pursuant to section 36-2901, paragraph 6, subdivision (a).

B. A person meets the income requirements of this section if the person's countable income does not exceed two hundred fifty per cent of the federal poverty guidelines. The administration shall use the supplemental security income methodology. For the purposes of this subsection, countable income does not include the person's unearned income, the person's spouse's or any other family member's earned or unearned income or a deduction for a minor child.

C. The administration shall adopt rules for the collection of premiums from persons who qualify for services pursuant to this section. The premium shall not exceed two per cent of the person’s countable income.

D. The administration shall develop and implement a process for eligibility determinations for persons who apply for eligibility and annual redeterminations for continued eligibility. The administration shall also develop and implement a process to determine medically improved disabilities. The administration may enter into an intergovernmental agreement with the department of economic security or may contract with participating health plans to conduct eligibility determinations or redeterminations. The administration may not use a resource test to determine or redetermine eligibility.

DEPARTMENT OF HEALTH SERVICES
Title 9, Chapter 10, Article 1

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

MEETING DATE: August 1, 2023

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

FROM: Council Staff

DATE: **July 13, 2023**

SUBJECT: **Arizona Department of Health Services**
Title 9, Chapter 10, Article 1

This Five-Year-Review Report from the Department of Health Services relates to rules in Title 9, Chapter 10, Article 1, regarding health care institutions licensing.

In the last 5YRR of these rules, the Department proposed to amend several of its rules. The Department completed the changes through final rulemaking effective October 1, 2019.

Proposed Action

The Department is proposing to amend several of its rules in order to make them more clear, concise, understandable, effective, and consistent with other rules and statutes. The Department indicates they plan to submit a Notice of Final Rulemaking to the Council by February 2024.

1. Has the agency analyzed whether the rules are authorized by statute?

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

2. Summary of the agency's economic impact comparison and identification of stakeholders:

The Department indicates that the rules establish minimum standards for the construction, modification, and licensure of health care institutions necessary to ensure the public health, safety, and welfare. The Department currently licenses nearly 8,000 facilities as one of 27 classes/subclasses of health care institutions under the rules in 9 A.A.C. 10, Article 1. The Department states the rules have been revised 9 times in the past five years. The Department estimates that the actual costs and benefits experienced by persons affected by the rules are generally consistent with the costs and benefits considered in developing the rules.

Stakeholders include the Department, health care institutions licensed under the rules, medical practitioners in licensed health care institutions, personnel members in licensed care institutions, patients, residents, participants, recipients and their families, and the general public. In addition, architects, contractors, and engineers involved in the construction or modification of a health care institution are also stakeholders for R9-10-104 and R9-10-104.01. The Arizona Health Care Cost Containment System (AHCCCS) is also a stakeholder for R9-10-112.

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 has determined that the rules impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.

4. Has the agency received any written criticisms of the rules over the last five years?

Yes, the Department two comments regarding two rules from Maricopa County Planning and Developing and from Arizona Building Officials. The Department adequately addressed the comments, and are proposing to amend the rules in response.

5. Has the agency analyzed the rules' clarity, conciseness, and understandability?

Yes, the Department indicates the rules are overall clear, concise, and understandable with the exception of the following:

R9-10-101 - Definitions
R9-10-105 - License Application
R9-10-106 - Fees
R9-10-121 - Disease Prevention and Control

6. Has the agency analyzed the rules' consistency with other rules and statutes?

Yes, the Department indicates the rules are overall consistent with other rules and statutes with the exception of the following:

R9-10-101 - Definitions
R9-10-102 - Health Care Institution Classes and Subclasses; Requirement
R9-10-104 - Approval of Architectural Plans and Specifications
R9-10-105 - License Application
R9-10-106 - Fees
R9-10-108 - Time-Frames
R9-10-109 - Changes Affecting a License
R9-10-110 - Modification of a Health Care Institution
R9-10-120 - Opioid Prescribing and Treatment

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:

R9-10-112 - Denial, Revocation, or Suspension of License

8. Has the agency analyzed the current enforcement status of the rules?

Yes, the Department 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, there are no corresponding federal laws to the 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?

Yes, the rules indicate the rules require the issuance of specific authorization authorized by A.R.S. 36-405, and a general permit is not applicable.

11. Conclusion

As mentioned above, the Department is proposing to amend several of its rules in order to make them clear, concise, understandable, effective, and consistent with other rules and statutes. The Department plans to submit a Notice of Final Rulemaking to the Council by February 2024.

Council staff recommends approval of this report.

ARIZONA DEPARTMENT
OF HEALTH SERVICES

May 23, 2023

VIA: E-MAIL: grrc@azdoa.gov
Nicole Sornsin, Chairperson
Governor's Regulatory Review Council
Arizona Department of Administration
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

RE: ADHS, A.A.C. Title 9, Chapter 10, Article 1 Five Year Review Report

Dear Ms. Sornsin:

Please find enclosed the Five-Year Review Report from the Arizona Department of Health Services (Department) for A.A.C. Title 9, Chapter 10 Health Care Institutions, Article 1 General which is due on May 31, 2023.

The Department reviewed the following rules in A.A.C. Title 9, Chapter 10, Article 1 with the intention that those rules do not expire under A.R.S. § 41-1056(J).

The Department hereby certifies compliance with A.R.S. § 41-1091.

For questions about this report, please contact Emily Carey at 602-542-5121 or emily.carey@azdhs.gov.

Sincerely,

Stacie Gravito
Director's Designee

Enclosures

ARIZONA DEPARTMENT OF HEALTH SERVICES

Arizona Department of Health Services

Five-Year-Review Report

Title 9. Health Services

Chapter 10. Department of Health Services – Health Care Institutions: Licensing

Article 1. General

May 2023

1. Authorization of the rule by existing statutes:

Authorizing statutes: A.R.S. §§ 36-132(A)(17), and 36-136(G)

Implementing statutes: A.R.S. §§ 36-405, 36-406, and 36-430

In addition, the following rules have additional specific statutory authority:

Rule	Statutory Authority
R9-10-104	A.R.S. §§ 36-421 and 36-422
R9-10-105	A.R.S. §§ 36-407, 36-421, 36-422, 36-424, and 36-425
R9-10-106	A.R.S. § 36-405(B)(5)
R9-10-107	A.R.S. §§ 36-407, 36-422, and 36-425
R9-10-108	A.R.S. §§ 41-1073 through 41-1076, and 41-1079
R9-10-109	A.R.S. §§ 36-407, 36-422, and 36-425
R9-10-110	A.R.S. §§ 36-407, 36-421, and 36-422
R9-10-111	A.R.S. §§ 36-424, 36-425, 36-427, and 36-429
R9-10-112	A.R.S. §§ 36-424, 36-425, 36-427, 36-429, and 36-2901.08
R9-10-113	A.R.S. § 36-136(I)(1)
R9-10-114	A.R.S. § 36-423
R9-10-116	A.R.S. § 36-413
R9-10-119	A.R.S. § 36-2161

2. The objective of each rule:

Rule	Objective
R9-10-101	To define terms used in 9 Arizona Administrative Code (A.A.C.) 10 so that a reader can consistently interpret requirements in the Chapter.
R9-10-102	To identify the classes and subclasses under which a health care institution may apply for a license; and To require a health care institution to comply with the requirements in Article 17 if there are no specific rules in 9 A.A.C. 10 for the health care institution's class or subclass, or if the Department determines that the health care institution is an unclassified health care institution.
R9-10-103	To establish exceptions to health care institution licensing requirements for certain health care institutions or parts of health care institutions; and

	To identify when a hospital and its facilities do not require separate health care institution licenses.
R9-10-104	To establish requirements for an application for approval of architectural plans and specifications for construction or modification of a health care institution required to comply with any physical plant codes and standards in A.A.C. R9-1-412; To specify that an applicant may request an architectural evaluation from the Department; To require the Department to approve or deny architectural plans and specifications for a health care institution according to R9-10-108; and To clarify that obtaining Departmental approval of applicable architectural plans and specifications is a part of, but does not replace, the requirement to obtain a health care institution license before operating a health care institution.
R9-10-105	To establish initial license application requirements for health care institutions, including information regarding the health care institution's location, contact information, class or subclass, owner, governing authority, chief administrative officer, and physical plant; and To require a health care institution to comply with the initial application requirements in 9 A.A.C. 10 for the class or subclass for which licensure is requested.
R9-10-106	To establish a range of fees that the Department collects for licensing of health care institutions.
R9-10-107	To establish renewal license application requirements for health care institutions, including information regarding the health care institution's location, contact information, class or subclass, owner, governing authority, chief administrative officer, and physical plant; and To establish criteria for when a license is issued for a one-year or two-year period or for the duration of an accreditation period.
R9-10-108	To delineate time-frames for the Department to grant or deny an initial or a renewal license, or grant or deny approval of an application from a health care institution.
Table 1.1	To specify time-frames for the Department’s review of architectural plans and specifications, an initial or a renewal license, or an application for a modification for a health care institution.
R9-10-109	To establish which changes to a health care institution, require a licensee to notify the Department; To establish the information a licensee or a health care institution's governing authority is required to provide to the Department when a change specified in the rule occurs; To establish notification requirements for an adult behavioral health therapeutic home, a behavioral health respite home, an affiliated outpatient treatment center, or a counseling facility; To specify when a new initial license application is required and when documentation of a health care institution's architectural plans and specifications are not required to be submitted with an initial application; To require the Department to approve or deny a request for a change in services or modification of a health care institution according to R9-10-108; and To prohibit a licensee from implementing a change or modification described in the rule until an approved or amended license is issued by the Department.
R9-10-110	To specify when a health care institution is required to submit an application for approval of architectural plans and specifications for a modification to the Department, To establish the documentation a licensee is required to submit to the Department when requesting approval of a modification, To require the Department to approve or deny a request for a modification according to R9-10-108, and

	To prohibit a licensee from implementing a modification described in the rule until an approval or amended license is issued by the Department.
R9-10-111	To establish the actions that the Department may take if an applicant or licensee is not in substantial compliance with applicable rules, and To establish the factors that the Department will consider in determining the appropriate enforcement action.
R9-10-112	To establish the circumstances under which the Department may deny, revoke, or suspend a license to operate a health care institution for an applicant, licensee, or controlling person of the health care institution.
R9-10-113	To establish requirements related to screening for tuberculosis.
R9-10-114	To establish clinical practice restrictions for a hemodialysis technician trainee working in a health care institution.
R9-10-115	To establish requirements for a health care institution using behavioral health technicians or behavioral health paraprofessionals for providing services to patients of the health care institution.
R9-10-116	To establish requirements related to the approval and operation of a nutrition and feeding assistant training program.
R9-10-118	To establish requirements for a collaborating health care institution related to documentation and to the collaborating health care institution's responsibilities for patients referred by the collaborating health care institution to an adult behavioral health therapeutic home or a behavioral health respite home.
R9-10-119	To clarify the abortion reporting requirements in A.R.S. § 36-2161, and To specify situations where a transfer of custody of fetal tissue would require reporting and when it would not require reporting.
R9-10-120	To establish requirements for a health care institution related to prescribing, ordering, or administering opioids as part of treatment.
R9-10-121	To establish requirements for a health care institution related to disease prevention and control.

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.

Rule	Explanation
R9-10-112	The rule could be more effective if the circumstances of when the Department may deny, revoke, or suspend a license to operate a health care institution were reviewed and potentially expanded in regards to health care institutions that have been operating without seeing a patient within twelve months to assist in protecting the health and safety of the public.

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.

Rule	Explanation

R9-10-101	The rule is consistent with other rules and statutes, however the definition in subsection (232) regarding "telemedicine" could be amended to adhere to the statutory change that occurred based on Laws 2021, Ch. 320, which amended A.R.S. § 36-3601 revising the definition and use of the term "telemedicine" to "telehealth."
R9-10-102	The rule could be improved by adding in an exemption for the subclass of outpatient treatment centers specified by Laws 2022, Ch. 128, that allow exemptions for licensing requirements of specified outpatient treatment centers that have the same governing authority as a hospital licensed pursuant to A.R.S. Title 36, Chapter 4. In addition, the rule could be amended to add in a subclass of a health care institution for a secured behavioral health residential facility to align more with Laws 2022, Ch. 352. In addition, Laws 2022, Ch. 352 amends A.R.S. § 36-425.06 to add in another commitment court order for admission to a licensed secure behavioral health residential facility. The Department believes that adding in another subclass for secure behavioral health residential facilities will make the rules clearer, and more understandable.
R9-10-104, R9-10-108, & R9-10-110	The rule could be improved to align more with Laws 2022, Ch. 34, by removing sections related to the approval of architectural plans and specifications that an applicant must submit if the health care institution is constructing or modifying due to the legislation requiring a notarized attestation from an architect registered pursuant to A.R.S. Title 32, Chapter 1. The submission of the architectural plans and specifications for this type of change will no longer be required, therefore the rules should be amended to include the requirement of a notarized attestation from an architect.
R9-10-105	The rule is consistent with other rules and statutes, however may be amended to include language for the exception of nursing supported group homes in the license application to be aligned with other rules. Laws 2021, Ch. 60 added an exception for nursing supported group homes in licensing applications in A.R.S. § 36-421 that are not required to comply with zoning standards for a health care institution. This change will make the rule clearer and more consistent with other rules and statutes. In addition, the rule could be improved to remove the references to approval of architectural plans and specifications in R9-10-104 in reference to Laws 2022, Ch. 34 now requiring a notarized attestation from an architect for modifications of a health care institution. In addition, the rule would be more effective and consistent with other Department rules, if changes were made to an application to more accurately reflect the types of documentation applicants provide on the license application regarding citizen status if an owner is a sole proprietorship.
R9-10-106, Table 1.1	The rule is consistent with other rules and statutes, however may be amended to be in compliance with Laws 2022, Ch. 34, to remove subsection (A) that relates to the fees associated with the architectural plans and specifications that an applicant must submit if the health care institution is constructing or modifying the facility. Laws 2022 Ch. 34 requires a notarized attestation from an architect registered pursuant to A.R.S. Title 32, Chapter 1 that will verify the architectural plans and specifications meet or exceed the standards adopted by the Department. The submission of the architectural plans and specifications for this type of change will no longer be required pursuant to A.R.S. § 36-405, therefore the fees associated with the changes should be removed from the rules. In addition, the rule could be more effective if the fee amounts were reviewed and potentially changed. For example, an addition of fees associated with issuing a duplicate license, and fees associated with a modification of a health care institution. These changes would be made so the rules could more accurately reflect the costs to the Department, and be more consistent with other rules prescribed by the Department.
R9-10-109	The rule is consistent with other rules and statutes, however may be amended to correct subsection (E) regarding the cross-reference to A.R.S. § 36-424(B). Laws 2021 Ch. 15 amended A.R.S. § 36-424(B) regarding exceptions of health care institutions for inspections, suspensions, or revocations of licenses if a health care institution can provide the appropriate

	documentation to the Department. The subsection should be amended to be aligned with the statute.
R9-10-120	The rule is consistent with other rules and statutes, however may be amended in subsections (D)(1)(b) and (E)(1)(b) to update the statutory reference from A.R.S. § 36-2606(G) to A.R.S. § 36-2606(H) to be consistent with the context of the rules.

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.

Rule	Explanation

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.

Rule	Explanation
Multiple	Several rules contain minor punctuation or grammatical errors that do not affect the meaning of the rule or prevent the rule from being clear, concise, and understandable.
R9-10-101	The rule is clear, concise, and understandable, however definitions (35) and (38) could be amended to be clearer and more understandable.
R9-10-105	The rule is clear, concise, and understandable, but subsection (A)(5) could be amended to correct a grammatical error, and amend language to adhere to changes in R9-10-104. Subsection (A)(2) could also be amended to clarify the documentation that a property owner must provide to the Department, if the health care institution is located on a leased facility.
R9-10-106	The rule is clear, concise, and understandable, however several subsections could be amended to correct subsection cross-references to adhere to the changes of removing subsection (A).
R9-10-121	The rule is clear, concise, and understandable, however, subsection (G)(3) could be amended to remove or correct the website reference to the EPA-approved household disinfectant specified list, as the website link does not provide the list referenced in the rule.

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:

Commenter	Comment	Agency's Response
Maricopa County, Planning and Development	The Department received a written comment to revise the rules in R9-10-104 regarding the fire code reference that is specific to the incorporated reference from 2016. The commenter stated that Maricopa County does not have a fire department, therefore does not adopt a fire code, and follows the local fire authority having jurisdiction. The commenter requests that the Department remove the specific year of the fire code	The Department plans to amend the rules in R9-10-104 to remove the reference to a specific year of the fire code, in order to make the rules clearer, and more effective.

	incorporation in the rules, and amend the rules to state "As adopted by the Office of the State Fire Marshal (OSFM)."	
Arizona Building Officials	The Department received a written suggestion to revise the rules in R9-10-105 regarding the documentation a health care institution must provide in licensing applications for intuitions that not are required to comply with the physical plant codes and standards incorporated in R9-10-104.01. The commenter requests that R9-10-105(A)(5)(b) be amended make the applicant provide on a department provided formatted document from the local jurisdiction of compliance with applicable local building codes and zoning ordinances. The commenter has concerns with the lack of a common State form due to there being inconsistent methods and documents used for customers and applicants, for example, a certificate of occupancy.	The Department plans to amend the rules in R9-10-105 regarding license applications to include the requirement of documentation being completed in a Department-provided format.

8. Economic, small business, and consumer impact comparison (summary):

Arizona Revised Statutes ("A.R.S.") § 36-405(A) requires the Arizona Department of Health Services ("Department") to adopt rules establishing minimum standards and requirements for the construction, modification, and licensure of health care institutions necessary to ensure the public health, safety, and welfare. It further requires that the standards and requirements related to the construction, equipment, sanitation, staffing, and recordkeeping pertaining to the administration of medical, nursing, and personal care services according to generally accepted practices of health care.

The Department currently licenses nearly 8,000 facilities as one of 27 classes/subclasses of health care institutions under the rules in 9 A.A.C. 10, Article 1. As of January 1, 2023, these include: 111 hospitals; 64 behavioral health inpatient facilities; 142 nursing care institutions; five recovery care centers; 17 hospice inpatient facilities; 273 outpatient surgical centers; 2,766 outpatient treatment centers; one behavioral health specialized transitional facility; nine abortion clinics; three substance abuse transitional facilities; 1,017 behavioral health residential facilities; 46 unclassified health care institutions; 413 hospice service agencies; 229 home health agencies; 330 assisted living centers; 1,615 assisted living homes; 37 adult foster care homes; 17 adult day health care facilities; 10 behavioral health respite homes; 58 adult behavioral health therapeutic homes; and 455 counseling facilities. Under R9-10-111 and R9-10-112, the Department has undertaken 1,896 enforcement actions in the past year, resulting in the suspension or revocation of 12 licenses, and $1,444,901 in civil money penalties were assessed.

In the past five years, these rules have been revised 9 times. All of the rules, except R9-10-103 and R9-10-117, were amended through the rulemakings between 2019 and 2022. R9-10-101, R9-10-102, R9-10-106, and R9-10-120 was adopted by regular rulemaking at 24 A.A.R. 3020, effective January 1, 2019. An economic, small business, and consumer impact statement (EIS) was prepared as part of the regular rulemaking for these rules. Annual costs/revenues changes were designated in the EIS for R9-10-101, R9-10-102, R9-10-106, and R9-10-120 as minimal when less than $10,000, moderate when between $10,000 and $50,000, and substantial when greater

than $50,000. A cost was listed as significant when meaningful or important, but not readily subject to quantification. The rules were also amended by regular rulemaking at 25 A.A.R. 1583, effective October 1, 2019, as specified in the EIS, costs were delegated as minimal when $2,000 or less, moderate when between $2,000 and $10,000, and substantial when $10,000 or greater in additional costs or revenues. Lastly, an EIS was completed for the rules amended by regular rulemaking at 26 A.A.R. 2793, with an immediate effective date of October 7, 2020. The EIS for this rulemaking quantified annual costs/revenue changes as minimal when $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. An EIS was not prepared as part of the expedited or exempt rulemakings. The Department believes the costs and benefits related to these rulemakings provided a benefit to all stakeholders. Stakeholders affected by these rules include the Department, health care institutions licensed under the rules, medical practitioners in licensed health care institutions, personnel members in licensed health care institutions, patients, residents, participants, recipients and their families, and the general public. In addition, architects, contractors, and engineers involved in the construction or modification of a health care institution are also stakeholders for R9-10-104 and R9-10-104.01. The Arizona Health Care Cost Containment System (AHCCCS) is also a stakeholder for R9-10-112.

The rules in R9-10-101, R9-10-102, R9-10-106, and R9-10-120 were amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019. Laws 2018, Ch. 1 was enacted to require the Department to license a pain management clinic as a health care institution and create rules for a pain management clinic that included informed consent requirements, the responsibilities of a medical director, reporting requirements, and physical examination requirements. The rules in Article 1 were amended to adhere to these statutory changes, and cross-reference the new Article 20 implemented in this rulemaking. R9-10-101 was revised to add in definitions for "active malignancy," "benzodiazepine," "end-of-life," "opioid," "opioid antagonist," "pain management clinic," "prescribe," "sedative-hypnotic medication," "short-acting opioid antagonist" "substance use disorder," "substance use risk," and "tapering." The section was also amended to renumber the definitions to align with the formatting requirements established by the Secretary of State (SOS). The health care institution classes and subclasses in R9-10-102, were revised to include pain management clinics in subsection (A). The rules in R9-10-106 regarding fees were amended in subsection (C)(5) to specify what fees are required of pain management clinics when submitting an initial or renewal application to the Department. Lastly, the Department revised R9-10-120, to specify this section does not apply to the pain management clinics licensed under new Article 20. In addition, subsection (B) was removed from the rules that included the definitions, as these definitions were added into R9-10-101 to make the rules clearer. The rules were also reformatted to adhere to SOS requirements, and corrected cross-references to make the rules more understandable. The Department believes these changes may have imposed a minimal-to-moderate cost on health care institutions, and provided a significant benefit to other stakeholders by protecting the health and safety of patients, residents, families, and the general public. The Department believes that the costs and benefits identified in this EIS are generally consistent with the actual costs and benefits of the rules.

In addition, the rules in R9-10-101, R9-10-102, and R9-10-106 were amended by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019. The rules were revised to adhere to Laws 2019, Ch. 133 that required intermediate care facilities to be licensed by the Department under A.R.S. Title 36, Chapter 4. Previously to Laws 2019, Ch. 133, intermediate care facilities were certified only under the federal Center for Medicare and Medicaid Services. The Department revised the rules to adhere to this statutory change by revising R9-10-101, R9-10-102, and R9-10-106. Changes in R9-10-101 revised the definitions by adding the terms, "common area," "full-time," "interdisciplinary team," "intermediate care facility for individuals with intellectual disabilities," "placement evaluation," and "rehabilitation services." The definition of "resident" was amended to include intermediate care facility for individuals with intellectual disabilities. Also, the section was renumbered to be in compliance with the additional definitions and amendments. The health care institution classes and subclasses in R9-10-102, were revised to include intermediate care facilities for individuals with intellectual disabilities in subsection (A). Lastly, rules related to fees in R9-10-106(C)(4) were amended to specify what fees are required of intermediate care facilities for individuals with intellectual disabilities when submitting an initial or renewal application to the Department. The Department believes these changes may have imposed a minimal-to-moderate cost on health care institutions, but provided a significant benefit to other stakeholders by protecting the health and safety of patients, residents, participants, and recipients.

The Department amended the rules in R9-10-119 by final expedited rulemaking at 25 A.A.R. 1893, effective July 2, 2019. The rules were revised to comply with Laws 2018, Ch. 219 which amended A.R.S. §§ 36-2161 and 36-2162 regarding abortion providers to report to the Department additional information in abortion procedures and compliance reports. The cross-reference to A.R.S. § 36-2161 was amended in R9-10-119 to adhere to the new statutory changes. The Department believes that these changes did not increase any costs of regulatory compliance, or affect any fees or reduce procedural rights of person regulated, but did provide a significant benefit to all health care institutions by reducing a burden due to outdated requirements without comprising health and safety.

Per the 2018 five-year-review report, the rules in R9-10-101, R9-10-102, R9-10-104, R9-10-105, R9-10-106, R9-10-107, R9-10-108, R9-10-109, R9-10-110, R9-10-111, R9-10-112, R9-10-113, R9-10-114, R9-10-115, R9-10-116, and R9-10-118, were amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019. The definitions in R9-10-101, were revised to add multiple definitions, include statutory reference A.R.S. § 36-439 as additional definitions for the rules in Chapter 10, renumbered to meet reformatting SOS requirements, correct grammatical errors, and remove obsolete definitions. The health care institution classes and subclasses in R9-10-102 were revised to simplify and to include adult residential care institutions in subsection (A), and to reformat in compliance with formatting requirements provided by the SOS. R9-10-104 was revised to clarify the mailing and street address in the application for approval of architectural plans, specify the types of services or modifications that require an architect to review architectural plans and specifications rather than licensing personnel to review a floor plan/site plan, reformat and renumber sections, and correct grammatical errors. The rules in R9-10-105 were amended to change the title of the section from "Initial" to "License Application," clarify the application that a

person has to provide a Department-provided format, correct typographical errors, include the cross-reference, and provide clarification to R9-10-104 regarding approval of architectural plans. R9-10-106, regarding fees, was amended by clarifying grammatical errors, including a licensee with a single group license submitting an annual health care institution licensing fees to subsection (D), and revising subsection (F) for a late payment fee if a licensee is submitting an annual licensing fee according to R9-10-107. The rules in R9-10-107 amended the title of the section from "Renewal License Application" to "Submission of Health Care Institution Licensing Fees," removed all language in the rule and created new subsections to align with updated practices and make the rules be more clear, concise, and understandable. In addition, the rule was amended to be in compliance with Laws 2017, Ch. 122 regarding the licensing requirements in A.R.S. Title 36, Chapter 4. The rules in Time-frames and Table 1.1 according to R9-10-108 were amended to align with new definitions added to this Article, created a time limit for keeping open an application for approval of architectural plans and specifications before the application is considered withdrawn, corrected cross-references, and revised Table 1.1 in reference to approval of an alternative licensing fee due date, in compliance with Laws 2017, Ch. 122. R9-10-109 was revised to include notification of a change in the chief administrative officer of a health care institution consistent with A.R.S. 36-425(I); specified notification of a change in hours of operation; included requirements for a health care institution being a nationally recognized accrediting organization; corrected cross-references; and amended language to adhere to Laws 2017, Ch. 122 by removing language regarding an initial or renewal license application process. Amendments in R9-10-110, included specifying the needed information and documentation regarding a requested change being a modification; reformatting the subsections; and correcting cross-references. R9-10-111 was revised to correct subsection (A) cross-references to other rules in this Chapter. The rules in R9-10-112 for denial, revocation, or suspension of a license were amended to comply with Laws 2017, Ch. 122 regarding applicable requirements for an application and licensing fees. Tuberculosis screening rules in R9-10-113 were amended to be clearer, remove redundant rules, and use language to align with the definitions of the Chapter. R9-10-114, R9-10-115, and R9-10-116 were amended to correct cross-references, correct typographical errors, and make the rules more clear, concise and understandable. Lastly, R9-10-118 was amended to correct grammatical errors, and cross-references in subsections (B)(8) and (9). The Department believes these changes may have imposed a minimal-to-moderate cost on health care institutions and provided a significant benefit to other stakeholders by protecting the health and safety of patients, residents, participants, and recipients.

An expedited rulemaking was conducted at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019, to revise the rules regarding codes and standards that the Department incorporates by reference. The Department adopted rules in R9-1-411 and R9-1-412. R9-1-411 established rules of construction and provides other information for persons using the codes and standards incorporated by reference in R9-1-412. R9-1-412 incorporated by reference physical plant health and safety codes and standards that the Department referenced in its different sets of healthcare institution licensing rules in 9 A.A.C. 10. The Department has updated many of the incorporations by reference to the current codes and standards, from the 2012 versions to the 2018 versions. Since the codes and standards are used only in 9 A.A.C 10, the Department moved applicable

requirements from R9-1-411 and R9-1-412 into a new Section being added to 9 A.A.C. 10, Article 1, and updated cross-references throughout 9 A.A.C. 10 to the new Section. The rules in R9-10-101, R9-10-104, R9-10-105, and R9-10-110 were amended to correct cross-references to the new section in Article 1. R9-10-104.01 was made as a new section regarding codes and standards for health care institutions. The Department believes that these changes provided a significant benefit to all stakeholders to make the rules more clear, concise, and understandable.

The Department amended rules in 2020 in two rulemakings. R9-10-109 was amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020. The rules were revised to adhere to an exception regarding changes affecting a license. A.R.S. § 36-424(B) allows for exception to ensure a licensee provides current accreditation reports, and the Department not conducting onsite compliance inspection of the health care institution during the time the accreditation report is valid. A new section, R9-10-121, regarding disease prevention and control was made by final rulemaking at 26 A.A.R. 2793, with an immediate effective date of October 7, 2020. This new section was enacted from an emergency rulemaking found at 26 A.A.R. 509, effective March 20, 2020, due to the Governor declaring a state of emergency due to the COVID-19 outbreak and requiring the Department to adopt requirements to prevent the spread of COVID-19 to vulnerable Arizonans residing in nursing care institutions, intermediate care facilities for individuals with intellectual disabilities, or assisted living facilities. The section prescribes rules for when the governor has declared a state of emergency, as defined in A.R.S. § 26-301, to address a situation described under A.R.S. § 36-787, and how health care institutions administration shall ensure that policies and procedures are set into place to ensure the health and safety of their residents in this type of state of emergency. The Department believes that the costs and benefits identified in this EIS are generally consistent with the actual costs and benefits of the rules. The Department believes these changes provided a significant benefit to all stakeholders by protecting the health and safety of patients, residents, participants, and recipients.

An exempt rulemaking was conducted to amend R9-10-101, R9-10-102, and R9-10-106, found at 28 A.A.R. 927, with an immediate effective date of April 15, 2022. The rulemaking was conducted to add requirements for the licensing of nursing-supported group homes. R9-10-101 was revised to add in two new definitions of “habilitation services”, and “nursing care institution administrator,” and renumber the subsections to adhere to these revisions. Nursing-supported group homes were added in R9-10-102 to be a health care institutions classes or subclass in subsection (A). In R9-10-106 regarding fees, nursing-supported group homes were included in subsection (C)(4) to provide guidance on the fees nursing-supported group homes are required to provide for licensing. The Department believes that these changes provided a significant benefit to all stakeholders, with some providing a minimal benefit.

Lastly, the Department amended rules in R9-10-113 through expedited rulemaking at 28 A.A.R. 1113, with an immediate effective date of May 4, 2022. The rules were amended to comply with the U.S. Department of Health and Human Services, Center for Disease Control and Prevention (CDC) updated recommendations on tuberculosis screening in a manner that removed the requirement for annual screening if certain conditions are

met. Health care institutions requested the Department to amend the rules to incorporate by reference the 2019 CDC recommendations. The Department believes that these changes did not increase any costs of regulatory compliance, or affect any fees or reduce procedural rights of a person regulated, but did provide a significant benefit to all health care institutions by reducing a burden due to outdated requirements without comprising health and safety.

The Department believes the rule changes, as described above, that are more easily understood, complied with, and enforced, may have provided a significant benefit to the affected persons, including the Department, patients, residents, and participants. On the basis of the information described above, the Department estimates that the actual costs and benefits experienced by persons affected by the rules are generally consistent with the costs and benefits considered in developing the 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?

Please state what the previous course of action was and if the agency did not complete the action, please explain why not.

In the 2018 five-year review report, the Department proposed to amend the rules in a rulemaking. The Department completed this plan of action by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019.

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 Department has determined that 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.

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)?

Federal laws are not applicable to the rules in 9 A.A.C. 10, Article 1.

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 rules require the issuance of a specific agency authorization, which is authorized by A.R.S. § 36-405, so a general permit is not applicable.

14. Proposed course of action:

If possible, please identify a month and year by which the agency plans to complete the course of action.

The Department plans to amend the rules in 9 A.A.C. 10, Article 1 as necessary to comply with statutory changes, address public comments, and correct grammatical errors. These changes will improve the effectiveness of the rules and the health and safety of patients receiving care at health care institutions. Therefore, the Department plans to submit a Notice of Final Rulemaking to the Governor's Regulatory Review Council by February 2024.

ARTICLE 1. GENERAL

R9-10-101. Definitions

In addition to the definitions in A.R.S. §§ 36-401(A) and 36-439, the following definitions apply in this Chapter unless otherwise specified:

1. "Abortion clinic" has the same meaning as in A.R.S. § 36-449.01.
2. "Abuse" means:
   a. The same:
      i. For an individual 18 years of age or older, as in A.R.S. § 46-451; and
      ii. For an individual less than 18 years of age, as in A.R.S. § 8-201;
   b. A pattern of ridiculing or demeaning a patient;
   c. Making derogatory remarks or verbally harassing a patient; or
   d. Threatening to inflict physical harm on a patient.
3. "Accredited" has the same meaning as in A.R.S. § 36-422.
4. "Active malignancy" means a cancer for which:
   a. A patient is undergoing treatment, such as through:
      i. One or more surgical procedures to remove the cancer;
      ii. Chemotherapy, as defined in A.A.C. R9-4-401; or
      iii. Radiation treatment, as defined in A.A.C. R9-4-401;
   b. There is no treatment; or
   c. A patient is refusing treatment.
5. "Activities of daily living" means ambulating, bathing, toileting, grooming, eating, and getting in or out of a bed or a chair.
6. "Acuity" means a patient's need for medical services, nursing services, or behavioral health services based on the patient's medical condition or behavioral health issue.
7. "Acuity plan" means a method for establishing nursing personnel requirements by unit based on a patient's acuity.
8. "Adjacent" means not intersected by:
   a. Property owned, operated, or controlled by a person other than the applicant or licensee; or
   b. A public thoroughfare.
9. "Administrative completeness review time-frame" has the same meaning as in A.R.S. § 41-1072.
10. "Administrative office" means a location used by personnel for recordkeeping and record retention but not for providing medical services, nursing services, behavioral health services, or health-related services.
11. "Admission" or "admitted" means, after completion of an individual's screening or registration by a health care institution, the individual begins receiving physical health services or behavioral health services and is accepted as a patient of the health care institution.
12. "Adult" has the same meaning as in A.R.S. § 1-215.
13. "Adult behavioral health therapeutic home" means a residence that provides room and board, assists in acquiring daily living skills, coordinates transportation to scheduled appointments, monitors behaviors, assists in the self-administration of medication, and provides feedback to a case manager related to behavior for an individual 18 years of age or older based on the individual's behavioral health issue and need for behavioral health services and may provide behavioral health services under the clinical oversight of a behavioral health professional.
14. "Adult residential care institution" means a subclass of behavioral health residential facility that only admits residents 18 years of age and older and provides recidivism reduction services.
15. "Adverse reaction" means an unexpected outcome that threatens the health or safety of a patient as a result of a medical service, nursing service, or health-related service provided to the patient.
16. "Affiliated counseling facility" means a counseling facility that shares administrative support with one or more other counseling facilities that operate under the same governing authority.
17. "Affiliated outpatient treatment center" means an outpatient treatment center authorized by the Department to provide behavioral health services that provides administrative support to a counseling facility or counseling facilities that operate under the same governing authority as the outpatient treatment center.
18. "Alternate licensing fee due date" means the last calendar day in a month each year, other than the anniversary date of a facility's health care institution license, by which a licensee is required to pay the applicable fees in R9-10-106.
19. "Ancillary services" means services other than medical services, nursing services, or health-related services provided to a patient.
20. "Anesthesiologist" means a physician granted clinical privileges to administer anesthesia.
21. "Applicant" means a governing authority requesting:
   a. Approval of a health care institution's architectural plans and specifications for construction or modification,
   b. Approval of a modification,
   c. Approval of an alternate licensing fee due date, or
   d. A health care institution license.
22. "Application packet" means the information, documents, and fees required by the Department for the:
   a. Approval of a health care institution's architectural plans and specifications for construction or modification,
   b. Approval of a modification,
   c. Approval of an alternate licensing fee due date, or
   d. Licensing of a health care institution.
23. "Assessment" means an analysis of a patient's need for physical health services or behavioral health services to determine which services a health care institution will provide to the patient.
24. "Assistance in the self-administration of medication" means restricting a patient's access to the patient's medication and providing support to the patient while the patient takes the medication to ensure that the medication is taken as ordered.
25. "Attending physician" means a physician designated by a patient to participate in or coordinate the medical services provided to the patient.
26. "Authenticate" means to establish authorship of a document or an entry in a medical record by:
   a. A written signature;
   b. An individual's initials, if the individual's written signature appears on the document or in the medical record;
   c. A rubber-stamp signature; or
   d. An electronic signature code.

27. "Authorized service" means specific medical services, nursing services, behavioral health services, or health-related services provided by a specific health care institution class or subclass for which the health care institution is required to obtain approval from the Department before providing the medical services, nursing services, or health-related services.
28. "Available" means:
    a. For an individual, the ability to be contacted and to provide an immediate response by any means possible;
    b. For equipment and supplies, physically retrievable at a health care institution; and
    c. For a document, retrievable by a health care institution or accessible according to the applicable timeframes in this Chapter.
29. "Behavioral care"
    a. Means limited behavioral health services, provided to a patient whose primary admitting diagnosis is related to the patient's need for physical health services, that include:
        i. Assistance with the patient's psychosocial interactions to manage the patient's behavior that can be performed by an individual without a professional license or certificate including:
            (1) Direction provided by a behavioral health professional, and
            (2) Medication ordered by a medical practitioner or behavioral health professional; or
        ii. Behavioral health services provided by a behavioral health professional on an intermittent basis to address the patient's significant psychological or behavioral response to an identifiable stressor or stressors; and
    b. Does not include court-ordered behavioral health services.
30. "Behavioral health facility" means a behavioral health inpatient facility, a behavioral health residential facility, a substance abuse transitional facility, a behavioral health specialized transitional facility, an outpatient treatment center that only provides behavioral health services, an adult behavioral health therapeutic home, a behavioral health respite home, or a counseling facility.
31. "Behavioral health inpatient facility" means a health care institution that 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.
32. "Behavioral health issue" means an individual's condition related to a mental disorder, a personality disorder, substance abuse, or a significant psychological or behavioral response to an identifiable stressor or stressors.
33. "Behavioral health observation/stabilization services" means crisis services provided, in an outpatient setting, to an individual whose behavior or condition indicates that the individual:
    a. Requires nursing services,
    b. May require medical services, and
    c. May be a danger to others or a danger to self.
34. "Behavioral health paraprofessional" means an individual who is not a behavioral health professional who provides the following services to a patient to address the patient's behavioral health issue:
    a. Under supervision by a behavioral health professional, services that, if provided in a setting other than a health care institution, would be required to be provided by an individual licensed under A.R.S. Title 32, Chapter 33; or
    b. Health-related services.
35. "Behavioral health professional" means:
    a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
        i. Independently engage in the practice of behavioral health, as defined in A.R.S. § 32-3251; or
        ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health, as defined in A.R.S. § 32-3251, under direct supervision as defined in A.A.C. R4-6-101;
    b. A psychiatrist as defined in A.R.S. § 36-501;
    c. A psychologist as defined in A.R.S. § 32-2061;
    d. A physician;
    e. A behavior analyst as defined in A.R.S. § 32-2091; or
    f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or
    g. A registered nurse with:
        i. A psychiatric-mental health nursing certification, or
        ii. One year of experience providing behavioral health services.
36. "Behavioral health residential facility" means a health care institution that provides treatment to an individual experiencing a behavioral health issue that:
    a. Limits the individual's ability to be independent, or
    b. Causes the individual to require treatment to maintain or enhance independence.
37. "Behavioral health respite home" means a residence where respite care services, which may include assistance in the self-administration of medication, are provided to an individual based on the individual's behavioral health issue and need for behavioral health services.
38. "Behavioral health specialized transitional facility" means a health care institution that provides inpatient behavioral health services and physical health services to an individual determined to be a sexually violent person according to A.R.S. Title 36, Chapter 37.
39. "Behavioral health technician" means an individual who is not a behavioral health professional who provides the following services to a patient to address the patient's behavioral health issue:
    a. With clinical oversight by a behavioral health professional, services that, if provided in a setting other than a health care institution, would be required to be provided by an individual licensed under A.R.S. Title 32, Chapter 33; or
    b. Health-related services.

40. "Benzodiazepine" means any one of a class of sedative-hypnotic medications, characterized by a chemical structure that includes a benzene ring linked to a seven-membered ring containing two nitrogen atoms, that are commonly used in the treatment of anxiety.
41. "Biohazardous medical waste" has the same meaning as in A.A.C. R18-13-1401.
42. "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.
43. "Case manager" means an individual assigned by an entity other than a health care institution to coordinate the physical health services or behavioral health services provided to a patient at the health care institution.
44. "Certification" means, in this Article, a written statement that an item or a system complies with the applicable requirements incorporated by reference in R9-10-104.01.
45. "Certified health physicist" means an individual recognized by the American Board of Health Physics as complying with the health physics criteria and examination requirements established by the American Board of Health Physics.
46. "Change in ownership" means conveyance of the ability to appoint, elect, or otherwise designate a health care institution's governing authority from an owner of the health care institution to another person.
47. "Chief administrative officer" or "administrator" means an individual designated by a governing authority to implement the governing authority's direction in a health care institution.
48. "Clinical laboratory services" means the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of a disease or impairment of a human being, or for the assessment of the health of a human being, including procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body.
49. "Clinical oversight" means:
    a. Monitoring the behavioral health services provided by a behavioral health technician to ensure that the behavioral health technician is providing the behavioral health services according to the health care institution's policies and procedures and, if applicable, a patient's treatment plan;
    b. Providing on-going review of a behavioral health technician's skills and knowledge related to the provision of behavioral health services;
    c. Providing guidance to improve a behavioral health technician's skills and knowledge related to the provision of behavioral health services; and
    d. Recommending training for a behavioral health technician to improve the behavioral health technician's skills and knowledge related to the provision of behavioral health services.
50. "Clinical privileges" means authorization to a medical staff member to provide medical services granted by a governing authority or according to medical staff bylaws.
51. "Collaborating health care institution" means a health care institution licensed to provide outpatient behavioral health services that has a written agreement with an adult behavioral health therapeutic home or a behavioral health respite home to:
    a. Coordinate behavioral health services provided to a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home, and
    b. Work with the provider to ensure a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home receives behavioral health services according to the resident's treatment plan.
52. "Common area" means licensed space in health care institution that is:
    a. Not a resident's bedroom or a residential unit,
    b. Not restricted to use by employees or volunteers of the health care institution, and
    c. Available for use by visitors and other individuals on the premises.
53. "Communicable disease" has the same meaning as in A.R.S. § 36-661.
54. "Conspicuously posted" means placed:
    a. At a location that is visible and accessible; and
    b. Unless otherwise specified in the rules, within the area where the public enters the premises of a health care institution.
55. "Consultation" means an evaluation of a patient requested by a medical staff member or personnel member.
56. "Contracted services" means medical services, nursing services, behavioral health services, health-related services, ancillary services, or environmental services provided according to a documented agreement between a health care institution and the person providing the medical services, nursing services, health-related services, ancillary services, or environmental services.
57. "Contractor" has the same meaning as in A.R.S. § 32-1101.
58. "Controlled substance" has the same meaning as in A.R.S. § 36-2501.
59. "Counseling" has the same meaning as "practice of professional counseling" in A.R.S. § 32-3251.
60. "Counseling facility" means a health care institution that only provides counseling, which may include:
    a. DUI screening, education, or treatment according to the requirements in 9 A.A.C. 20, Article 1; or
    b. Misdemeanor domestic violence offender treatment according to the requirements in 9 A.A.C. 20, Article 2.
61. "Court-ordered evaluation" has the same meaning as "evaluation" in A.R.S. § 36-501.
62. "Court-ordered treatment" means treatment provided according to A.R.S. Title 36, Chapter 5.
63. "Crisis services" means immediate and unscheduled behavioral health services provided to a patient to address an acute behavioral health issue affecting the patient.
64. "Current" means up-to-date, extending to the present time.
65. "Daily living skills" means activities necessary for an individual to live independently and include meal preparation, laundry, house-cleaning, home maintenance, money management, and appropriate social interactions.

66. "Danger to others" has the same meaning as in A.R.S. § 36-501.
67. "Danger to self" has the same meaning as in A.R.S. § 36-501.
68. "Detoxification services" means behavioral health services and medical services provided to an individual to:
    a. Treat the individual's signs or symptoms of withdrawal from alcohol or other drugs, and
    b. Reduce or eliminate the individual's dependence on alcohol or other drugs.
69. "Diagnostic procedure" means a method or process performed to determine whether an individual has a medical condition or behavioral health issue.
70. "Dialysis" means the process of removing dissolved substances from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane.
71. "Dialysis services" means medical services, nursing services, and health-related services provided to a patient receiving dialysis.
72. "Dialysis station" means a designated treatment area approved by the Department for use by a patient receiving dialysis or dialysis services.
73. "Dialyzer" means an apparatus containing semi-permeable membranes used as a filter to remove wastes and excess fluid from a patient's blood.
74. "Disaster" means an unexpected occurrence that adversely affects a health care institution's ability to provide services.
75. "Discharge" means a documented termination of services to a patient by a health care institution.
76. "Discharge instructions" means documented information relevant to a patient's medical condition or behavioral health issue provided by a health care institution to the patient or the patient's representative at the time of the patient's discharge.
77. "Discharge planning" means a process of establishing goals and objectives for a patient in preparation for the patient's discharge.
78. "Discharge summary" means a documented brief review of services provided to a patient, current patient status, and reasons for the patient's discharge.
79. "Disinfect" means to clean in order to prevent the growth of or to destroy disease-causing microorganisms.
80. "Documentation" or "documented" means information in written, photographic, electronic, or other permanent form.
81. "Drill" means a response to a planned, simulated event.
82. "Drug" has the same meaning as in A.R.S. § 32-1901.
83. "Electronic" has the same meaning as in A.R.S. § 44-7002.
84. "Electronic signature" has the same meaning as in A.R.S. § 44-7002.
85. "Emergency" means an immediate threat to the life or health of a patient.
86. "Emergency medical services provider" has the same meaning as in A.R.S. § 36-2201.
87. "Emergency services" means unscheduled medical services provided in a designated area to an outpatient in an emergency.
88. "End-of-life" means that a patient has a documented life expectancy of six months or less.
89. "Environmental services" means activities such as housekeeping, laundry, facility maintenance, or equipment maintenance.
90. "Equipment" means, in this Article, an apparatus, a device, a machine, or a unit that is required to comply with the specifications incorporated by reference in R9-10-104.01.
91. "Exploitation" has the same meaning as in A.R.S. § 46-451.
92. "Factory-built building" has the same meaning as in A.R.S. § 41-4001.
93. "Family" or "family member" means an individual's spouse, sibling, child, parent, grandparent, or another individual designated by the individual.
94. "Follow-up instructions" means information relevant to a patient's medical condition or behavioral health issue that is provided to the patient, the patient's representative, or a health care institution.
95. "Food services" means the storage, preparation, serving, and cleaning up of food intended for consumption in a health care institution.
96. "Full-time" means 40 hours or more every consecutive seven calendar days.
97. "Garbage" has the same meaning as in A.A.C. R18-13-302.
98. "General consent" means documentation of an agreement from an individual or the individual's representative to receive physical health services to address the individual's medical condition or behavioral health services to address the individual's behavioral health issues.
99. "General hospital" means a subclass of hospital that provides surgical services and emergency services.
100. "Gravely disabled" has the same meaning as "grave disability" in A.R.S. § 36-501.
101. "Habilitation services" means activities provided to an individual to assist the individual with habilitation, as defined in A.R.S. § 36-551.
102. "Hazard" or "hazardous" means a condition or situation where a patient or other individual may suffer physical injury.
103. "Health care directive" has the same meaning as in A.R.S. § 36-3201.
104. "Hemodialysis" means the process for removing wastes and excess fluids from a patient's blood by passing the blood through a dialyzer.
105. "Home health agency" has the same meaning as in A.R.S. § 36-151.
106. "Home health aide" means an individual employed by a home health agency to provide home health services under the direction of a registered nurse or therapist.
107. "Home health aide services" means those tasks that are provided to a patient by a home health aide under the direction of a registered nurse or therapist.
108. "Home health services" has the same meaning as in A.R.S. § 36-151.
109. "Hospice inpatient facility" means a subclass of hospice that provides hospice services to a patient on a continuous basis with the expectation that the patient will remain on the hospice's premises for 24 hours or more.
110. "Hospital" means a class of health care institution that provides, through an organized medical staff, inpatient beds, medical services, continuous nursing services, and diagnosis or treatment to a patient.
111. "Immediate" means without delay.

112. "Incident" means an unexpected occurrence that harms or has the potential to harm a patient, while the patient is:
    a. On the premises of a health care institution, or
    b. Not on the premises of a health care institution but directly receiving physical health services or behavioral health services from a personnel member who is providing the physical health services or behavioral health services on behalf of the health care institution.
113. "Infection control" means to identify, prevent, monitor, and minimize infections.
114. "Infectious tuberculosis" has the same meaning as "infectious active tuberculosis" in A.A.C. R9-6-101.
115. "Informed consent" means:
    a. Advising a patient of a proposed treatment, surgical procedure, psychotropic medication, opioid, or diagnostic procedure; alternatives to the treatment, surgical procedure, psychotropic medication, opioid, or diagnostic procedure; and associated risks and possible complications; and
    b. Obtaining documented authorization for the proposed treatment, surgical procedure, psychotropic medication, opioid, or diagnostic procedure from the patient or the patient's representative.
116. "In-service education" means organized instruction or information that is related to physical health services or behavioral health services and that is provided to a medical staff member, personnel member, employee, or volunteer.
117. "Interdisciplinary team" means a group of individuals consisting of a resident's attending physician, a registered nurse responsible for the resident, and other individuals as determined in the resident's comprehensive assessment or, if applicable, placement evaluation.
118. "Intermediate care facility for individuals with intellectual disabilities" or "ICF/IID" has the same meaning as in A.R.S. § 36-551.
119. "Interval note" means documentation updating a patient's:
    a. Medical condition after a medical history and physical examination is performed, or
    b. Behavioral health issue after an assessment is performed.
120. "Isolation" means the separation, during the communicable period, of infected individuals from others, to limit the transmission of infectious agents.
121. "Leased facility" means a facility occupied or used during a set time period in exchange for compensation.
122. "License" means:
    a. Written approval issued by the Department to a person to operate a class or subclass of health care institution at a specific location; or
    b. Written approval issued to an individual to practice a profession in this state.
123. "Licensed occupancy" means the total number of individuals for whom a health care institution is authorized by the Department to provide crisis services in a unit providing behavioral health observation/stabilization services.
124. "Licensee" means an owner approved by the Department to operate a health care institution.
125. "Manage" means to implement policies and procedures established by a governing authority, an administrator, or an individual providing direction to a personnel member.
126. "Medical condition" means the state of a patient's physical or mental health, including the patient's illness, injury, or disease.
127. "Medical director" means a physician who is responsible for the coordination of medical services provided to patients in a health care institution.
128. "Medical history" means an account of a patient's health, including past and present illnesses, diseases, or medical conditions.
129. "Medical practitioner" means a physician, physician assistant, or registered nurse practitioner.
130. "Medical record" has the same meaning as "medical records" in A.R.S. § 12-2291.
131. "Medical staff" means physicians and other individuals licensed pursuant to A.R.S. Title 32 who have clinical privileges at a health care institution.
132. "Medical staff bylaws" means standards, approved by the medical staff and the governing authority, that provide the framework for the organization, responsibilities, and self-governance of the medical staff.
133. "Medical staff member" means an individual who is part of the medical staff of a health care institution.
134. "Medication" means one of the following used to maintain health or to prevent or treat a medical condition or behavioral health issue:
    a. Biologicals as defined in A.A.C. R18-13-1401,
    b. Prescription medication as defined in A.R.S. § 32-1901, or
    c. Nonprescription drug as defined in A.R.S. § 32-1901.
135. "Medication administration" means restricting a patient's access to the patient's medication and providing the medication to the patient or applying the medication to the patient's body, as ordered by a medical practitioner.
136. "Medication error" means:
    a. The failure to administer an ordered medication;
    b. The administration of a medication not ordered; or
    c. The administration of a medication:
        i. In an incorrect dosage,
        ii. More than 60 minutes before or after the ordered time of administration unless ordered to do so, or
        iii. By an incorrect route of administration.
137. "Mental disorder" means the same as in A.R.S. § 36-501.
138. "Mobile clinic" means a movable structure that:
    a. Is not physically attached to a health care institution's facility;
    b. Provides medical services, nursing services, behavioral health services, or health related service to an outpatient under the direction of the health care institution's personnel; and
    c. Is not intended to remain in one location indefinitely.
139. "Monitor" or "monitoring" means to check systematically on a specific condition or situation.
140. "Neglect" has the same meaning:
    a. For an individual less than 18 years of age, as in A.R.S. § 8-201; and
    b. For an individual 18 years of age or older, as in A.R.S. § 46-451.
141. "Nephrologist" means a physician who is board eligible or board certified in nephrology by a professional credentialing board.

142. "Nurse" has the same meaning as "registered nurse" or "practical nurse" as defined in A.R.S. § 32-1601.
143. "Nursing care institution administrator" means an individual licensed according to A.R.S. Title 36, Chapter 4, Article 6.
144. "Nursing personnel" means individuals authorized according to A.R.S. Title 32, Chapter 15 to provide nursing services.
145. "Observation chair" means a physical piece of equipment that:
    a. Is located in a designated area where behavioral health observation/stabilization services are provided,
    b. Allows an individual to fully recline, and
    c. Is used by the individual while receiving crisis services.
146. "Occupational therapist" has the same meaning as in A.R.S. § 32-3401.
147. "Occupational therapy assistant" has the same meaning as in A.R.S. § 32-3401.
148. "Ombudsman" means a resident advocate who performs the duties described in A.R.S. § 46-452.02.
149. "On-call" means a time during which an individual is available and required to come to a health care institution when requested by the health care institution.
150. "Opioid" means a controlled substance, as defined in A.R.S. § 36-2501, that meets the definition of "opiate" in A.R.S. § 36-2501.
151. "Opioid agonist treatment medication" means a prescription medication that is approved by the U.S. Food and Drug Administration under 21 U.S.C. § 355 for use in the treatment of opioid-related substance use disorder.
152. "Opioid antagonist" means a prescription medication, as defined in A.R.S. § 32-1901, that:
    a. Is approved by the U.S. Department of Health and Human Services, Food and Drug Administration; and
    b. When administered, reverses, in whole or in part, the pharmacological effects of an opioid in the body.
153. "Opioid treatment" means providing medical services, nursing services, behavioral health services, health-related services, and ancillary services to a patient receiving an opioid agonist treatment medication for opioid-related substance use disorder.
154. "Order" means instructions to provide:
    a. Physical health services to a patient from a medical practitioner or as otherwise provided by law; or
    b. Behavioral health services to a patient from a behavioral health professional.
155. "Orientation" means the initial instruction and information provided to an individual before the individual starts work or volunteer services in a health care institution.
156. "Outing" means a social or recreational activity that:
    a. Occurs away from the premises,
    b. Is not part of a behavioral health inpatient facility's or behavioral health residential facility's daily routine, and
    c. Lasts longer than four hours.
157. "Outpatient surgical center" means a class of health care institution that has the facility, staffing, and equipment to provide surgery and anesthesia services to a patient whose recovery, in the opinions of the patient's surgeon and, if an anesthesiologist would be providing anesthesia services to the patient, the anesthesiologist, does not require inpatient care in a hospital.
158. "Outpatient treatment center" means a class of health care institution without inpatient beds that provides physical health services or behavioral health services for the diagnosis and treatment of patients.
159. "Overall time-frame" means the same as in A.R.S. § 41-1072.
160. "Owner" means a person who appoints, elects, or designates a health care institution's governing authority.
161. "Pain management clinic" has the same meaning as in A.R.S. § 36-448.01.
162. "Participant" means a patient receiving physical health services or behavioral health services from an adult day health care facility or a substance abuse transitional facility.
163. "Participant's representative" means the same as "patient's representative" for a participant.
164. "Patient" means an individual receiving physical health services or behavioral health services from a health care institution.
165. "Patient's representative" means:
    a. A patient's legal guardian;
    b. If a patient is less than 18 years of age and not an emancipated minor, the patient's parent;
    c. If a patient is 18 years of age or older or an emancipated minor, an individual acting on behalf of the patient with the written consent of the patient or patient's legal guardian; or
    d. A surrogate as defined in A.R.S. § 36-3201.
166. "Person" means the same as in A.R.S. § 1-215 and includes a governmental agency.
167. "Personnel member" means, except as defined in specific Articles in this Chapter and excluding a medical staff member, a student, or an intern, an individual providing physical health services or behavioral health services to a patient.
168. "Pest control program" means activities that minimize the presence of insects and vermin in a health care institution to ensure that a patient's health and safety is not at risk.
169. "Pharmacist" has the same meaning as in A.R.S. § 32-1901.
170. "Physical examination" means to observe, test, or inspect an individual's body to evaluate health or determine cause of illness, injury, or disease.
171. "Physical health services" means medical services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's medical condition.
172. "Physical therapist" has the same meaning as in A.R.S. § 32-2001.
173. "Physical therapist assistant" has the same meaning as in A.R.S. § 32-2001.
174. "Physician assistant" has the same meaning as in A.R.S. § 32-2501.
175. "Placement evaluation" means the same as in A.R.S. § 36-551.
176. "Pre-petition screening" has the same meaning as "prepetition screening" in A.R.S. § 36-501.
177. "Premises" means property that is designated by an applicant or licensee and licensed by the Department as part of a health care institution where physical health services or behavioral health services are provided to a patient.

178. "Prescribe" means to issue written or electronic instructions to a pharmacist to deliver to the ultimate user, or another individual on the ultimate user's behalf, a specific dose of a specific medication in a specific quantity and route of administration.
179. "Professional credentialing board" means a non-governmental organization that designates individuals who have met or exceeded established standards for experience and competency in a specific field.
180. "Progress note" means documentation by a medical staff member, nurse, or personnel member of:
    a. An observed patient response to a physical health service or behavioral health service provided to the patient,
    b. A patient's significant change in condition, or
    c. Observed behavior of a patient related to the patient's medical condition or behavioral health issue.
181. "PRN" means *pro re nata* or given as needed.
182. "Project" means specific construction or modification of a facility stated on an architectural plans and specifications approval application.
183. "Provider" means an individual to whom the Department issues a license to operate an adult behavioral health therapeutic home or a behavioral health respite home in the individual's place of residence.
184. "Provisional license" means the Department's written approval to operate a health care institution issued to an applicant or licensee that is not in substantial compliance with the applicable laws and rules for the health care institution.
185. "Psychotropic medication" means a chemical substance that:
    a. Crosses the blood-brain barrier and acts primarily on the central nervous system where it affects brain function, resulting in alterations in perception, mood, consciousness, cognition, and behavior; and
    b. Is provided to a patient to address the patient's behavioral health issue.
186. "Quality management program" means ongoing activities designed and implemented by a health care institution to improve the delivery of medical services, nursing services, health-related services, and ancillary services provided by the health care institution.
187. "Recovery care center" has the same meaning as in A.R.S. § 36-448.51.
188. "Referral" means providing an individual with a list of the class or subclass of health care institution or type of health care professional that may be able to provide the behavioral health services or physical health services that the individual may need and may include the name or names of specific health care institutions or health care professionals.
189. "Registered dietitian" means an individual approved to work as a dietitian by the American Dietetic Association's Commission on Dietetic Registration.
190. "Registered nurse" has the same meaning as in A.R.S. § 32-1601.
191. "Registered nurse practitioner" has the same meaning as A.R.S. § 32-1601.
192. "Regular basis" means at recurring, fixed, or uniform intervals.
193. "Rehabilitation services" means medical services provided to a patient to restore or to optimize functional capability.
194. "Research" means the use of a human subject in the systematic study, observation, or evaluation of factors related to the prevention, assessment, treatment, or understanding of a medical condition or behavioral health issue.
195. "Resident" means an individual living in and receiving physical health services or behavioral health services, including rehabilitation services or habilitation services if applicable, from a nursing care institution, an intermediate care facility for individuals with intellectual disabilities, a behavioral health residential facility, an assisted living facility, or an adult behavioral health therapeutic home.
196. "Resident's representative" means the same as "patient's representative" for a resident.
197. "Respiratory care services" has the same meaning as "practice of respiratory care" as defined in A.R.S. § 32-3501.
198. "Respiratory therapist" has the same meaning as in A.R.S. § 32-3501.
199. "Respite capacity" means the total number of children who do not stay overnight for whom an outpatient treatment center or a behavioral health residential facility is authorized by the Department to provide respite services on the premises of the outpatient treatment center or behavioral health residential facility.
200. "Respite services" means respite care services provided to an individual who is receiving behavioral health services.
201. "Restraint" means any physical or chemical method of restricting a patient's freedom of movement, physical activity, or access to the patient's own body.
202. "Risk" means potential for an adverse outcome.
203. "Room" means space contained by a floor, a ceiling, and walls extending from the floor to the ceiling that has at least one door.
204. "Rural general hospital" means a subclass of hospital:
    a. Having 50 or fewer inpatient beds,
    b. Located more than 20 surface miles from a general hospital or another rural general hospital, and
    c. Requesting to be and being licensed as a rural general hospital rather than a general hospital.
205. "Satellite facility" has the same meaning as in A.R.S. § 36-422.
206. "Scope of services" means a list of the behavioral health services or physical health services the governing authority of a health care institution has designated as being available to a patient at the health care institution.
207. "Seclusion" means the involuntary solitary confinement of a patient in a room or an area where the patient is prevented from leaving.
208. "Sedative-hypnotic medication" means any one of several classes of drugs that have sleep-inducing, anti-anxiety, anti-convulsant, and muscle-relaxing properties.
209. "Self-administration of medication" means a patient having access to and control of the patient's medication and may include the patient receiving limited support while taking the medication.
210. "Sexual abuse" means the same as in A.R.S. § 13-1404(A).

211. "Sexual assault" means the same as in A.R.S. § 13-1406(A).
212. "Shift" means the beginning and ending time of a continuous work period established by a health care institution's policies and procedures.
213. "Short-acting opioid antagonist" means an opioid antagonist that, when administered, quickly but for a small period of time reverses, in whole or in part, the pharmacological effects of an opioid in the body.
214. "Signature" means:
    a. A handwritten or stamped representation of an individual's name or a symbol intended to represent an individual's name, or
    b. An electronic signature.
215. "Significant change" means an observable deterioration or improvement in a patient's physical, cognitive, behavioral, or functional condition that may require an alteration to the physical health services or behavioral health services provided to the patient.
216. "Single group license" means a license that includes authorization to operate health care institutions according to A.R.S. § 36-422(F) or (G).
217. "Speech-language pathologist" means an individual licensed according to A.R.S. Title 36, Chapter 17, Article 4 to engage in the practice of speech-language pathology, as defined in A.R.S. § 36-1901.
218. "Special hospital" means a subclass of hospital that:
    a. Is licensed to provide hospital services within a specific branch of medicine; or
    b. Limits admission according to age, gender, type of disease, or medical condition.
219. "Student" means an individual attending an educational institution and working under supervision in a health care institution through an arrangement between the health care institution and the educational institution.
220. "Substance abuse" means an individual's misuse of alcohol or other drug or chemical that:
    a. Alters the individual's behavior or mental functioning;
    b. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical; and
    c. Impairs, reduces, or destroys the individual's social or economic functioning.
221. "Substance abuse transitional facility" means a class of health care institution that provides behavioral health services to an individual over 18 years of age who is intoxicated or may have a substance abuse problem.
222. "Substance use disorder" means a condition in which the misuse or dependence on alcohol or a drug results in adverse physical, mental, or social effects on an individual.
223. "Substance use risk" means an individual's unique likelihood for addiction, misuse, diversion, or another adverse consequence resulting from the individual being prescribed or receiving treatment with opioids.
224. "Substantial" when used in connection with a modification means:
    a. An addition or removal of an authorized service;
    b. The addition or removal of a colocator;
    c. A change in a health care institution's licensed capacity, licensed occupancy, respite capacity, or the number of dialysis stations;
    d. A change in the physical plant, including facilities or equipment, that costs more than $300,000; or
    e. A change in the building where a health care institution is located that affects compliance with:
        i. Applicable physical plant codes and standards incorporated by reference in R9-10-104.01, or
        ii. Physical plant requirements in the specific Article in this Chapter applicable to the health care institution.
225. "Substantive review time-frame" means the same as in A.R.S. § 41-1072.
226. "Supportive services" has the same meaning as in A.R.S. § 36-151.
227. "Surgical procedure" means the excision of or incision in a patient's body for the:
    a. Correction of a deformity or defect;
    b. Repair of an injury; or
    c. Diagnosis, amelioration, or cure of disease.
228. "Swimming pool" has the same meaning as "semipublic swimming pool" in A.A.C. R18-5-201.
229. "System" means interrelated, interacting, or interdependent elements that form a whole.
230. "Tapering" means the gradual reduction in the dosage of a medication administered to a patient, often with the intent of eventually discontinuing the use of the medication for the patient.
231. "Tax ID number" means a numeric identifier that a person uses to report financial information to the United States Internal Revenue Service.
232. "Telemedicine" has the same meaning as in A.R.S. § 36-3601.
233. "Therapeutic diet" means foods or the manner in which food is to be prepared that are ordered for a patient.
234. "Therapist" means an occupational therapist, a physical therapist, a respiratory therapist, or a speech-language pathologist.
235. "Time-out" means providing a patient a voluntary opportunity to regain self-control in a designated area from which the patient is not physically prevented from leaving.
236. "Transfer" means a health care institution discharging a patient and sending the patient to another licensed health care institution as an inpatient or resident without intending that the patient be returned to the sending health care institution.
237. "Transport" means a licensed health care institution:
    a. Sending a patient to a receiving licensed health care institution for outpatient services with the intent of the patient returning to the sending licensed health care institution, or
    b. Discharging a patient to return to a sending licensed health care institution after the patient received outpatient services from the receiving licensed health care institution.
238. "Treatment" means a procedure or method to cure, improve, or palliate an individual's medical condition or behavioral health issue.
239. "Treatment plan" means a description of the specific physical health services or behavioral health services that a health care institution anticipates providing to a patient.
240. "Unclassified health care institution" means a health care institution not classified or subclassified in statute or in rule.

241. "Vascular access" means the point on a patient's body where blood lines are connected for hemodialysis.
242. "Volunteer" means an individual authorized by a health care institution to work for the health care institution on a regular basis without compensation from the health care institution and does not include a medical staff member who has clinical privileges at the health care institution.
243. "Working day" means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state and federal holiday or a statewide furlough day.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Amended by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-102. Health Care Institution Classes and Subclasses; Requirements

A. A person may apply for a license as one of the following classes or subclasses of health care institution:
1. General hospital,
2. Rural general hospital,
3. Special hospital,
4. Behavioral health inpatient facility,
5. Nursing care institution,
6. Intermediate care facility for individuals with intellectual disabilities,
7. Recovery care center,
8. Hospice inpatient facility,
9. Hospice service agency,
10. Behavioral health residential facility,
11. Adult residential care institution,
12. Assisted living center,
13. Assisted living home,
14. Adult foster care home,
15. Outpatient surgical center,
16. Outpatient treatment center,
17. Abortion clinic,
18. Adult day health care facility,
19. Home health agency,
20. Substance abuse transitional facility,
21. Behavioral health specialized transitional facility,
22. Counseling facility,
23. Adult behavioral health therapeutic home,
24. Behavioral health respite home,
25. Unclassified health care institution,
26. Pain management clinic, or
27. Nursing-supported group home.

B. A person shall apply for a license for the class or subclass that authorizes the provision of the highest level of physical health services or behavioral health services the proposed health care institution plans to provide.

C. The Department shall review a proposed health care institution's scope of services to determine whether the requested health care institution class or subclass is appropriate.

D. A health care institution shall comply with the requirements in Article 17 of this Chapter if:
1. There are no specific rules in another Article of this Chapter for the health care institution's class or subclass, or
2. The Department determines that the health care institution is an unclassified health care institution.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Amended by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-103. Licensing Exceptions

A. A health care institution license is required for each health care institution facility except:
1. A facility exempt from licensing under A.R.S. § 36-402, or
2. A health care institution's administrative office.

B. The Department does not require a separate health care institution license for:
1. A satellite facility of a hospital under A.R.S. § 36-422(F);
2. An accredited facility of an accredited hospital under A.R.S. § 36-422(G);
3. A facility operated by a licensed health care institution that is:
   a. Adjacent to and contiguous with the licensed health care institution premises; or
   b. Not adjacent to or contiguous with the licensed health care institution but connected to the licensed health care institution facility by an all-weather enclosure and:
      i. Owned by the health care institution, or
      ii. Leased by the health care institution with exclusive rights of possession;
4. A mobile clinic operated by a licensed health care institution; or
5. A facility located on grounds that are not adjacent to or contiguous with the health care institution premises where only ancillary services are provided to a patient of the health care institution.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-104. Approval of Architectural Plans and Specifications

A. For approval of architectural plans and specifications for the construction or modification of a health care institution that is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01, an applicant shall submit to the Department an application packet including:

1. An application in a Department-provided format that contains:
   a. For construction of a new health care institution:
      i. The health care institution's name, street address, city, state, zip code, telephone number, and e-mail address;
      ii. The name and mailing address of the health care institution's governing authority;
      iii. The requested health care institution class or subclass; and
      iv. If applicable, the requested licensed capacity, licensed occupancy, respite capacity, and number of dialysis stations for the health care institution;
   b. For modification of a licensed health care institution that requires approval of architectural plans and specifications:
      i. The health care institution's license number,
      ii. The name and mailing address of the licensee,
      iii. The health care institution's class or subclass, and
      iv. The health care institution's existing licensed capacity, licensed occupancy, respite capacity, or number of dialysis stations; and the requested licensed capacity, licensed occupancy, respite capacity, or number of dialysis stations for the health care institution;
   c. The health care institution's contact person's name, street mailing address, city, state, zip code, telephone number, and e-mail address;
   d. The name, street mailing address, city, state, zip code, telephone number, and e-mail address of:
      i. The project architect; or
      ii. If the construction or modification of the health care institution does not require a project architect, the project engineer or other individual responsible for the completion of the construction or modification;
   e. A narrative description of the project;
   f. The estimated total project cost including the costs of:
      i. Site acquisition,
      ii. General construction,
      iii. Architect fees,
      iv. Fixed equipment, and
      v. Movable equipment;
   g. If providing or planning to provide medical services, nursing services, or health-related services that require compliance with specific physical plant codes and standards incorporated by reference in R9-10-104.01, the number of rooms or inpatient beds designated for providing the medical services, nursing services, or health-related services;
   h. If providing or planning to provide behavioral health observation/stabilization services, the number of behavioral health observation/stabilization observation chairs designated for providing the behavioral health observation/stabilization services;
   i. For construction of a new health care institution and if modification of a health care institution requires a project architect, a statement signed and sealed by the project architect, according to the requirements in 4 A.A.C. 30, Article 3, that the:
      i. Project architect has complied with A.A.C. R4-30-301; and
      ii. Architectural plans and specifications comply with applicable licensing requirements in A.R.S. Title 36, Chapter 4 and this Chapter;
   j. If construction or modification of a health care institution requires a project engineer, a statement signed and sealed by the project engineer, according to the requirements in 4 A.A.C. 30, Article 3, that the project engineer has complied with A.A.C. R4-30-301; and
   k. A statement signed by the governing authority or the licensee that the architectural plans and specifications comply with applicable licensing requirements in A.R.S. Title 36, Chapter 4 and this Chapter;
2. If the health care institution is located on land under the jurisdiction of a local governmental agency, one of the following:
   a. A building permit for the construction or modification issued by the local governmental agency; or
   b. If a building permit issued by the local governmental agency is not required, zoning clearance issued by the local governmental agency that includes:
      i. The health care institution's name, street address, city, state, zip code, and county;
      ii. The health care institution's class or subclass and each type of medical services, nursing services, or health-related services to be provided; and
      iii. A statement signed by a representative of the local governmental agency stating that the address listed is zoned for the health care institution's class or subclass;
3. The following information that is as necessary to demonstrate that the project described on the application complies with applicable codes and standards incorporated by reference in R9-10-104.01:
   a. A table of contents containing:
      i. The architectural plans and specifications submitted;
      ii. The physical plant codes and standards incorporated by reference in R9-10-104.01 that apply to the project;
      iii. The physical plant codes and standards that are required by a local governmental agency, if applicable;
      iv. An index of the abbreviations and symbols used in the architectural plans and specifications; and
      v. The facility's specific International Building Code construction type and International Building Code occupancy type;
   b. If the facility is larger than 3,000 square feet and is or will be occupied by more than 20 individuals, the seal of an architect on the architectural plans and specifications according to the requirements in

A.R.S. Title 32, Chapter 1 and 4 A.A.C. 30, Article 3;

c. A site plan, drawn to scale, of the entire premises showing streets, property lines, facilities, parking areas, outdoor areas, fences, swimming pools, fire access roads, fire hydrants, and access to water mains;

d. For each facility, on architectural plans and specifications:

i. A floor plan, drawn to scale, for each level of the facility, showing the layout and dimensions of each room, the name and function of each room, means of egress, and natural and artificial lighting sources;

ii. A diagram of a section of the facility, drawn to scale, showing the vertical cross-section view from foundation to roof and specifying construction materials;

iii. Building elevations, drawn to scale, showing the outside appearance of each facility;

iv. The materials used for ceilings, walls, and floors;

v. The location, size, and fire rating of each door and each window and the materials and hardware used, including safety features such as fire exit door hardware and fireproofing materials;

vi. A ceiling plan, drawn to scale, showing the layout of each light fixture, each fire protection device, and each element of the mechanical ventilation system;

vii. An electrical floor plan, drawn to scale, showing the wiring diagram and the layout of each lighting fixture, each outlet, each switch, each electrical panel, and electrical equipment;

viii. A mechanical floor plan, drawn to scale, showing the layout of heating, ventilation, and air conditioning systems;

ix. A plumbing floor plan, drawn to scale, showing the layout and materials used for water, sewer, and medical gas systems, including the water supply and plumbing fixtures;

x. A floor plan, drawn to scale, showing the communication system within the health care institution including the nurse call system, if applicable;

xi. A floor plan, drawn to scale, showing the automatic fire extinguishing, fire detection, and fire alarm systems; and

xii. Technical specifications or drawings describing installation of equipment or medical gas and the materials used for installation in the health care institution;

4. The estimated total project cost including the costs of:
   a. Site acquisition,
   b. General construction,
   c. Architect fees,
   d. Fixed equipment, and
   e. Movable equipment;
5. The following, as applicable:
   a. If the health care institution is located on land under the jurisdiction of a local governmental agency, one of the following provided by the local governmental agency:
      i. A copy of the certificate of occupancy for the facility,
      ii. Documentation that the facility was approved for occupancy, or
      iii. Documentation that a certificate of occupancy for the facility is not available;
   b. A certification and a statement that the construction or modification of the facility is in substantial compliance with applicable licensing requirements in A.R.S. Title 36, Article 4 and this Chapter signed by the project architect, the contractor, and the owner;
   c. A written description of any work necessary to complete the construction or modification submitted by the project architect;
   d. If the construction or modification affects the health care institution's fire alarm system, a contractor certification and description of the fire alarm system in a Department-provided format provided by the Department;
   e. If the construction or modification affects the health care institution's automatic fire extinguishing system, a contractor certification of the automatic fire extinguishing system in a Department-provided format provided by the Department;
   f. If the construction or modification affects the health care institution's heating, ventilation, or air conditioning system, a copy of the heating, ventilation, air conditioning, and air balance tests and a contractor certification of the heating, ventilation, or air conditioning system;
   g. If draperies, cubicle curtains, or floor coverings are installed or replaced, a copy of the manufacturer's certification of flame spread for the draperies, cubicle curtains, or floor coverings;
   h. For a health care institution using inhalation anesthetics or nonflammable medical gas, a copy of the Compliance Certification for Inhalation Anesthetics or Nonflammable Medical Gas System required in the National Fire Codes incorporated by reference in R9-10-104.01;
   i. If a generator is installed, a copy of the installation acceptance required in the National Fire Codes incorporated by reference in R9-10-104.01;
   j. If equipment is installed, a certification from an engineer or from a technical representative of the equipment's manufacturer that the equipment has been installed according to the manufacturer's recommendations and, if applicable, calibrated;
   k. For a health care institution providing radiology, a written report from a certified health physicist of the location, type, and amount of radiation protection; and
   l. If a factory-built building is used by a health care institution:
      i. A copy of the installation permit and the copy of a certificate of occupancy for the factory-built building from the Office of Manufactured Housing; or
      ii. A written report from an individual registered as an architect or a professional structural engineer under 4 A.A.C. 30, Article 2, stating that the factory-built building complies with applicable design standards;

6. For construction of a new health care institution and for a modification of a health care institution that requires a project architect, a statement signed by the project architect that final architectural plans and specifications have been submitted to the person applying for a health care institution license or the licensee of the health care institution;
7. For modification of a health care institution that does not require a project architect, a statement signed by the project engineer or other individual responsible for the completion of the modification that final architectural plans and specifications have been submitted to the person applying for a health care institution license or the licensee of the health care institution; and
8. The applicable fee required by R9-10-106.

B. Before an applicant submits an application for approval of architectural plans and specifications for the construction or modification of a health care institution, an applicant may request an architectural evaluation by providing the documents in subsection (A)(3) to the Department.

C. The Department may conduct on-site facility reviews during the construction or modification of a health care institution.

D. The Department shall approve or deny an application for approval of architectural plans and specifications of a health care institution in this Section according to R9-10-108.

E. In addition to obtaining an approval of a health care institution's architectural plans and specifications, a person shall obtain a health care institution license before operating the health care institution.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Publication error corrected in R9-10-104(A)(1) removing "provided by the Department;" publication error corrected in R9-10-104(B) removing "submitting;" with both amendments made at 25 A.A.R. 1583. Publication error corrected in R9-10-104(A), incorporated by reference Section updated as amended at 25 A.A.R. 3481 (Supp. 21-2).

R9-10-104.01. Codes and Standards

A. For a health care institution that is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in this Section, an applicant shall follow the requirements in subsection (B), except as follows:
1. Physical plant standards specified in applicable Articles of this Chapter shall govern over the codes and standards incorporated by reference in subsection (B); and
2. If a conflict occurs among the codes and standards incorporated by reference in subsection (B), the more restrictive codes and standards shall govern over the less restrictive.

B. The following physical plant health and safety codes and standards are incorporated by reference as modified, are on file with the Department, and include no future editions or amendments:
1. Guidelines for Design and Construction of Health Care Facilities (2018 ed.), published by the American Society for Healthcare Engineering and available from The Facility Guidelines Institute at www.fgiguidelines.org;
2. The following National Fire Codes (2012), published by and available from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269, and at www.nfpa.org/catalog:
   a. NFPA70 National Electrical Code,
   b. NFPA101 Life Safety Code, and
   c. 2012 Supplements;
3. ICC/A117.1-2017, American National Standard: Accessible and Usable Buildings and Facilities (2017), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org;
4. International Building Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
   a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]";
   b. Section 101.2 is modified by deleting the "Exception";
   c. Section 101.4.7 is deleted;
   d. Sections 103.1 through 103.3 are deleted;
   e. Sections 104.1 through 104.11.2 are deleted;
   f. Sections 105.1 through 105.7 are deleted;
   g. Sections 106.1 through 106.3 are deleted;
   h. Sections 107.1 through 107.5 are deleted;
   i. Sections 108.1 through 108.4 are deleted;
   j. Sections 109.1 through 109.6 are deleted;
   k. Sections 110.1 through 110.6 are deleted;
   l. Sections 111.1 through 111.4 are deleted;
   m. Sections 112.1 through 112.3 are deleted;
   n. Sections 113.1 through 113.3 are deleted;
   o. Sections 114.1 through 114.4 are deleted;
   p. Sections 115.1 through 115.3 are deleted;
   q. Sections 116.1 through 116.5 are deleted; and
   r. Appendices A, B, C, D, K, L, and M are deleted;
5. International Mechanical Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
   a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",
   b. Sections 103.1 through 103.4.1 are deleted,
   c. Sections 104.1 through 104.7 are deleted,
   d. Sections 105.1 through 105.5 are deleted,
   e. Sections 106.1 through 106.5.3 are deleted,
   f. Sections 107.1 through 107.6 are deleted,
   g. Sections 108.1 through 108.7.3 are deleted,
   h. Sections 109.1 through 109.7 are deleted,
   i. Sections 110.1 through 110.4 are deleted, and
   j. Appendix B is deleted;
6. International Plumbing Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
   a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",

b. Sections 103.1 through 103.4.1 are deleted,
c. Sections 104.1 through 104.7 are deleted,
d. Sections 105.1 through 105.4.1 are deleted,
e. Sections 106.1 through 106.6.3 are deleted,
f. Sections 107.1 through 107.7 are deleted,
g. Sections 108.1 through 108.7.3 are deleted,
h. Sections 109.1 through 109.7 are deleted,
i. Sections 110.1 through 110.4 are deleted, and
j. Appendix A is deleted;

7. International Fire Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
   a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",
   b. Sections 102.3 and 102.5 are deleted,
   c. Sections 103.1 through 103.4.1 are deleted,
   d. Sections 104.1 through 104.11.3 are deleted,
   e. Sections 105.1 through 105.7.25 are deleted,
   f. Sections 106.1 through 106.5 are deleted,
   g. Sections 107.1 through 107.4 are deleted,
   h. Sections 109.1 through 109.3 are deleted,
   i. Sections 110.1 through 110.4.1 are deleted,
   j. Sections 111.1 through 111.4 are deleted,
   k. Section 112.1 through 112.4 is deleted,
   l. Section 113.1.is deleted, and
   m. Appendix A is deleted;
8. International Fuel Gas Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
   a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",
   b. Section 101.2 is modified by deleting the "Exception",
   c. Sections 103.1 through 103.4.1 are deleted,
   d. Sections 104.1 through 104.7 are deleted,
   e. Sections 105.1 through 105.5 are deleted,
   f. Sections 106.1 through 106.6.3 are deleted,
   g. Sections 107.1 through 107.6 are deleted,
   h. Sections 108.1 through 108.7.3 are deleted,
   i. Sections 109.1 through 109.7 are deleted, and
   j. Sections 110.1 through 110.4 are deleted;
9. International Private Sewage Disposal Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
   a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",
   b. Sections 103.1 through 103.4.1 are deleted,
   c. Sections 104.1 through 104.7 are deleted,
   d. Sections 105.1 through 105.5 are deleted,
   e. Sections 106.1 through 106.4.3 are deleted,
   f. Sections 107.1 through 107.9 are deleted,
   g. Sections 108.1 through 108.7.2 are deleted,
   h. Sections 109.1 through 109.7 are deleted, and
   i. Sections 110.1 through 110.4 are deleted.

C. The Department shall not assess any penalty or fee specified in the physical plant health and safety codes and standards that are incorporated by reference in this Section.

Historical Note
New Section made by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

R9-10-105. License Application

A. A person applying for an initial a health care institution license shall submit to the Department an application packet that contains:
1. An application in a Department-provided format provided by the Department including:
   a. The health care institution's:
      i. Name;
      ii. Street address, city, state, zip code;
      iii. Mailing address;
      iv. Telephone number, and;
      v. E-mail address;
      vi. Tax ID number; and
      vii. Class or subclass listed in R9-10-102 for which licensing is requested;
   b. Except for a home health agency, or hospice service agency, or behavioral health facility, whether the health care institution is located within 1/4 mile of agricultural land;
   c. Whether the health care institution is located in a leased facility;
   d. Whether the health care institution is ready for a licensing inspection by the Department;
   e. If the health care institution is not ready for a licensing inspection by the Department, the date the health care institution will be ready for a licensing inspection;
   f. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-10-108;
   g. Owner information including:
      i. The owner's name, mailing address, telephone number, and e-mail address;
      ii. Whether the owner is a sole proprietorship, a corporation, a partnership, a limited liability partnership, a limited liability company, or a governmental agency;
      iii. If the owner is a partnership or a limited liability partnership, the name of each partner;
      iv. If the owner is a limited liability company, the name of the designated manager or, if no manager is designated, the names of any two members of the limited liability company;
      v. If the owner is a corporation, the name and title of each corporate officer;
      vi. If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the name of an individual in charge of the health care institution designated in writing by the individual in charge of the governmental agency;
      vii. Whether the owner or any person with 10% or more business interest in the health care institution has had a license to operate a health care institution denied, revoked, or suspended; the reason for the denial, suspension, or revocation; the date of the denial, suspension, or revocation; and the name and address of the licensing agency that denied, suspended, or revoked the license;

viii. Whether the owner or any person with 10% or more business interest in the health care institution has had a health care professional license or certificate denied, revoked, or suspended; the reason for the denial, suspension, or revocation; the date of the denial, suspension, or revocation; and the name and address of the licensing agency that denied, suspended, or revoked the license or certificate; and

ix. The name, title, address, and telephone number of the owner's statutory agent or the individual designated by the owner to accept service of process and subpoenas;

h. The name and mailing address of the governing authority;

i. The chief administrative officer's:

i. Name,

ii. Title,

iii. Highest educational degree, and

iv. Work experience related to the health care institution class or subclass for which licensing is requested; and

j. Signature required in A.R.S. § 36-422(B);

2. If the health care institution is located in a leased facility, a copy of the lease showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility;

3. If applicable, a copy of the owner's articles of incorporation, partnership or joint venture documents, or limited liability documents;

4. If applicable, the name and mailing address of each owner or lessee of any agricultural land regulated under A.R.S. § 3-365 and a copy of the written agreement between the applicant and the owner or lessee of agricultural land as prescribed in A.R.S. § 36-421(D);

5. Except for a home health agency or a hospice service agency, one of the following:

a. If the health care institution or a part of the health care institution is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01:

i. An application packet for approval of architectural plans and specifications in R9-10-104(A), or

ii. Documentation of the Department's approval of the health care institution's architectural plans and specifications approval in R9-10-104 R9-10-104(D); or

b. If a no part of the health care institution or a part of the health care institution is not required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01:

i. One of the following:

(1) Documentation from the local jurisdiction of compliance with applicable local building codes and zoning ordinances; or

(2) If documentation from the local jurisdiction is not available, documentation of the unavailability of the local jurisdiction compliance and documentation of a general contractor's inspection of the facility that states the facility is safe for occupancy as the applicable health care institution class or subclass;

ii. The licensed capacity requested by the applicant for the health care institution;

iii. If applicable, the licensed occupancy requested by the applicant for the health care institution;

iv. If applicable, the respite capacity requested by the applicant for the health care institution;

v. A site plan showing each facility, the property lines of the health care institution, each street and walkway adjacent to the health care institution, parking for the health care institution, fencing and each gate on the health care institution premises, and, if applicable, each swimming pool on the health care institution premises; and

vi. A floor plan showing, for each story of a facility, the room layout, room usage, each door and each window, plumbing fixtures, each exit, and the location of each fire protection device;

6. The health care institution's proposed scope of services; and

7. The applicable application fee required by R9-10-106.

B. In addition to the initial license application requirements in this Section, an applicant shall comply with the supplemental application requirements in specific rules in this Chapter for the health care institution class or subclass for which licensing is requested.

C. The Department shall approve or deny a license application in this Section according to R9-10-108.

D. A health care institution license is valid:

1. Unless, as specified in A.R.S. § 36-425(C):

a. The Department revokes or suspends the license according to R9-10-112, or

b. The license is considered void because the licensee did not pay the applicable fees in R9-10-106 according to R9-10-107; or

2. Until a licensee voluntarily surrenders the license to the Department when terminating the operation of the health care institution, according to R9-10-109(B).

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

R9-10-106. Fees

A. An applicant who submits to the Department architectural plans and specifications for the construction or modification of a health care institution shall also submit an architectural plans and specifications review fee as follows:

1. Fifty dollars for a project with a cost of $100,000 or less;

2. One hundred dollars for a project with a cost of more than $100,000 but less than $500,000; or

3. One hundred fifty dollars for a project with a cost of $500,000 or more.

B. An applicant submitting an application for a health care institution license shall submit to the Department an application fee of $50.

C. Except as provided in subsection (D) or (E), an applicant submitting an application for a health care institution license or a licensee submitting annual health care institution licensing fees shall submit to the Department the following licensing fee:
1. For an adult day health care facility, assisted living home, or assisted living center:
   a. For a facility with no licensed capacity, $280;
   b. For a facility with a licensed capacity of one to 59 beds, $280, plus the licensed capacity times $70;
   c. For a facility with a licensed capacity of 60 to 99 beds, $560, plus the licensed capacity times $70;
   d. For a facility with a licensed capacity of 100 to 149 beds, $840, plus the licensed capacity times $70; or
   e. For a facility with a licensed capacity of 150 beds or more, $1,400, plus the licensed capacity times $70;
2. For a behavioral health facility:
   a. For a facility with no licensed capacity, $375;
   b. For a facility with a licensed capacity of one to 59 beds, $375, plus the licensed capacity times $94;
   c. For a facility with a licensed capacity of 60 to 99 beds, $750, plus the licensed capacity times $94;
   d. For a facility with a licensed capacity of 100 to 149 beds, $1,125, plus the licensed capacity times $94; or
   e. For a facility with a licensed capacity of 150 beds or more, $1,875, plus the licensed capacity times $94;
3. For a behavioral health facility providing behavioral health observation/stabilization services, in addition to the applicable fee in subsection (C)(2), the licensed occupancy times $94;
4. For a nursing care institution, an intermediate care facility for individuals with intellectual disabilities, or a nursing-supported group home:
   a. For a facility with a licensed capacity of one to 59 beds, $290, plus the licensed capacity times $73;
   b. For a facility with a licensed capacity of 60 to 99 beds, $580, plus the licensed capacity times $73;
   c. For a facility with a licensed capacity of 100 to 149 beds, $870, plus the licensed capacity times $73; or
   d. For a facility with a licensed capacity of 150 beds or more, $1,450, plus the licensed capacity times $73;
5. For a hospital, a home health agency, a hospice service agency, a hospice inpatient facility, an abortion clinic, a recovery care center, an outpatient surgical center, an outpatient treatment center that is not a behavioral health facility, a pain management clinic, or an unclassified health care institution:
   a. For a facility with no licensed capacity, $365;
   b. For a facility with a licensed capacity of one to 59 beds, $365, plus the licensed capacity times $91;
   c. For a facility with a licensed capacity of 60 to 99 beds, $730, plus the licensed capacity times $91;
   d. For a facility with a licensed capacity of 100 to 149 beds, $1,095, plus the licensed capacity times $91; or
   e. For a facility with a licensed capacity of 150 beds or more, $1,825, plus the licensed capacity times $91;
6. For a hospital providing behavioral health observation/stabilization services, in addition to the applicable fee in subsection (C)(5), the licensed occupancy times $91; and
7. For an outpatient treatment center that is not a behavioral health facility and provides:
   a. Dialysis services, in addition to the applicable fee in subsection (C)(5), the number of dialysis stations times $91; and
   b. Behavioral health observation/stabilization services, in addition to the applicable fee in subsection (C)(5), the licensed occupancy times $91.

D. In addition to the applicable fees in subsections (C)(5) and (C)(6), an applicant submitting an application for a single group hospital license or a licensee with a single group license submitting annual health care institution licensing fees shall submit to the Department an additional fee of $365 for each of the hospital's satellite facilities and, if applicable, the fees required in subsection (C)(7).

E. Subsections (C) and (D) do not apply to a health care institution operated by a state agency according to state or federal law or to an adult foster care home.

F. In addition to the applicable fees in subsections (C) and (D), a licensee shall submit a late payment fee of $250 if submitting annual licensing fees according to R9-10-107(E)(1) or (2)(d).

G. All fees are nonrefundable except as provided in A.R.S. § 41-1077.

Historical Note

New Section R9-10-106 renumbered from R9-10-122 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Amended by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-107. Submission of Health Care Institution Licensing Fees

A. An applicant for a health care institution license shall submit the applicable licensing fees in R9-10-106 to the Department:
1. Within 60 calendar days after the date of the written notice of approval in R9-10-108(C)(3); or
2. Within 90 calendar days after the date of the written notice of approval in R9-10-108(C)(3), with the payment of an additional late payment fee of $250.

B. The Department shall notify a licensee of the due date of the facility's health care institution licensing fees no later than 90 calendar days before the date the facility's health care institution licensing fee is due to the Department.

C. Except as specified in subsection (E), a licensee shall submit to the Department, no earlier than 60 calendar days before the anniversary date of the facility's health care institution license:
1. The following information in a Department-provided format:
   a. The licensee's name, and
   b. The facility's name and license number;
2. Verification of the information in the Department's current records for the health care institution;
3. If applicable, information or documentation required in another Article of this Chapter, specific to the health care institution, to be submitted with the relevant fees required in R9-10-106; and
4. The applicable annual licensing fees in R9-10-106.

D. If any information in the Department's current records for a health care institution is incorrect, before a licensee submits annual licensing fees according to subsection (C), the licensee shall comply with the applicable requirements in R9-10-109 or R9-10-110 to update the Department's records for the health care institution.

E. A licensee may submit to the Department the information in subsection (C)(1), verification in subsection (C)(2), applicable information or documentation in subsection (C)(3), and applicable annual licensing fees in R9-10-106:

1. Within 30 calendar days after the anniversary date of the facility's health care institution license, with the payment of the additional late payment fee in R9-10-106(F); or
2. If an alternate licensing fee due date has been established for the licensee according to subsections (F) and (G):
   a. By the anniversary date of the facility's health care institution license, with the appropriate fee amount to prorate the annual licensing fees in R9-10-106 for a facility to the alternate licensing fee due date;
   b. By the alternate licensing fee due date;
   c. If a new alternate licensing fee due date has been established, by the current alternate licensing fee due date, with the appropriate fee amount to prorate the annual licensing fees in R9-10-106 for a facility to the new alternate licensing fee due date; or
   d. Within 30 calendar days after the alternate licensing fee due date, with the payment of the additional late payment fee in R9-10-106(F).

F. Except as specified in subsection (H), a licensee may request a licensing fee due date for a facility that is different from the anniversary date of a facility's health care institution license by submitting an application for an alternate licensing fee due date to the Department, at least 30 calendar days before the anniversary date of the facility's health care institution license, that includes the following information in a Department-provided format:

1. The licensee's name and e-mail address,
2. The facility's name and license number,
3. The current licensing fee due date,
4. The proposed alternate licensing fee due date,
5. The reason the licensee is requesting an alternate licensing fee due date, and
6. The name of the health care institution's administrator's or individual representing the health care institution as designated in A.R.S. § 36-422 and the dated signature of the administrator or individual.

G. The Department shall review a request made according to subsection (F) according to R9-10-108.

H. A licensee may not request an alternate licensing fee due date according to subsection (F):

1. More frequently than once in each three-year period, or
2. For a facility for which the payment of licensing fees is not up-to-date.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-108. Time-frames

A. The overall time-frame for each type of approval granted by the Department is listed in Table 1.1. 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.

B. The administrative completeness review time-frame for each type of approval granted by the Department as prescribed in this Article is listed in Table 1.1. The administrative completeness review time-frame begins on the date the Department receives an application packet or a written request for an alternate licensing fee due date.

1. The application packet for a health care institution license is not complete until the applicant provides the Department with written notice that the health care institution is ready for a licensing inspection by the Department.
2. If the application packet or written request is incomplete, the Department shall provide a written notice to the applicant specifying the missing document or incomplete information. 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 missing document or information from the applicant.
3. When an application packet or written request is complete, the Department shall provide a written notice of administrative completeness to the applicant.
4. For an application packet for review of architectural plans and specifications, a health care institution license application packet, an application packet for a modification not requiring review of architectural plans and specifications, or a written request for an alternate licensing fee due date, the Department shall consider the application or written request withdrawn if the applicant fails to supply the missing documents or information included in the notice described in subsection (B)(2) within 60 calendar days after the date of the notice described in subsection (B)(2).
5. If the Department issues a license or grants an approval during the time provided to assess administrative completeness, the Department shall not issue a separate written notice of administrative completeness.

C. The substantive review time-frame is listed in Table 1.1 and begins on the date of the notice of administrative completeness.

1. The Department may conduct an onsite inspection of the facility:
   a. As part of the substantive review for approval of architectural plans and specifications;
   b. As part of the substantive review for issuing a health care institution license; or
   c. As part of the substantive review for approving a modification of a health care institution's license.
2. During the substantive review time-frame, the Department may make one comprehensive written request for additional information or documentation. If the Department and the applicant agree in writing, the Department may make supplemental requests for additional information or documentation. The time-frame for the Department to complete the substantive review is suspended from the date of a written request for additional information or documentation until the Department receives the additional information or documentation.

3. The Department shall send a written notice of approval to an applicant that is in substantial compliance with applicable requirements in A.R.S. Title 36, Chapter 4 and this Chapter.
4. After an applicant for a health care institution license receives the written notice of approval in subsection (C)(3), the applicant shall submit the applicable health care institution license fee in R9-10-106 according to R9-10-107(A).
5. After receiving the applicable health care institution licensing fee from an applicant according to subsection (C)(4) and R9-10-107(A), the Department shall send a health care institution license to the applicant.
6. The Department shall provide a written notice of denial that complies with A.R.S. § 41-1076 to an applicant who does not:
   a. For a health care institution license application or a request for approval of a modification of a health care institution requiring architectural plans and specifications, submit the information or documentation in subsection (C)(2) within 120 calendar days after the Department's written request to the applicant;
   b. For a request for approval of a modification of a health care institution not requiring architectural plans and specifications or a written request for an alternate licensing fee due date, submit the information or documentation in subsection (C)(2) within 30 calendar days after the Department's written request to the applicant;
   c. Comply with the applicable requirements in A.R.S. Title 36, Chapter 4 and this Chapter; or
   d. If applicable, submit a fee required in R9-10-106 or R9-10-107.
7. An applicant may file a written notice of appeal with the Department within 30 calendar days after receiving the notice described in subsection (C)(6). The appeal shall be conducted according to A.R.S. Title 41, Chapter 6, Article 10.
8. If a time-frame's last day falls on a Saturday, a Sunday, or an official state holiday, the Department shall consider the next working day to be the time-frame's last day.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 859, effective April 2, 2005 (Supp. 05-1). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

Table 1.1 Time-frames

Type of Approval	Statutory Authority	Overall Time-frame	Administrative Completeness Time-frame	Substantive Review Time-frame
Approval of architectural plans and specifications R9-10-104	A.R.S. §§ 36-405, 36-406(1)(b), and 36-421	105 calendar days	45 calendar days	60 calendar days
Health care institution license R9-10-105	A.R.S. §§ 36-405, 36-407, 36-421, 36-422, 36-424, and 36-425	120 calendar days	30 calendar days	90 calendar days
Approval of an alternate licensing fee due date R9-10-107	A.R.S. § 36-405	30 calendar days	10 calendar days	20 calendar days
Approval of a modification of a health care institution R9-10-110	A.R.S. §§ 36-405, 36-407, and 36-422	75 calendar days	15 calendar days	60 calendar days

Historical Note

New Table 1 made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 859, effective April 2, 2005 (Supp. 05-1). Table 1 number amended to Table 1.1 and contents amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Table 1.1 amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Table 1.1 amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Table 1.1 heading added for clarity by the Division (21-2).

R9-10-109. Changes Affecting a License

A. A licensee shall ensure that:
1. The Department is notified in writing at least 30 calendar days before the effective date of:
   a. Except as provided in subsection (I), a change in the name of:
      i. A health care institution, or
      ii. The licensee;
   b. A change in the hours of operation:
      i. Of an administrative office, or
      ii. For providing physical health services or behavioral health services to patients of the health care institution;
   c. A change in the address of a health care institution that does not provide medical services, nursing services, behavioral health services, or health-related services on the premises; or

d. A change in the geographic region to be served by the hospice service agency or home health agency; and

2. Documentation supporting the change is provided to the Department with the notification required in subsection (A)(1).

B. If a licensee intends to terminate the operation of a health care institution, the licensee shall ensure that the Department is notified in writing of:

1. The termination of the health care institution's operations, as required in A.R.S. § 36-422(D), at least 30 calendar days before the termination, and
2. The address and contact information for the location where the health care institution's medical records will be retained as required in A.R.S. § 12-2297.

C. A licensee shall ensure that the Department is notified in writing, according to A.R.S. § 36-425(I), of a change in the chief administrative officer of the health care institution.

D. If a health care institution is accredited by a nationally recognized accrediting organization, a licensee may submit to the Department the health care institution's current accreditation report.

E. Except as provided in A.R.S. § 36-424(B), if a licensee submits to the Department a health care institution's current accreditation report from a nationally recognized accrediting organization, the Department shall not conduct an onsite compliance inspection of the health care institution during the time the accreditation report is valid.

F. If a licensee is an adult behavioral health therapeutic home or a behavioral health respite home, the licensee shall ensure that:

1. The Department is notified in writing if the licensee does not have a written agreement with a collaborating health care institution, as required in R9-10-1603(A)(3) or R9-10-1803(A)(3) as applicable; and
2. The adult behavioral health therapeutic home or behavioral health respite home does not accept an individual as a resident or recipient, as applicable, or provide services to a resident or recipient, as applicable, until:
   a. The adult behavioral health therapeutic home or behavioral health respite home has a written agreement with a collaborating health care institution;
   b. The collaborating health care institution has approved the adult behavioral health therapeutic home's or behavioral health respite home's:
      i. Scope of services, and
      ii. Policies and procedures; and
   c. The collaborating health care institution has verified the provider's skills and knowledge.

G. If a licensee is an affiliated outpatient treatment center, the licensee shall ensure that if the affiliated outpatient treatment center:

1. Plans to begin providing administrative support to a counseling facility at a time other than during the affiliated outpatient treatment center's license application process, the following information for each counseling facility is submitted to the Department before the affiliated outpatient treatment center begins providing administrative support:
   a. The counseling facility's name,
   b. The license number assigned to the counseling facility by the Department, and
   c. The date the affiliated outpatient treatment center will begin providing administrative support to the counseling facility; or
2. No longer provides administrative support to a counseling facility previously identified by the affiliated outpatient treatment center as receiving administrative support from the affiliated outpatient treatment center, the following information for each counseling facility is submitted to the Department within 30 calendar days after the affiliated outpatient treatment center no longer provides administrative support:
   a. The counseling facility's name,
   b. The license number assigned to the counseling facility by the Department, and
   c. The date the affiliated outpatient treatment center stopped providing administrative support to the counseling facility.

H. If a licensee is a counseling facility, the licensee shall ensure that if the counseling facility:

1. Plans to begin receiving administrative support from an affiliated outpatient treatment center at a time other than during the counseling facility's license application process, the following information for the affiliated outpatient treatment center is submitted to the Department before the counseling facility begins receiving administrative support:
   a. The affiliated outpatient treatment center's name,
   b. The license number assigned to the affiliated outpatient treatment center by the Department, and
   c. The date the counseling facility will begin receiving administrative support;
2. No longer receives administrative support from an affiliated outpatient treatment center previously identified by the counseling facility as providing administrative support to the counseling facility, the following information for the affiliated outpatient treatment center is submitted to the Department within 30 calendar days after the counseling facility no longer receives administrative support from the affiliated outpatient treatment center:
   a. The affiliated outpatient treatment center's name,
   b. The license number assigned to the affiliated outpatient treatment center by the Department, and
   c. The date the counseling facility stopped receiving administrative support from the affiliated outpatient treatment center;
3. Plans to begin sharing administrative support with an affiliated counseling facility at a time other than during the counseling facility's license application process, the following information for each affiliated counseling facility sharing administrative support with the counseling facility is submitted to the Department before the counseling facility and affiliated counseling facility begin sharing administrative support:
   a. The affiliated counseling facility's name,
   b. The license number assigned to the affiliated counseling facility by the Department, and
   c. The date the counseling facility and the affiliated counseling facility will begin sharing administrative support; or
4. No longer shares administrative support with an affiliated counseling facility previously identified by the counseling facility as sharing administrative support with the counseling facility, the following information is submitted for each affiliated counseling facility within 30 calendar days after the counseling facility and affiliated counseling facility no longer share administrative support:

a. The affiliated counseling facility's name,
b. The license number assigned to the affiliated counseling facility by the Department, and
c. The date the counseling facility and affiliated counseling facility will no longer be sharing administrative support.

I. A governing authority shall submit a license application required in R9-10-105 for:
1. A change in ownership of a health care institution;
2. A change in the address or location of a health care institution that provides medical services, nursing services, health-related services, or behavioral health services on the premises; or
3. A change in a health care institution's class or subclass.

J. A governing authority is not required to submit the documentation required in R9-10-105(A)(5) for a license application if:
1. The health care institution has not ceased operations for more than 30 calendar days,
2. A modification has not been made to the health care institution,
3. The services the health care institution is authorized by the Department to provide are not changed, and
4. The location of the health care institution's premises is not changed.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020 (Supp. 20-1).

R9-10-110. Modification of a Health Care Institution

A. A licensee shall submit a request for approval of a modification of a health care institution when planning to make:
1. An addition or removal of an authorized service;
2. An addition or removal of a colocator;
3. A change in a health care institution's licensed capacity, licensed occupancy, respite capacity, or the number of dialysis stations;
4. A change in the physical plant, including facilities or equipment, that costs more than $300,000; or
5. A change in the building where a health care institution is located that affects compliance with:
   a. Applicable physical plant codes and standards incorporated by reference in R9-10-104.01, or
   b. Physical plant requirements in the specific Article in this Chapter applicable to the health care institution.

B. A licensee of a health care institution that is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01 shall submit an application packet, according to R9-10-104(A), for approval of architectural plans and specifications for a modification of the health care institution described in subsections (A)(3) through (5).

C. A licensee of a health care institution shall submit a written request an application packet for a modification of the health care institution in a Department-provided format that contains:
1. The following information in a Department-provided format:
   a. The health care institution's name, mailing address, e-mail address, and license number;
   b. A narrative description of the modification, including as applicable:
      i. The services the licensee is requesting be added or removed as an authorized service;
      ii. The name and license number of an associated licensed provider being added or removed as a colocator;
      iii. The name and professional license number of an exempt health care provider being added or removed as a colocator;
      iv. If an associated licensed provider or exempt health care provider is being added as a colocator, the proposed scope of services;
      v. The current and proposed licensed capacity, licensed occupancy, respite capacity, and number of dialysis stations;
      vi. The change being made in the physical plant; and
      vii. The change being made that affects compliance with applicable physical plant codes and standards incorporated by reference in R9-10-104.01; and
   c. The name and e-mail address of the health care institution's administrator's or individual representing the health care institution as designated in according to A.R.S. § 36-422 and the dated signature of the administrator or individual; and
2. Documentation that demonstrates that the requested modification complies with applicable requirements in this Chapter, including as applicable:
   a. A floor plan showing the location of each colocator's proposed treatment area and the areas of the collaborating outpatient treatment center's premises shared with a colocator;
   b. For a change in the licensed capacity, licensed occupancy, respite capacity, or number of dialysis stations or a modification of the physical plant:
      i. A floor plan showing, for each story of the facility affected by the modification, the room layout, room usage, each door and each window, plumbing fixtures, each exit, and the location of each fire protection device; or
      ii. For a health care institution or part of the health care institution that is required to comply with the physical plant codes and standards incorporated by reference in R9-10-104.01 or the building, documentation of the Department's approval of the health care institution's architectural plans and specifications in R9-10-104(D); and
   c. Any other documentation to support the requested modification; and
3. If applicable, a copy of the written agreement the associated licensed provider or exempt health care provider has with the collaborating outpatient treatment center.

D. The Department shall approve or deny a request for a modification described in subsection (C) according to R9-10-108.

E. A licensee shall not implement a modification described in subsection (C) until an approval or amended license is issued by the Department.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-110 renumbered to Section R9-10-111; new Section R9-10-110 made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

R9-10-111. Enforcement Actions

A. If the Department determines that an applicant or licensee is violating applicable statutes and rules and the violation poses a direct risk to the life, health, or safety of a patient, the Department may:
1. Issue a provisional license to the applicant or licensee under A.R.S. § 36-425,
2. Assess a civil penalty under A.R.S. § 36-431.01,
3. Impose an intermediate sanction under A.R.S. § 36-427,
4. Remove a licensee and appoint another person to continue operation of the health care institution pending further action under A.R.S. § 36-429,
5. Suspend or revoke a license under A.R.S. § 36-427 and R9-10-112,
6. Deny a license under A.R.S. § 36-425 and R9-10-112, or
7. Issue an injunction under A.R.S. § 36-430.

B. In determining which action in subsection (A) is appropriate, the Department shall consider the direct risk to the life, health, or safety of a patient in the health care institution based on:
1. Repeated violations of statutes or rules,
2. Pattern of violations,
3. Types of violation,
4. Severity of violation, and
5. Number of violations.

Historical Note

Amended effective February 4, 1981 (Supp. 81-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 97, effective January 1, 2014 (Supp. 13-4). Section R9-10-111 renumbered to Section R9-10-112; new Section R9-10-111 renumbered from R9-10-110 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-112. Denial, Revocation, or Suspension of License

A. The Department may deny, revoke, or suspend a license to operate a health care institution if an applicant, a licensee, or a controlling person of the health care institution:
1. Provides false or misleading information to the Department;
2. Has had in any state or jurisdiction any of the following:
   a. An application or license to operate a health care institution denied, suspended, or revoked, unless the denial was based on failure to complete the licensing process or to pay a required licensing fee within a required time-frame; or
   b. A health care professional license or certificate denied, revoked, or suspended;
3. Does not comply with the applicable requirements in A.R.S. Title 36, Chapter 4 and this Chapter; or
4. Has operated a health care institution, within the preceding ten years, in violation of A.R.S. Title 36, Chapter 4 or this Chapter, that posed a direct risk to the life, health, or safety of a patient.

B. The Department shall suspend or revoke a hospital's license if the Department receives, pursuant to A.R.S. § 36-2901.08(H), notice from the Arizona Health Care Cost Containment System that the hospital's provider agreement registration with the Arizona Health Care Cost Containment System has been suspended or revoked.

Historical Note

Amended effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section made by exempt rulemaking at 9 A.A.R. 526, effective April 1, 2003 (Supp. 03-1). Section R9-10-112 renumbered to R9-10-113; new Section R9-10-112 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-112 renumbered to Section R9-10-113; new Section R9-10-112 renumbered from R9-10-111 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-113. Tuberculosis Screening

A. If a health care institution is subject to the requirements of this Section, as specified in an Article in this Chapter, the health care institution's chief administrative officer shall ensure that the health care institution establishes, documents, and implements tuberculosis infection control activities that:
1. Are consistent with recommendations in Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019, published by the U.S. Department of Health and Human Services, Atlanta, GA 30333, available at https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm, incorporated by reference, on file with the Department, and including no future editions or amendments; and
2. Include:
   a. For each individual who is employed by the health care institution, provides volunteer services for the health care institution, or is admitted to the health care institution and who is subject to the requirements of this Section, baseline screening, on or before the date specified in the applicable Article of this Chapter, that consists of:
      i. Assessing risks of prior exposure to infectious tuberculosis,
      ii. Determining if the individual has signs or symptoms of tuberculosis, and
      iii. Obtaining documentation of the individual's freedom from infectious tuberculosis according to subsection (B)(1);
   b. If an individual may have a latent tuberculosis infection, as defined in A.A.C. R9-6-1201:
      i. Referring the individual for assessment or treatment; and

ii. Annually obtaining documentation of the individual's freedom from symptoms of infectious tuberculosis, signed by a medical practitioner, occupation health provider, as defined in A.A.C. R9-6-801, or local health agency, as defined in A.A.C. R9-6-101;

c. Annually providing training and education related to recognizing the signs and symptoms of tuberculosis to individuals employed by or providing volunteer services for the health care institution;

d. Annually assessing the health care institution's risk of exposure to infectious tuberculosis;

e. Reporting, as specified in A.A.C. R9-6-202, an individual who is suspected of exposure to infectious tuberculosis; and

f. If an exposure to infectious tuberculosis occurs in the health care institution, coordinating and sharing information with the local health agency, as defined in A.A.C. R9-6-101, for identifying, locating, and investigating contacts, as defined in A.A.C. R9-6-101.

B. A health care institution's chief administrative officer shall:

1. For an individual for whom baseline screening and documentation of freedom from infectious tuberculosis is required by an Article in this Chapter, as specified in subsection (A)(2)(a), obtain one of the following as evidence of freedom from infectious tuberculosis:
   a. Documentation of a negative Mantoux skin test or other tuberculosis screening test that:
      i. Is recommended by the U.S. Centers for Disease Control and Prevention (CDC),
      ii. Was administered within 12 months before the date the individual begins providing services at or on behalf of the health care institution or is admitted to the health care institution, and
      iii. Includes the date and the type of tuberculosis screening test;
   b. If the individual had a history of tuberculosis or documentation of latent tuberculosis infection, as defined in A.A.C. R9-6-1201, compliance with subsection (A)(2)(b); or
   c. If the individual had a positive Mantoux skin test or other tuberculosis screening test according to subsection (B)(1)(a) and does not have history of tuberculosis or documentation of latent tuberculosis infection, as defined in A.A.C. R9-6-1201, a written statement:
      i. That the individual is free from infectious tuberculosis, signed by a medical practitioner or local health agency, as defined in A.A.C. R9-6-101; and
      ii. Dated within 12 months before the date the individual begins providing services at or on behalf of the health care institution or is admitted to the health care institution; and
2. As part of the annual assessment of the health care institution's risk of exposure to infectious tuberculosis according to subsection (A)(2)(d), ensure that documentation is obtained for each individual required to be screened for infectious tuberculosis that:
   a. Indicates the individual's freedom from symptoms of infectious tuberculosis; and
   b. Is signed by a medical practitioner, occupation health provider, as defined in A.A.C. R9-6-801, or local health agency, as defined in A.A.C. R9-6-101.

Historical Note

Former Section R9-10-113 repealed, new Section R9-10-113 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section R9-10-113 renumbered from R9-10-112 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-113 renumbered to Section R9-10-114; new Section R9-10-113 renumbered from R9-10-112 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 28 A.A.R. 1113 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-10-114. Clinical Practice Restrictions for Hemodialysis Technician Trainees

A. The following definitions apply in this Section:

1. "Assess" means collecting data about a patient by:
   a. Obtaining a history of the patient,
   b. Listening to the patient's heart and lungs, and
   c. Checking the patient for edema.
2. "Blood-flow rate" means the quantity of blood pumped into a dialyzer per minute of hemodialysis.
3. "Blood lines" means the tubing used during hemodialysis to carry blood between a vascular access and a dialyzer.
4. "Central line catheter" means a type of vascular access created by surgically implanting a tube into a large vein.
5. "Clinical practice restriction" means a limitation on the hemodialysis tasks that may be performed by a hemodialysis technician trainee.
6. "Conductivity test" means a determination of the electrolytes in a dialysate.
7. "Dialysate" means a mixture of water and chemicals used in hemodialysis to remove wastes and excess fluid from a patient's body.
8. "Dialysate-flow rate" means the quantity of dialysate pumped per minute of hemodialysis.
9. "Directly observing" or "direct observation" means a medical person stands next to an inexperienced hemodialysis technician trainee and watches the inexperienced hemodialysis technician trainee perform a hemodialysis task.
10. "Direct supervision" has the same meaning as "supervision" in A.R.S. § 36-401.
11. "Electrolytes" means chemical compounds that break apart into electrically charged particles, such as sodium, potassium, or calcium, when dissolved in water.
12. "Experienced hemodialysis technician trainee" means an individual who has passed all didactic, skills, and competency examinations provided by a health care institution that measure the individual's knowledge and ability to perform hemodialysis.
13. "Fistula" means a type of vascular access created by a surgical connection between an artery and vein.
14. "Fluid-removal rate" means the quantity of wastes and excess fluid eliminated from a patient's blood per minute of hemodialysis to achieve the patient's prescribed weight, determined by:

a. Dialyzer size,
b. Blood-flow rate,
c. Dialysate-flow rate, and
d. Hemodialysis duration.

15. "Germicide-negative test" means a determination that a chemical used to kill microorganisms is not present.
16. "Germicide-positive test" means a determination that a chemical used to kill microorganisms is present.
17. "Graft" means a vascular access created by a surgical connection between an artery and vein using a synthetic tube.
18. "Hemodialysis machine" means a mechanical pump that controls:
    a. The blood-flow rate,
    b. The mixing and temperature of dialysate,
    c. The dialysate-flow rate,
    d. The addition of anticoagulant, and
    e. The fluid-removal rate.
19. "Hemodialysis technician" has the same meaning as in A.R.S. § 36-423(A).
20. "Hemodialysis technician trainee" means an individual who is working in a health care institution to assist in providing hemodialysis and who is not certified as a hemodialysis technician according to A.R.S. § 36-423(A).
21. "Inexperienced hemodialysis technician trainee" means an individual who has not passed all didactic, skills, and competency examinations provided by a health care institution that measure the individual's knowledge and ability to perform hemodialysis.
22. "Medical person" means:
    a. A physician who is experienced in dialysis;
    b. A registered nurse practitioner who is experienced in dialysis;
    c. A nurse who is experienced in dialysis;
    d. A hemodialysis technician who meets the requirements in A.R.S. § 36-423(A) approved by the governing authority; and
    e. An experienced hemodialysis technician trainee approved by the governing authority.
23. "Not established" means not approved by a patient's nephrologist for use in hemodialysis.
24. "Patient" means an individual who receives hemodialysis.
25. "pH test" means a determination of the acidity of a dialysate.
26. "Preceptor course" means a health care institution's instruction and evaluation provided to a nurse, hemodialysis technician, or hemodialysis technician trainee that enables the nurse, hemodialysis technician, or hemodialysis technician trainee to provide direct observation and education to hemodialysis technician trainees.
27. "Respond" means to mute, shut off, reset, or troubleshoot an alarm.
28. "Safety check" means successful completion of tests recommended by the manufacturer of a hemodialysis machine, a dialyzer, or a water system used for hemodialysis before initiating a patient's hemodialysis.
29. "Water-contaminant test" means a determination of the presence of chlorine or chloramine in a water system used for hemodialysis.

B. An experienced hemodialysis technician trainee may:
1. Perform hemodialysis under direct supervision, and
2. Provide direct observation to another hemodialysis technician trainee only after completing the health care institution's preceptor course approved by the governing authority.

C. An experienced hemodialysis technician trainee shall not access a patient's:
1. Fistula that is not established, or
2. Graft that is not established.

D. An inexperienced hemodialysis technician trainee may perform the following hemodialysis tasks only under direct observation:
1. Access a patient's central line catheter;
2. Respond to a hemodialysis-machine alarm;
3. Draw blood for laboratory tests;
4. Perform a water-contaminant test on a water system used for hemodialysis;
5. Inspect a dialyzer and perform a germicide-positive test before priming a dialyzer;
6. Set up a hemodialysis machine and blood lines before priming a dialyzer;
7. Prime a dialyzer;
8. Test a hemodialysis machine for germicide presence;
9. Perform a hemodialysis machine safety check;
10. Prepare a dialysate;
11. Perform a conductivity test and a pH test on a dialysate;
12. Assess a patient;
13. Check and record a patient's vital signs, weight, and temperature;
14. Determine the amount and rate of fluid removal from a patient;
15. Administer local anesthetic at an established fistula or graft, administer anticoagulant, or administer replacement saline solution;
16. Perform a germicide-negative test on a dialyzer before initiating hemodialysis;
17. Initiate or discontinue a patient's hemodialysis;
18. Adjust blood-flow rate, dialysate-flow rate, or fluid-removal rate during hemodialysis; or
19. Prepare a blood, water, or dialysate culture to determine microorganism presence.

E. An inexperienced hemodialysis technician trainee shall not:
1. Access a patient's:
    a. Fistula that is not established, or
    b. Graft that is not established; or
2. Provide direct observation.

F. When a hemodialysis technician trainee performs hemodialysis tasks for a patient, the patient's medical record shall include:
1. The name of the hemodialysis technician trainee;
2. The date, time, and hemodialysis task performed;
3. The name of the medical person directly observing or the nurse or physician directly supervising the hemodialysis technician trainee; and
4. The initials or signature of the medical person directly observing or the nurse or physician directly supervising the hemodialysis technician trainee.

G. If the Department determines that a health care institution is not in substantial compliance with this Section, the Department may take enforcement action according to R9-10-111.

Historical Note

Former Section R9-10-114 repealed, new Section R9-10-114 adopted effective February 4, 1981 (Supp. 81-1). Amended by adding paragraph (7) as an emergency effective November 17, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Amended by adding paragraph (7) as a permanent amendment effec-

tive August 2, 1984 (Supp. 84-4). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section R9-10-114 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-114 renumbered to Section R9-10-115; new Section R9-10-114 renumbered from R9-10-113 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-115. Behavioral Health Paraprofessionals; Behavioral Health Technicians

If a health care institution is a behavioral health facility or is authorized by the Department to provide behavioral health services, an administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented that:
   a. Delineate the services a behavioral health paraprofessional is allowed to provide at or for the health care institution;
   b. Cover supervision of a behavioral health paraprofessional, including documentation of supervision;
   c. Establish the qualifications for a behavioral health professional providing supervision to a behavioral health paraprofessional;
   d. Delineate the services a behavioral health technician is allowed to provide at or for the health care institution;
   e. Cover clinical oversight for a behavioral health technician, including documentation of clinical oversight;
   f. Establish the qualifications for a behavioral health professional providing clinical oversight to a behavioral health technician;
   g. Delineate the methods used to provide clinical oversight, including when clinical oversight is provided on an individual basis or in a group setting; and
   h. Establish the process by which information pertaining to services provided by a behavioral health technician is provided to the behavioral health professional who is responsible for the clinical oversight of the behavioral health technician;
2. A behavioral health paraprofessional receives supervision according to policies and procedures;
3. Clinical oversight is provided to a behavioral health technician to ensure that patient needs are met based on, for each behavioral health technician:
   a. The scope and extent of the services provided,
   b. The acuity of the patients receiving services, and
   c. The number of patients receiving services;
4. A behavioral health technician receives clinical oversight at least once during each two week period, if the behavioral health technician provides services related to patient care at the health care institution during the two week period;
5. When clinical oversight is provided electronically:
   a. The clinical oversight is provided verbally with direct and immediate interaction between the behavioral health professional providing and the behavioral health technician receiving the clinical oversight,
   b. A secure connection is used, and
   c. The identities of the behavioral health professional providing and the behavioral health technician receiving the clinical oversight are verified before clinical oversight is provided; and
6. A behavioral health professional provides supervision to a behavioral health paraprofessional or clinical oversight to behavioral health technician within the behavioral health professional's scope of practice established in the applicable licensing requirements under A.R.S. Title 32.

Historical Note

Adopted effective February 4, 1981 (Supp. 81-1). Amended by final rulemaking 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-115 renumbered to Section R9-10-116; new Section R9-10-115 renumbered from R9-10-114 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-116. Nutrition and Feeding Assistant Training Programs

A. For the purposes of this Section, "agency" means an entity other than a nursing care institution that provides the nutrition and feeding assistant training required in A.R.S. § 36-413.

B. An agency shall apply for approval to operate a nutrition and feeding assistant training program by submitting:
1. An application in a Department-provided format that contains:
   a. The name of the agency;
   b. The name, telephone number, and e-mail address of the individual in charge of the proposed nutrition and feeding assistant training program;
   c. The address where the nutrition and feeding assistant training program records are maintained;
   d. A description of the training course being offered by the nutrition and feeding assistant training program including for each topic in subsection (I):
      i. The information presented for each topic,
      ii. The amount of time allotted to each topic,
      iii. The skills an individual is expected to acquire for each topic, and
      iv. The testing method used to verify an individual has acquired the stated skills for each topic;
   e. Whether the agency agrees to allow the Department to submit supplemental requests for information as specified in subsection (F)(2); and
   f. The signature of the individual in charge of the proposed nutrition and feeding assistant training program and the date signed; and
2. A copy of the materials used for providing the nutrition and feeding assistant training program.

C. For an application for an approval of a nutrition and feeding assistant training program, the administrative review time-frame is 30 calendar days, the substantive review time-frame is 30 calendar days, and the overall time-frame is 60 calendar days.

D. Within 30 calendar days after the receipt of an application in subsection (B), the Department shall:
1. Issue an approval of the agency's nutrition and feeding assistant training program;

2. Provide a notice of administrative completeness to the agency that submitted the application; or
3. Provide a notice of deficiencies to the agency that submitted the application, including a list of the information or documents needed to complete the application.

E. If the Department provides a notice of deficiencies to an agency:
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 agency;
2. If the agency does not submit the missing information or documents to the Department within 30 calendar days, the Department shall consider the application withdrawn; and
3. If the agency submits the missing information or documents to the Department within 30 calendar days, the substantive review time-frame begins on the date the Department receives the missing information or documents.

F. Within the substantive review time-frame, the Department:
1. Shall issue or deny an approval of a nutrition and feeding assistant training program; and
2. May make one written comprehensive request for more information, unless the Department and the agency agree in writing to allow the Department to submit supplemental requests for information.

G. 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 the information requested, and
2. The agency shall submit to the Department 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.

H. The Department shall issue:
1. An approval for an agency to operate a nutrition and feeding assistant training program if the Department determines that the agency and the application comply with A.R.S. § 36-413 and this Section; or
2. A denial for an agency that includes the reason for the denial and the process for appeal of the Department's decision if:
   a. The Department determines that the agency does not comply with A.R.S. § 36-413 and this Section; or
   b. The agency does not submit 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.

I. An individual in charge of a nutrition and feeding assistant training program shall ensure that:
1. The materials and coursework for the nutrition and feeding assistant training program demonstrate the inclusion of the following topics:
   a. Feeding techniques;
   b. Assistance with feeding and hydration;
   c. Communication and interpersonal skills;
   d. Appropriate responses to resident behavior;
   e. Safety and emergency procedures, including the Heimlich maneuver;
   f. Infection control;
   g. Resident rights;
   h. Recognizing a change in a resident that is inconsistent with the resident's normal behavior; and
   i. Reporting a change in subsection (I)(1)(h) to a nurse at a nursing care institution;
2. An individual providing the training course is:
   a. A physician,
   b. A physician assistant,
   c. A registered nurse practitioner,
   d. A registered nurse,
   e. A registered dietitian,
   f. A licensed practical nurse,
   g. A speech-language pathologist, or
   h. An occupational therapist; and
3. An individual taking the training course completes:
   a. At least eight hours of classroom time, and
   b. Demonstrates that the individual has acquired the skills the individual was expected to acquire.

J. An individual in charge of a nutrition and feeding assistant training program shall issue a certificate of completion to an individual who completes the training course and demonstrates the skills the individual was expected to acquire as a result of completing the training course that contains:
1. The name of the agency approved to operate the nutrition and feeding assistant training program;
2. The name of the individual completing the training course;
3. The date of completion;
4. The name, signature, and professional license of the individual providing the training course; and
5. The name and signature of the individual in charge of the nutrition and feeding assistant training program.

K. The Department may deny, revoke, or suspend an approval to operate a nutrition and feeding assistant training program if an agency operating or applying to operate a nutrition and feeding assistance training program:
1. Provides false or misleading information to the Department;
2. Does not comply with the applicable statutes and rules;
3. Issues a training completion certificate to an individual who did not:
   a. Complete the nutrition and feeding assistant training program, or
   b. Demonstrate the skills the individual was expected to acquire; or
4. Does not implement the nutrition and feeding assistant training program as described in or use the materials submitted with the agency's application.

L. In determining which action in subsection (K) is appropriate, the Department shall consider the following:
1. Repeated violations of statutes or rules,
2. Pattern of non-compliance,
3. Types of violations,
4. Severity of violations, and
5. Number of violations.

Historical Note

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October

1, 2013 (Supp. 13-2). Section R9-10-116 renumbered to Section R9-10-117; new Section R9-10-116 renumbered from R9-10-115 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-117. Repealed

Historical Note

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-117 renumbered to Section R9-10-118; new Section R9-10-117 renumbered from R9-10-116 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Repealed by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).

R9-10-118. Collaborating Health Care Institution

A. An administrator of a collaborating health care institution shall ensure that:
1. A list is maintained of adult behavioral health therapeutic homes and behavioral health respite homes for which the collaborating health care institution serves as a collaborating health care institution;
2. For each adult behavioral health therapeutic home or behavioral health respite home in subsection (A)(1), the collaborating health care institution maintains the following information:
   a. A copy of the documented agreement that establishes the responsibilities of the adult behavioral health therapeutic home or behavioral health respite home and the collaborating health care institution consistent with the requirements in this Chapter;
   b. For the adult behavioral health therapeutic home or behavioral health respite home, the following information:
      i. Provider's name;
      ii. Street address;
      iii. License number;
      iv. Whether the residence is an adult behavioral health therapeutic home or a behavioral health respite home;
      v. If the residence is a behavioral health respite home, whether the behavioral health respite home provides respite care services to:
         (1) Individuals 18 years of age or older, or
         (2) Individuals less than 18 years of age;
      vi. The beginning and ending dates of the documented agreement in subsection (A)(2)(a); and
      vii. The name and contact information for the individual assigned by the collaborating health care institution to monitor the adult behavioral health therapeutic home or behavioral health respite home;
   c. For the adult behavioral health therapeutic home or behavioral health respite home, a copy of the following that have been approved by the collaborating health care institution:
      i. Scope of services,
      ii. Policies and procedures, and
      iii. Documentation of the review and update of policies and procedures;
   d. A description of the required skills and knowledge for a provider, based on the scope of services of the adult behavioral health therapeutic home or behavioral health respite home, as established by the collaborating health care institution; and
   e. For a provider in the adult behavioral health therapeutic home or behavioral health respite home, documentation of:
      i. The provider's skills and knowledge;
      ii. If applicable, the provider's completion of training in assistance in the self-administration of medication;
      iii. Verification of the provider's skills and knowledge; and
      iv. If the provider is required to have clinical oversight according to R9-10-1805(C), the provider's receiving clinical oversight;
3. A provider's skills and knowledge are verified by a personnel member according to policies and procedures;
4. A provider who provides behavioral health services receives clinical oversight, required in R9-10-1805(C), from a behavioral health professional; and
5. A provider, other than a provider who is a medical practitioner or nurse, receives training in assistance in the self-administration of medication:
   a. From a medical practitioner or registered nurse or from a personnel member of the collaborating health care institution trained by a medical practitioner or registered nurse;
   b. That includes:
      i. A demonstration of the provider's skills and knowledge necessary to provide assistance in the self-administration of medication,
      ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
      iii. The process for notifying the appropriate entities when an emergency medical intervention is needed; and
   c. That is documented.

B. For a patient referred to an adult behavioral health therapeutic home or a behavioral health respite home, an administrator shall ensure that:
1. A resident or recipient accepted by and receiving services from the adult behavioral health therapeutic home or behavioral health respite home does not present a threat to the referred patient, based on the resident's or recipient's developmental levels, social skills, verbal skills, and personal history;
2. The referred patient does not present a threat to a resident or recipient accepted by and receiving services from the adult behavioral health therapeutic home or behavioral health respite home based the referred patient's developmental levels, social skills, verbal skills, and personal history;
3. The referred patient requires services within the adult behavioral health therapeutic home's or behavioral health respite home's scope of services;
4. A provider of the adult behavioral health therapeutic home or behavioral health respite home has the verified skills and knowledge to provide behavioral health services to the referred patient;

5. A treatment plan for the referred patient, which includes information necessary for a provider to meet the referred patient's needs for behavioral health services, is completed and forwarded to the provider before the referred patient is accepted as a resident or recipient;
6. A patient's treatment plan is reviewed and updated at least once every 12 months, and a copy of the patient's updated treatment plan is forwarded to the patient's provider;
7. If documentation of a significant change in a patient's behavioral, physical, cognitive, or functional condition and the action taken by a provider to address patient's changing needs is received by the collaborating health care institution, a behavioral health professional or behavioral health technician reviews the documentation and:
   a. Documents the review; and
   b. If applicable:
      i. Updates the patient's treatment plan, and
      ii. Forwards the updated treatment plan to the provider within 10 working days after receipt of the documentation of a significant change;
8. If the review and updated treatment plan required in subsection (B)(7) is performed by a behavioral health technician, a behavioral health professional reviews and signs the review and updated treatment plan to ensure the patient is receiving the appropriate behavioral health services; and
9. In addition to the requirements for a medical record for a patient in this Chapter, a referred patient's medical record contains:
   a. The provider's name and the street address and license number of the adult behavioral health therapeutic home or behavioral health respite home to which the patient is referred,
   b. A copy of the treatment plan provided to the adult behavioral health therapeutic home or behavioral health respite home,
   c. Documentation received according to and required by subsection (B)(7),
   d. Any information about the patient received from the adult behavioral health therapeutic home or behavioral health respite home, and
   e. Any follow-up actions taken by the collaborating health care institution related to the patient.

C. For a patient referred to an adult behavioral health therapeutic home, an administrator shall ensure that the collaborating health care institution has documentation in the patient's medical record of evidence of freedom from infectious tuberculosis that meets the requirements in R9-10-113.

Historical Note

New Section R9-10-118 renumbered from R9-10-117 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). The word twelve has been changed to the numeral 12 in subsection (B)(6) for consistency in Chapter style and format (Supp. 21-2).

R9-10-119. Abortion Reporting

A. A licensed health care institution where abortions are performed shall submit to the Department, in a Department-provided format and according to A.R.S. § 36-2161(D) and (E), a report that contains the information required in A.R.S. § 36-2161(A) and the following:
1. The final disposition of the fetal tissue from the abortion; and
2. Except as provided in subsection (B), if custody of the fetal tissue is transferred to another person or persons:
   a. The name and address of the person or persons accepting custody of the fetal tissue,
   b. The amount of any compensation received by the licensed health care institution for the transferred fetal tissue, and
   c. Whether a patient provided informed consent for the transfer of custody of the fetal tissue.

B. A licensed health care institution where abortions are performed is not required to include the information specified in subsections (A)(2)(a) through (c) in the report required in subsection (A) if the licensed health care institution where abortions are performed:
1. Transfers custody of the fetal tissue:
   a. To a funeral establishment, as defined in A.R.S. § 32-1301;
   b. To a crematory, as defined in A.R.S. § 32-1301; or
   c. According to requirements in A.A.C. R18-13-1406, A.A.C. R18-13-1407, and A.A.C. R18-13-1408; or
2. Complies with requirements in A.A.C. R18-13-1405.

C. For purposes of this Section, the following definition applies: "Fetal tissue" means cells, or groups of cells with a specific function, obtained from an aborted human embryo or fetus.

Historical Note

New Section made by emergency rulemaking at 21 A.A.R. 1787, effective August 14, 2015 for 180 days (Supp. 15-3). Emergency expired February 10, 2016. Section amended by emergency rulemaking at 22 A.A.R. 420, effective February 11, 2016, for an additional 180 days; filed in the Office February 8, 2016 (Supp. 16-1). New Section made by final rulemaking at 22 A.A.R. 1343, with an immediate effective date upon filing under A.R.S. § 41-1032(A)(1) and (4) of May 5, 2016 (Supp. 16-2). Amended by final expedited rulemaking at 25 A.A.R. 1893, effective July 2, 2019 (Supp. 19-3).

R9-10-120. Opioid Prescribing and Treatment

A. This Section does not apply to a health care institution licensed under Article 20 of this Chapter.

B. In addition to the definitions in A.R.S. §§ 32-3248.01 and 36-401(A) and R9-10-101, the following definitions apply in this Section:
1. "Episode of care" means medical services, nursing services, or health-related services provided by a health care institution to a patient for a specific period of time, ending in discharge, the completion of the patient's treatment plan, or 90 days from the start of service provision to the patient, whichever is later.
2. "Order" means to issue written, verbal, or electronic instructions for a specific dose of a specific medication in a specific quantity and route of administration to be obtained and administered to a patient in a health care institution.

C. An administrator of a health care institution where opioids are prescribed or ordered as part of treatment shall:
1. Establish, document, and implement policies and procedures for prescribing or ordering an opioid as part of treatment, to protect the health and safety of a patient, that:

a. Cover which personnel members may prescribe or order an opioid in treating a patient and the required knowledge and qualifications of these personnel members;
b. As applicable and except when contrary to medical judgment for a patient, are consistent with A.R.S. § 32-3248.01 and the Arizona Opioid Prescribing Guidelines or national opioid-prescribing guidelines, such as guidelines developed by the:
   i. Centers for Disease Control and Prevention, or
   ii. U.S. Department of Veterans Affairs and the U.S. Department of Defense;
c. As applicable, include how, when, and by whom:
   i. A patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database is reviewed;
   ii. An assessment is conducted of a patient's substance use risk;
   iii. The potential risks, adverse outcomes, and complications, including death, associated with the use of opioids are explained to a patient or the patient's representative;
   iv. Alternatives to a prescribed or ordered opioid are explained to a patient or the patient's representative;
   v. Informed consent is obtained from a patient or the patient's representative and, if applicable, in what situations, described in subsection (G), (H), or (I), informed consent would not be obtained before an opioid is prescribed or ordered for a patient;
   vi. A patient receiving an opioid is monitored; and
   vii. The actions taken according to subsections (C)(1)(c)(i) through (vi) are documented;
d. Address conditions that may impose a higher risk to a patient when prescribing or ordering an opioid as part of treatment, including:
   i. Concurrent use of a benzodiazepine or other sedative-hypnotic medication,
   ii. History of substance use disorder,
   iii. Co-occurring behavioral health issue, or
   iv. Pregnancy;
e. Cover the criteria for co-prescribing a short-acting opioid antagonist for a patient who is not an inpatient, as defined in R9-10-201;
f. Include that, if continuing control of a patient's pain after discharge is medically indicated due to the patient's medical condition, a method for continuing pain control will be addressed as part of discharge planning;
g. Include the frequency of the following for a patient being prescribed an opioid for longer than a 30-calendar-day period:
   i. Face-to-face interactions with the patient,
   ii. Conducting an assessment of a patient's substance use risk,
   iii. Renewal of a prescription for an opioid without a face-to-face interaction with the patient, and
   iv. Monitoring the effectiveness of the treatment;
h. If applicable according to A.R.S. § 36-2608, include documenting a dispensed opioid in the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
   i. As applicable and consistent with A.R.S. § 32-3248.01, cover the criteria and procedures for tapering opioid prescription or ordering as part of treatment; and
   j. Cover the criteria and procedures for offering or referring a patient for treatment for substance use disorder;
2. Include in the plan for the health care institution's quality management program a process for:
   a. Review of known incidents of opioid-related adverse reactions or other negative outcomes a patient experiences or opioid-related deaths, and
   b. Surveillance and monitoring of adherence to the policies and procedures in subsection (C)(1);
3. Except as prohibited by 42 CFR, Chapter I, Subchapter A, Part 2, or as provided in subsection (H)(1), ensure that, if a patient's death may be related to an opioid prescribed or ordered as part of treatment, written notification, in a Department-provided format, is provided to the Department of the patient's death within one working day after the health care institution learns of the patient's death; and
4. Ensure that informed consent, if required from a patient or the patient's representative, includes:
   a. The patient's:
      i. Name,
      ii. Date of birth or other patient identifier, and
      iii. Condition for which opioids are being prescribed;
   b. That an opioid is being prescribed or ordered;
   c. The potential risks, adverse reactions, complications, and medication interactions associated with the use of an opioid;
   d. If applicable, the potential risks, adverse outcomes, and complications associated with the concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication;
   e. Alternatives to a prescribed or ordered opioid;
   f. The name and signature of the individual explaining the use of an opioid to the patient; and
   g. The signature of the patient or the patient's representative and the date signed.

D. Except as provided in subsection (H) or (I), an administrator of a health care institution where opioids are prescribed as part of treatment shall ensure that a medical practitioner authorized by policies and procedures to prescribe an opioid in treating a patient:
1. Before prescribing an opioid for a patient of the health care institution:
   a. Conducts a physical examination of the patient or reviews the documentation from a physical examination conducted during the patient's same episode of care;
   b. Except as exempted by A.R.S. § 36-2606(G), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
   c. Conducts an assessment of the patient's substance use risk or reviews the documentation from an assessment of the patient's substance use risk conducted during the same episode of care by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to conduct an assessment of the patient's substance use risk;

d. Explains to the patient or the patient's representative the risks and benefits associated with the use of opioids or ensures that the patient or the patient's representative understands the risks and benefits associated with the use of opioids, as explained to the patient or the patient's representative by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to explain to the patient or the patient's representative the risks and benefits associated with the use of opioids;
e. If applicable, explains alternatives to a prescribed opioid; and
f. Obtains informed consent from the patient or the patient's representative that meets the requirements in subsection (C)(4), including the potential risks, adverse outcomes, and complications associated with the concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication, if the patient:
i. Is also prescribed or ordered a sedative-hypnotic medication, or
ii. Has been prescribed a sedative-hypnotic medication by another medical practitioner;

2. Includes the following information in the patient's medical record, an existing treatment plan, or a new treatment plan developed for the patient:
a. The patient's diagnosis;
b. The patient's medical history, including co-occurring disorders;
c. The opioid to be prescribed;
d. Other medications or herbal supplements being taken by the patient;
e. If applicable:
i. The effectiveness of the patient's current treatment,
ii. The duration of the current treatment, and
iii. Alternative treatments tried by or planned for the patient;
f. The expected benefit of the treatment and, if applicable, the benefit of the new treatment compared with continuing the current treatment; and
g. Other factors relevant to the patient's being prescribed an opioid; and

3. If applicable, specifies in the patient's discharge plan how medically indicated pain control will occur after discharge to meet the patient's needs.

E. Except as provided in subsection (G) or (H), an administrator of a health care institution where opioids are ordered for administration to a patient in the health care institution as part of treatment shall ensure that a medical practitioner authorized by policies and procedures to order an opioid in treating a patient:

1. Before ordering an opioid for a patient of the health care institution:
a. Conducts a physical examination of the patient or reviews the documentation from a physical examination conducted:
i. During the patient's same episode of care; or
ii. Within the previous 30 calendar days, at a health care institution transferring the patient to the health care institution or by the medical practitioner who referred the patient for admission to the health care institution;
b. Except as exempted by A.R.S. § 36-2606(G), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
c. If medically appropriate based on the physical examination in subsection (E)(1)(a) and the patient's medical history, assesses the patient's substance use risk or reviews the documentation from an assessment of the patient's substance use risk conducted within the previous 30 calendar days by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to conduct an assessment of the patient's substance use risk;
d. Ensures that the patient or the patient's representative understands the risks and benefits associated with the use of opioids, as explained to the patient or the patient's representative according to policies and procedures; and
e. If applicable, explains alternatives to an ordered opioid; and

2. Includes the following information in the patient's medical record, an existing treatment plan, or a new treatment plan developed for the patient:
a. The patient's diagnosis;
b. The patient's medical history, including co-occurring disorders;
c. The opioid being ordered and the reason for the order;
d. Other medications or herbal supplements being taken by the patient; and
e. If applicable:
i. The effectiveness of the patient's current treatment,
ii. The duration of the current treatment,
iii. Alternative treatments tried by or planned for the patient,
iv. The expected benefit of a new treatment compared with continuing the current treatment, and
v. Other factors relevant to the patient's being ordered an opioid.

F. For a health care institution where opioids are administered as part of treatment or where a patient is provided assistance in the self-administration of medication for a prescribed opioid, including a health care institution in which an opioid may be prescribed or ordered as part of treatment, an administrator, a manager as defined in R9-10-801, or a provider, as applicable to the health care institution, shall:

1. Establish, document, and implement policies and procedures for administering an opioid as part of treatment or providing assistance in the self-administration of medication for a prescribed opioid, to protect the health and safety of a patient, that:
a. Cover which personnel members may administer an opioid in treating a patient and the required knowledge and qualifications of these personnel members;
b. Cover which personnel members may provide assistance in the self-administration of medication for a prescribed opioid and the required knowledge and qualifications of these personnel members;
c. Include how, when, and by whom a patient's need for opioid administration is assessed;
d. Include how, when, and by whom a patient receiving an opioid is monitored; and

e. Cover how, when, and by whom the actions taken according to subsections (F)(1)(c) and (d) are documented;
2. Include in the plan for the health care institution's quality management program a process for:
a. Review of incidents of opioid-related adverse reactions or other negative outcomes a patient experiences or opioid-related deaths, and
b. Surveillance and monitoring of adherence to the policies and procedures in subsection (F)(1);
3. Except as prohibited by 42 CFR, Chapter I, Subchapter A, Part 2, or as provided in subsection (H)(1), ensure that, if a patient's death may be related to an opioid administered as part of treatment, written notification, in a Department-provided format, is provided to the Department of the patient's death within one working day after the patient's death; and
4. Except as provided in subsection (H), ensure that an individual authorized by policies and procedures to administer an opioid in treating a patient or to provide assistance in the self-administration of medication for a prescribed opioid:
a. Before administering an opioid or providing assistance in the self-administration of medication for a prescribed opioid in compliance with an order as part of the treatment for a patient, identifies the patient's need for the opioid;
b. Monitors the patient's response to the opioid; and
c. Documents in the patient's medical record:
i. An identification of the patient's need for the opioid before the opioid was administered or assistance in the self-administration of medication for a prescribed opioid was provided, and
ii. The effect of the opioid administered or for which assistance in the self-administration of medication for a prescribed opioid was provided.

G. A medical practitioner authorized by a health care institution's policies and procedures to order an opioid in treating a patient is exempt from the requirements in subsection (E), if:
1. The health care institution's policies and procedures, required in subsection (C)(1) or the applicable Article in 9 A.A.C. 10, contain procedures for:
a. Providing treatment without obtaining the consent of a patient or the patient's representative,
b. Ordering and administering opioids in an emergency situation, and
c. Complying with the requirements in subsection (E) after the emergency is resolved;
2. The order for the administration of an opioid is:
a. Part of the treatment for a patient in an emergency, and
b. Issued in accordance with policies and procedures; and
3. The emergency situation is documented in the patient's medical record.

H. The requirements in subsections (D), (E), and (F)(4), as applicable, do not apply to a health care institution's:
1. Prescribing, ordering, or administration of an opioid as part of treatment for a patient with an end-of-life condition or pain associated with an active malignancy;
2. Prescribing an opioid as part of treatment for a patient when changing the type or dosage of an opioid, which had previously been prescribed by a medical practitioner of the health care institution for the patient according to the requirements in subsection (D):
a. Before a pharmacist dispenses the opioid for the patient; or
b. If changing the opioid because of an adverse reaction to the opioid experienced by the patient, within 72 hours after the opioid was dispensed for the patient by a pharmacist;
3. Ordering an opioid as part of treatment for no longer than three calendar days for a patient remaining in the health care institution and receiving continuous medical services or nursing services from the health care institution; or
4. Ordering an opioid as part of treatment:
a. For a patient receiving a surgical procedure or other invasive procedure; or
b. When changing the type, dosage, or route of administration of an opioid, which had previously been ordered by a medical practitioner of the health care institution for a patient according to the requirements in subsection (E), to meet the patient's needs.

I. The requirements in subsections (D)(1)(c) through (f) do not apply to a health care institution's prescribing an opioid as part of treatment for a patient with chronic, intractable pain who has had an established health professional-patient relationship with the prescribing medical practitioner for at least 90 days before the opioid is prescribed.

Historical Note

New Section made by emergency rulemaking at 23 A.A.R. 2203, effective July 28, 2017, for 180 days (Supp. 17-3). Emergency expired; new Section renewed by emergency rulemaking at 24 A.A.R. 303, effective January 25, 2018, for 180 days; new Section made by final rulemaking at 24 A.A.R. 657, with an immediate effective date of March 6, 2018 (Supp. 18-1). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Amended by final expedited rulemaking at 28 A.A.R. 3568 (November 18, 2022), with an immediate effective date November 2, 2022 (Supp. 22-4).

R9-10-121. Disease Prevention and Control

A. This Section applies:
1. When the Governor has declared a state of emergency, as defined in A.R.S. § 26-301, to address a situation described under A.R.S. § 36-787; and
2. To health care institutions licensed under Article 4, 5, or 8 of this Chapter.

B. The following definitions apply in this Section:
1. "Communicable disease" has the same meaning as in A.A.C. R9-6-101.
2. "Infection" has the same meaning as in A.A.C. R9-6-101.
3. "Respiratory symptoms" means coughing, shortness of breath, or wheezing not known to be caused by asthma or another chronic lung-related disease.

C. An administrator or manager, as applicable, shall ensure that policies and procedures are established, documented, and implemented, to protect the health and safety of a resident, that:
1. Cover screening and triage of personnel members, employees, visitors, and, except as provided in subsection (E), any other individuals entering the facility;
2. Cover the manner and frequency of assessing residents to determine a change in a resident's medical condition;
3. Establish disinfection protocols and schedules for frequently touched surfaces; and

4. Specify requirements for distancing residents who exhibit symptoms of a communicable disease from other residents to reduce the chance for infection of another individual.

D. An administrator or manager, as applicable, shall ensure that:
1. Except as provided in subsection (E), before entering the facility, each individual, including a personnel member, employee, or visitor, is screened for fever or respiratory symptoms indicative of a communicable disease;
2. If an individual refuses to be screened, the individual is excluded from entry to the facility;
3. If an individual is determined to have a fever or respiratory symptoms, the individual is excluded from entry to the facility until symptoms have resolved or the individual has been evaluated and cleared by a medical practitioner;
4. If an individual, other than a resident, develops a fever or respiratory symptoms while in the facility, the individual is required to leave the facility and not return until symptoms have resolved or the individual has been evaluated and cleared by a medical practitioner; and
5. If insufficient personnel members are available to meet the needs of all residents in the facility, the administrator or manager, as applicable, implements the disaster plan required in R9-10-424, R9-10-523, or R9-10-818, as applicable, which may include moving a resident to a different facility.

E. An administrator or manager, as applicable, may allow an emergency medical care technician, as defined in A.R.S. § 36-2201, to enter the facility without screening if the emergency medical care technician is responding to a call for providing emergency medical services, as defined in A.R.S. § 36-2201, to a resident or other individual in the facility.

F. An administrator or manager, as applicable, shall ensure that:
1. An assessment of a resident includes whether the resident has a fever or respiratory symptoms indicative of a communicable disease and is documented in the resident's medical record; and
2. If a resident is found to have a fever or respiratory symptoms indicative of a communicable disease:
   a. The resident is evaluated by a medical practitioner within 24 hours to determine what services need to be provided to the resident and what precautions need to be taken by the facility, and the evaluation is documented in the resident's medical record;
   b. To reduce the chance for infection of another individual, the resident is:
      i. Kept at a distance of at least six feet from other residents; or
      ii. If not possible to keep the resident at a distance from other residents, required to wear a facemask;
   c. A personnel member:
      i. Takes precautions, which may include the use of gloves and a facemask or other personal protection equipment, while providing services to the resident; and
      ii. Removes and, if applicable, disposes of the personal protection equipment and washes the personnel member's hands with soap and water for at least 20 seconds or, if soap and water are not available, uses a hand sanitizer containing at least 60% alcohol immediately after providing services to the resident and before providing services to another resident;
   d. Linens, dishes, utensils, and other items used by the resident are:
      i. Kept separate from similar items used by a resident who does not have a fever or respiratory symptoms indicative of a communicable disease, and
      ii. Disinfected or disposed of in a manner to reduce the chance for infection of another individual; and
   e. Surfaces touched by the resident are disinfected before another individual touches the surface.

G. An administrator or manager, as applicable, shall ensure that door handles, tables, chair backs and arm rests, light switches, and other frequently touched surfaces are cleaned and disinfected, according to policies and procedures, with:
1. An alcohol solution containing at least 70% alcohol;
2. A bleach solution containing four teaspoons of bleach per quart of water; or
3. An EPA-approved household disinfectant specified in a list, which is incorporated by reference, available at https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19, and does not include any later amendments or editions of the incorporated matter.

Historical Note

Amended effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section made by emergency rulemaking at 26 A.A.R. 509, with an immediate effective date of March 16, 2020, for 180 days (Supp. 19-1). Emergency expired. New Section made by final rulemaking at 26 A.A.R. 2793, with an immediate effective date of October 7, 2020 (Supp. 20-4).

R9-10-122. Repealed

Historical Note

New Section made by final rulemaking at 7 A.A.R. 2145, effective May 1, 2001 (Supp. 01-2). Amended by final rulemaking at 8 A.A.R. 3578, effective July 26, 2002 (Supp. 02-3). Amended by exempt rulemaking at 14 A.A.R. 3958, effective September 26, 2008 (Supp. 08-3). Amended by exempt rulemaking at 15 A.A.R. 2100, effective January 1, 2010 (Supp. 09-4). Section repealed by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-123. Repealed

Historical Note

Amended effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3).

R9-10-124. Repealed

Historical Note

Former Section R9-10-124 repealed, new Section R9-10-124 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3).

ARTICLE 2. HOSPITALS

R9-10-201. Definitions

Authorizing Statutes

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.

36-405. Powers and duties of the director

A. The director shall adopt rules to establish minimum standards and requirements for constructing, modifying and licensing health care institutions necessary to ensure the public health, safety and welfare. The standards and requirements shall relate to the construction, equipment, sanitation, staffing for medical, nursing and personal care services, and recordkeeping pertaining to administering medical, nursing, behavioral health and personal care services, in accordance with generally accepted practices of health care. The standards shall require that a physician who is licensed pursuant to title 32, chapter 13 or 17 medically discharge patients from surgery and shall allow an outpatient surgical center to require that either an anesthesia provider who is licensed pursuant to title 32, chapter 13, 15 or 17 or a physician who is licensed pursuant to title 32, chapter 13 or 17 remain present on the premises until all patients are discharged from the recovery room. Except as otherwise provided in this subsection, the director shall use the current standards adopted by the joint commission on accreditation of hospitals and the commission on accreditation of the American osteopathic association or those adopted by any recognized accreditation organization approved by the department as guidelines in prescribing minimum standards and requirements under this section.

B. The director, by rule, may:

1. Classify and subclassify health care institutions according to character, size, range of services provided, medical or dental specialty offered, duration of care and standard of patient care required for the purposes of licensure. Classes of health care institutions may include hospitals, infirmaries, outpatient treatment centers, health screening services centers and residential care facilities. Whenever the director reasonably deems distinctions in rules and standards to be appropriate among different classes or subclasses of health care institutions, the director may make such distinctions.

2. Prescribe standards for determining a health care institution's substantial compliance with licensure requirements.

3. Prescribe the criteria for the licensure inspection process.

4. Prescribe standards for selecting health care-related demonstration projects.

5. Establish nonrefundable application and licensing fees for health care institutions, including a grace period and a fee for the late payment of licensing fees.

6. Establish a process for the department to notify a licensee of the licensee's licensing fee due date.

7. Establish a process for a licensee to request a different licensing fee due date, including any limits on the number of requests by the licensee.

C. The director, by rule, shall adopt licensing provisions that facilitate the colocation and integration of outpatient treatment centers that provide medical, nursing and health-related services with behavioral health services consistent with article 3.1 of this chapter.

D. Ninety percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the health services licensing fund established by section 36-414 and ten percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the state general fund.

E. Subsection B, paragraph 5 of this section does not apply to a health care institution operated by a state agency pursuant to state or federal law or to adult foster care residential settings.

36-406. Powers and duties of the department

In addition to its other powers and duties:

1. The department shall:

(a) Administer and enforce this chapter and the rules, regulations and standards adopted pursuant thereto.

(b) Review, and may approve, plans and specifications for construction or modification or additions to health care institutions regulated by this chapter.

(c) Have access to books, records, accounts and any other information of any health care institution reasonably necessary for the purposes of this chapter.

(d) Require as a condition of licensure that nursing care institutions and assisted living facilities make vaccinations for influenza and pneumonia available to residents on site on a yearly basis. The department shall prescribe the manner by which the institutions and facilities shall document compliance with this subdivision, including documenting residents who refuse to be immunized. The department shall not impose a violation on a licensee for not making a vaccination available if there is a shortage of that vaccination in this state as determined by the director.

2. The department may:

(a) Make or cause to be made inspections consistent with standard medical practice of every part of the premises of health care institutions which are subject to the provisions of this chapter as well as those which apply for or hold a license required by this chapter.

(b) Make studies and investigations of conditions and problems in health care institutions, or any class or subclass thereof, as they relate to compliance with this chapter and rules, regulations and standards adopted pursuant thereto.

(c) Develop manuals and guides relating to any of the several aspects of physical facilities and operations of health care institutions or any class or subclass thereof for distribution to the governing authorities of health care institutions and to the general public.

36-407. Prohibited acts; required acts

A. A person shall not establish, conduct or maintain in this state a health care institution or any class or subclass of health care institution unless that person holds a current and valid license issued by the department specifying the class or subclass of health care institution the person is establishing, conducting or maintaining. The license is valid only for the establishment, operation and maintenance of the class or subclass of health care institution, the type of services and, except for emergency admissions as prescribed by the director by rule, the licensed capacity specified by the license.

B. The licensee shall not imply by advertising, directory listing or otherwise that the licensee is authorized to perform services more specialized or of a higher degree of care than is authorized by this chapter and the underlying rules for the particular class or subclass of health care institution within which the licensee is licensed.

C. The licensee may not transfer or assign the license. A license is valid only for the premises occupied by the institution at the time of its issuance.

D. The licensee shall not personally or through an agent offer or imply an offer of rebate or fee splitting to any person regulated by title 32 or chapter 17 of this title.

E. The licensee shall submit an itemized statement of charges to each patient.

F. A health care institution shall refer a patient who is discharged after receiving emergency services for a drug-related overdose to a behavioral health services provider.

36-413. Nutrition and feeding assistants; training programs; regulation; civil penalty; definition

A. The department may adopt rules to prescribe minimum standards for training programs for nutrition and feeding assistants in licensed skilled nursing facilities, including instructor qualifications, and may grant, deny, suspend and revoke approval of any training program that violates these standards. These standards must include:

1. Screening requirements.

2. Initial qualifications.

3. Continuing education requirements.

4. Testing requirements to assure competency.

5. Supervision requirements.

6. Requirements for additional training based on patient needs.

7. Maintenance of records.

8. Special feeding requirements based on level of care.

B. Pursuant to section 36-431.01, the department may impose a civil penalty on a training program that violates standards adopted by the department.

C. If the department adopts standards for training programs pursuant to subsection A of this section, the department, as part of its routine inspection of a health care facility that provides a training program, shall determine the facility's compliance with these standards.

D. For the purposes of this section, "nutrition and feeding assistant" has the same meaning as paid feeding assistant as defined in 42 Code of Federal Regulations part 483 and section 488.301.

36-421. Construction or modification of a health care institution

A. A license application for a health care institution shall include, on a form provided by the department, a notarized attestation from an architect registered pursuant to title 32, chapter 1 that verifies the architectural plans and specifications meet or exceed standards adopted by the department. These plans and specifications shall meet the minimum standards for licensure within the class or subclass of health care institution for which it is intended. The application shall include the name and address of each owner and lessee of any agricultural land that is regulated pursuant to section 3-365.

B. Construction or modification of a licensed health care institution shall meet the minimum standards for licensure within the class or subclass of health care institution for which it is intended.

C. An applicant shall comply with all state statutes and rules and local codes and ordinances required for the health care institution's construction.

D. A health care institution or its facility shall not be licensed if it is located on property that is less than four hundred feet from agricultural land that is regulated pursuant to section 3-365, except that the owner of the agricultural land may agree to comply with the buffer zone requirements of section 3-365. If the owner agrees in writing to comply with the buffer zone requirements and records the agreement in the office of the county recorder as a restrictive covenant running with the title to the land, the health care institution or facility may be licensed and located within the affected buffer zone. The agreement may include any stipulations regarding the health care institution or facility, including conditions for future expansion of the health care institution or facility and changes in the operational status of the health care institution or facility that will result in a breach of the agreement. This subsection does not apply to the issuance of a license for a health care institution located in the same location for which a health care institution license was previously issued.

E. Notwithstanding any law to the contrary, a health care institution that was licensed as a level 1 psychiatric acute behavioral health facility-inpatient facility as of January 1, 2012 and that is not certified under title XIX of the social security act shall be licensed as a hospital and is not required to comply with the physical plant standards for a general hospital, rural general hospital or special hospital prescribed by the department.

F. An adult behavioral health therapeutic home is not required to comply with the building codes or zoning standards for a health care institution prescribed by the department.

G. The Arizona pioneers' home is not required to comply with subsection A of this section and the physical plant standards for a health care institution prescribed by the department.

H. A nursing-supported group home is not required to comply with the zoning standards for a health care institution prescribed by the department.

I. For the purposes of this section, health care institution does not include a home health agency or a hospice service agency.

36-422. Application for license; notification of proposed change in status; joint licenses; definitions

A. A person who wishes to apply for a license to operate a health care institution pursuant to this chapter shall submit to the department all of the following:

1. An application on a written or electronic form that is prescribed, prepared and furnished by the department and that contains all of the following:

(a) The name and location of the health care institution.

(b) Whether the health care institution is to be operated as a proprietary or nonproprietary institution.

(c) The name of the governing authority. The applicant shall be the governing authority having the operative ownership of, or the governmental agency charged with the administration of, the health care institution sought to be licensed. If the applicant is a partnership that is not a limited partnership, the partners shall apply jointly, and the partners are jointly the governing authority for purposes of this article.

(d) The name and business or residential address of each controlling person and an affirmation that none of the controlling persons has been denied a license or certificate by a health profession regulatory board pursuant to title 32 or by a state agency pursuant to chapter 6, article 7 or chapter 17 of this title or a license to operate a health care institution in this state or another state or has had a license or certificate issued by a health profession regulatory board pursuant to title 32 or issued by a state agency pursuant to chapter 6, article 7 or chapter 17 of this title or a license to operate a health care institution revoked. If a controlling person has been denied a license or certificate by a health profession regulatory board pursuant to title 32 or by a state agency pursuant to chapter 6, article 7 or chapter 17 of this title or a license to operate a health care institution in this state or another state or has had a health care professional license or a license to operate a health care institution revoked, the controlling person shall include in the application a comprehensive description of the circumstances for the denial or the revocation.

(e) The class or subclass of health care institution to be established or operated.

(f) The types and extent of the health care services to be provided, including emergency services, community health services and services to indigent patients.

(g) The name and qualifications of the chief administrative officer implementing direction in that specific health care institution.

(h) Other pertinent information required by the department for the proper administration of this chapter and department rules.

2. The attestation required by section 36-421, subsection A.

3. The applicable application fee.

B. An application submitted pursuant to this section shall contain the written or electronic signature of:

1. If the applicant is an individual, the owner of the health care institution.

2. If the applicant is a partnership, limited liability company or corporation, two of the officers of the corporation or managing members of the partnership or limited liability company or the sole member of the limited liability company if it has only one member.

3. If the applicant is a governmental unit, the head of the governmental unit.

C. An application for licensure shall be submitted at least sixty but not more than one hundred twenty days before the anticipated date of operation. An application for a substantial compliance survey submitted pursuant to section 36-425, subsection G shall be submitted at least thirty days before the date on which the substantial compliance survey is requested.

D. If a current licensee intends to terminate the operation of a licensed health care institution or if a change of ownership is planned, the current licensee shall notify the director in writing at least thirty days before the termination of operation or change in ownership is to take place. The current licensee is responsible for preventing any interruption of services required to sustain the life, health and safety of the patients or residents. A new owner shall not begin operating the health care institution until the director issues a license to the new owner.

E. A licensed health care institution for which operations have not been terminated for more than thirty days may be relicensed pursuant to the codes and standards for architectural plans and specifications that were applicable under its most recent license.

F. If a person operates a hospital in a county with a population of more than five hundred thousand persons in a setting that includes satellite facilities of the hospital that are located separately from the main hospital building, the department at the request of the applicant or licensee shall issue a single group license to the hospital and its designated satellite facilities located within one-half mile of the main hospital building if all of the facilities meet or exceed department licensure requirements

for the designated facilities. At the request of the applicant or licensee, the department shall also issue a single group license that includes the hospital and its designated satellite facilities that are located farther than one-half mile from the main hospital building if all of these facilities meet or exceed applicable department licensure requirements. Each facility included under a single group license is subject to the department's licensure requirements that are applicable to that category of facility. Subject to compliance with applicable licensure or accreditation requirements, the department shall reissue individual licenses for the facility of a hospital located in separate buildings from the main hospital building when requested by the hospital. This subsection does not apply to nursing care institutions and residential care institutions. The department is not limited in conducting inspections of an accredited health care institution to ensure that the institution meets department licensure requirements. If a person operates a hospital in a county with a population of five hundred thousand persons or less in a setting that includes satellite facilities of the hospital that are located separately from the main hospital building, the department at the request of the applicant or licensee shall issue a single group license to the hospital and its designated satellite facilities located within thirty-five miles of the main hospital building if all of the facilities meet or exceed department licensure requirements for the designated facilities. At the request of the applicant or licensee, the department shall also issue a single group license that includes the hospital and its designated satellite facilities that are located farther than thirty-five miles from the main hospital building if all of these facilities meet or exceed applicable department licensure requirements.

G. If a county with a population of more than one million persons or a special health care district in a county with a population of more than one million persons operates an accredited hospital that includes the hospital's accredited facilities that are located separately from the main hospital building and the accrediting body's standards as applied to all facilities meet or exceed the department's licensure requirements, the department shall issue a single license to the hospital and its facilities if requested to do so by the hospital. If a hospital complies with applicable licensure or accreditation requirements, the department shall reissue individual licenses for each hospital facility that is located in a separate building from the main hospital building if requested to do so by the hospital. This subsection does not limit the department's duty to inspect a health care institution to determine its compliance with department licensure standards. This subsection does not apply to nursing care institutions and residential care institutions.

H. An applicant or licensee must notify the department within thirty days after any change regarding a controlling person and provide the information and affirmation required pursuant to subsection A, paragraph 1, subdivision (d) of this section.

I. A behavioral health residential facility that provides services to children must notify the department within thirty days after the facility begins contracting exclusively with the federal government, receives only federal monies and does not contract with this state.

J. This section does not limit the application of federal laws and regulations to an applicant or licensee that is certified as a medicare or an Arizona health care cost containment system provider under federal law.

K. Except for an outpatient treatment center that provides dialysis services or abortion procedures or that is exempt from licensure pursuant to section 36-402, subsection A, paragraph 12, a person

wishing to begin operating an outpatient treatment center before a licensing inspection is completed shall submit all of the following:

1. The license application required pursuant to this section.

2. All applicable application and license fees.

3. A written request for a temporary license that includes:

(a) The anticipated date of operation.

(b) An attestation signed by the applicant that the applicant and the facility comply with and will continue to comply with the applicable licensing statutes and rules.

L. Within seven days after the department's receipt of the items required in subsection K of this section, but not before the anticipated operation date submitted pursuant to subsection C of this section, the department shall issue a temporary license that includes:

1. The name of the facility.

2. The name of the licensee.

3. The facility's class or subclass.

4. The temporary license's effective date.

5. The location of the licensed premises.

M. A facility may begin operating on the effective date of the temporary license.

N. The director may cease the issuance of temporary licenses at any time if the director believes that public health and safety is endangered.

O. An outpatient treatment center that is exempt from licensure pursuant to section 36-402, subsection A, paragraph 12 and that has the same governing authority as a hospital licensed pursuant to this chapter is subject to reasonable inspection by the department if the director has reasonable cause to believe that patient harm is or may be occurring at that outpatient treatment center. A substantiated complaint that harm is occurring at an exempt outpatient treatment center is a violation of this chapter against the hospital's license.

P. For the purposes of this section:

1. "Accredited" means accredited by a nationally recognized accreditation organization.

2. "Satellite facility" means an outpatient facility at which the hospital provides outpatient medical services.

36-423. Hemodialysis technicians; minimum requirements; definition

A. Except as provided in subsection B, beginning on April 1, 2003, a facility that provides hemodialysis treatment shall only use a hemodialysis technician who is certified by a national organization that certifies hemodialysis technicians.

B. Beginning on April 1, 2003, an employee who provides hemodialysis treatment and who is not certified pursuant to subsection A is a hemodialysis technician trainee. A hemodialysis technician trainee may provide hemodialysis treatment in any facility unless the trainee fails to pass the national certification examination within two years after employment. The department of health services shall establish by rule appropriate clinical practice restrictions for hemodialysis technician trainees. An employee who is employed to provide hemodialysis treatment before April 1, 2003 must meet the requirements of this section on or before April 1, 2006.

C. A facility that provides hemodialysis treatment must maintain the verification of certification in the hemodialysis technician's personnel file.

D. For the purposes of this section, "hemodialysis technician" means a person who, under the direct supervision of a physician licensed pursuant to title 32, chapter 13 or 17, or a registered nurse licensed pursuant to title 32, chapter 15, provides assistance in the treatment of patients who receive dialysis treatment for end stage renal disease.

36-424. Inspections; suspension or revocation of license; report to board of examiners of nursing care institution administrators and assisted living facility managers

A. Except as provided in subsection B of this section, the director shall inspect the premises of the health care institution and investigate the character and other qualifications of the applicant to ascertain whether the applicant and the health care institution are in substantial compliance with the requirements of this chapter and the rules established pursuant to this chapter. The director may prescribe rules regarding department background investigations into an applicant's character and qualifications.

B. The director may accept proof that a health care institution is an accredited hospital or is an accredited health care institution in lieu of all compliance inspections required by this chapter if the director receives a copy of the institution's accreditation report for the licensure period and the institution is accredited by an independent, nonprofit accrediting organization approved by the secretary of the United States department of health and human services. If the health care institution's accreditation report is not valid for the entire licensure period, the department may conduct a compliance inspection of the health care institution during the time period the department does not have a valid accreditation report for the health care institution. For the purposes of this subsection, each licensed premises of a health care institution must have its own

accreditation report. The director may not accept an accreditation report in lieu of a compliance inspection of:

1. An intermediate care facility for individuals with intellectual disabilities.

2. A health care institution if the health care institution has been subject to an enforcement action pursuant to section 36-427 or 36-431.01 within the year preceding the annual licensing fee anniversary date.

C. On a determination by the director that there is reasonable cause to believe a health care institution is not adhering to the licensing requirements of this chapter, the director and any duly designated employee or agent of the director, including county health representatives and county or municipal fire inspectors, consistent with standard medical practices, may enter on and into the premises of any health care institution that is licensed or required to be licensed pursuant to this chapter at any reasonable time for the purpose of determining the state of compliance with this chapter, the rules adopted pursuant to this chapter and local fire ordinances or rules. Any application for licensure under this chapter constitutes permission for and complete acquiescence in any entry or inspection of the premises during the pendency of the application and, if licensed, during the term of the license. If an inspection reveals that the health care institution is not adhering to the licensing requirements established pursuant to this chapter, the director may take action authorized by this chapter. Any health care institution, including an accredited hospital, whose license has been suspended or revoked in accordance with this section is subject to inspection on application for relicensure or reinstatement of license.

D. The director shall immediately report to the board of examiners of nursing care institution administrators and assisted living facility managers information identifying that a nursing care institution administrator's conduct may be grounds for disciplinary action pursuant to section 36-446.07.

36-425. Inspections; issuance of license; posting requirements; provisional license; denial of license

A. On receipt of a properly completed application for a health care institution license, the director shall conduct an inspection of the health care institution as prescribed by this chapter. If an application for a license is submitted due to a planned change of ownership, the director shall determine the need for an inspection of the health care institution. Based on the results of the inspection and after the submission of the applicable licensing fee, the director shall either deny the license or issue a regular or provisional license. A license issued by the department shall be posted in a conspicuous location in the reception area of that institution.

B. The director shall issue a license if the director determines that an applicant and the health care institution for which the license is sought substantially comply with the requirements of this chapter and rules adopted pursuant to this chapter and the applicant agrees to carry out a plan acceptable to the director to eliminate any deficiencies. The director shall not require a health care institution that was designated as a critical access hospital to make any modifications required by this chapter or rules adopted pursuant to this chapter in order to obtain an amended license with the same

licensed capacity the health care institution had before it was designated as a critical access hospital if all of the following are true:

1. The health care institution has subsequently terminated its critical access hospital designation.

2. The licensed capacity of the health care institution does not exceed its licensed capacity before its designation as a critical access hospital.

3. The health care institution remains in compliance with the applicable codes and standards that were in effect at the time the facility was originally licensed with the higher licensed capacity.

C. A health care institution license does not expire and remains valid unless:

1. The department subsequently revokes or suspends the license.

2. The license is considered void because the licensee did not pay the licensing fee before the licensing fee due date.

D. Except as provided in section 36-424, subsection B and subsection E of this section, the department shall conduct a compliance inspection of a health care institution to determine compliance with this chapter and rules adopted pursuant to this chapter at least once annually.

E. If the department determines a facility to be deficiency free on a compliance survey, the department shall not conduct a compliance survey of that facility for twenty-four months after the date of the deficiency free survey. This subsection does not prohibit the department from enforcing licensing requirements as authorized by section 36-424.

F. A hospital licensed as a rural general hospital may provide intensive care services.

G. The director shall issue a provisional license for a period of not more than one year if an inspection or investigation of a currently licensed health care institution or a health care institution for which an applicant is seeking a license reveals that the institution is not in substantial compliance with department licensure requirements and the director believes that the immediate interests of the patients and the general public are best served if the institution is given an opportunity to correct deficiencies. The applicant or licensee shall agree to carry out a plan to eliminate deficiencies that is acceptable to the director. The director shall not issue consecutive provisional licenses to a single health care institution. The director shall not issue a license to the current licensee or a successor applicant before the expiration of the provisional license unless the health care institution submits an application for a substantial compliance survey and is found to be in substantial compliance. The director may issue a license only if the director determines that the institution is in substantial compliance with the licensure requirements of the department and this chapter. This subsection does not prevent the director from taking action to protect the safety of patients pursuant to section 36-427.

H. Subject to the confidentiality requirements of articles 4 and 5 of this chapter, title 12, chapter 13, article 7.1 and section 12-2235, the licensee shall keep current department inspection reports at the health care institution. Unless federal law requires otherwise, the licensee shall post in a conspicuous location a notice that identifies the location at that institution where the inspection reports are available for review.

I. A health care institution shall immediately notify the department in writing when there is a change of the chief administrative officer specified in section 36-422, subsection A, paragraph 1, subdivision (g).

J. When the department issues an original license or an original provisional license to a health care institution, it shall notify the owners and lessees of any agricultural land within one-fourth mile of the health care institution. The health care institution shall provide the department with the names and addresses of owners or lessees of agricultural land within one-fourth mile of the proposed health care institution.

K. In addition to the grounds for denial of licensure prescribed pursuant to subsection A of this section, the director may deny a license because an applicant or anyone in a business relationship with the applicant, including stockholders and controlling persons, has had a license to operate a health care institution denied, revoked or suspended or a license or certificate issued by a health profession regulatory board pursuant to title 32 or issued by a state agency pursuant to chapter 6, article 7 or chapter 17 of this title denied, revoked or suspended or has a licensing history of recent serious violations occurring in this state or in another state that posed a direct risk to the life, health or safety of patients or residents.

L. In addition to the requirements of this chapter, the director may prescribe by rule other licensure requirements.

36-427. Suspension or revocation; intermediate sanctions

A. The director, pursuant to title 41, chapter 6, article 10, may suspend or revoke, in whole or in part, the license of any health care institution if its owners, officers, agents or employees:

1. Violate this chapter or the rules of the department adopted pursuant to this chapter.

2. Knowingly aid, permit or abet the commission of any crime involving medical and health-related services.

3. Have been, are or may continue to be in substantial violation of the requirements for licensure of the institution, as a result of which the health or safety of one or more patients or the general public is in immediate danger.

4. Fail to comply with section 36-2901.08.

5. Violate section 36-2302.

B. If the licensee, the chief administrative officer or any other person in charge of the institution refuses to permit the department or its employees or agents the right to inspect the institution's premises as provided in section 36-424, such action shall be deemed reasonable cause to believe that a substantial violation under subsection A, paragraph 3 of this section exists.

C. If the director reasonably believes that a violation of subsection A, paragraph 3 of this section has occurred and that life or safety of patients will be immediately affected, the director, on written notice to the licensee, may order the immediate restriction of admissions or readmissions, selected transfer of patients out of the facility, reduction of capacity and termination of specific services, procedures, practices or facilities.

D. The director may rescind, in whole or in part, sanctions imposed pursuant to this section on correction of the violation or violations for which the sanctions were imposed.

36-429. Removal of licensee; temporary management continued operation

A. If the director reasonably believes that a violation of this chapter by a licensee endangers the health, safety or welfare of one or more of the licensee's patients, in addition to other remedies provided by this chapter, the director may enter into an agreement with the licensee or bring an action requesting the superior court to:

1. Remove the administrative officers, agents or employees of such licensee by injunction, enjoin the licensee from continued operation and revoke the license.

2. Appoint temporary personnel to continue operation of the health care institution under conditions and requirements set by the court pending correction of the violation and restoration of the licensee, revocation of the license or correction of the violation and change of ownership.

B. The action shall be brought in the name of the people of the state through the attorney general in the superior court in the county in which the health care institution is located.

36-430. Unlicensed operation prohibited; injunction

The operation or maintenance of a health care institution which does not hold a current and valid license or which exceeds the range of the services authorized by the class or subclass for which it is licensed is a violation of this chapter and is declared a nuisance inimical to the public health and safety. The director, in the name of the people of the state, through the attorney general, may bring an action for an injunction to restrain such violation or to enjoin the future operation or maintenance of any such health care institution until substantial compliance with the provisions of this chapter and the rules and regulations and standards adopted pursuant thereto is obtained.

36-2161. Abortions; reporting requirements

A. A hospital or facility in this state where abortions are performed must submit to the department of health services on a form prescribed by the department a report of each abortion performed in the

hospital or facility. The report shall not identify the individual patient by name or include any other information or identifier that would make it possible to identify, in any manner or under any circumstances, a woman who has obtained or sought to obtain an abortion. The report must include the following information:

1. The name and address of the facility where the abortion was performed.

2. The type of facility where the abortion was performed.

3. The county where the abortion was performed.

4. The woman's age.

5. The woman's educational background by highest grade completed and, if applicable, level of college completed.

6. The county and state in which the woman resides.

7. The woman's race and ethnicity.

8. The woman's marital status.

9. The number of prior pregnancies and prior abortions of the woman.

10. The number of previous spontaneous terminations of pregnancy of the woman.

11. The gestational age of the unborn child at the time of the abortion.

12. The reason for the abortion, including at least one of the following:

(a) The abortion is elective.

(b) The abortion is due to maternal health considerations, including one of the following:

(i) A premature rupture of membranes.

(ii) An anatomical abnormality.

(iii) Chorioamnionitis.

(iv) Preeclampsia.

(v) Other.

(c) The abortion is due to fetal health considerations, including the fetus being diagnosed with at least one of the following:

(i) A lethal anomaly.

(ii) A central nervous system anomaly.

(iii) Other.

(d) The pregnancy is the result of a sexual assault.

(e) The pregnancy is the result of incest.

(f) The woman is being coerced into obtaining an abortion.

(g) The woman is a victim of sex trafficking.

(h) The woman is a victim of domestic violence.

(i) Other.

(j) The woman declined to answer.

13. The type of procedure performed or prescribed and the date of the abortion.

14. Any preexisting medical conditions of the woman that would complicate pregnancy.

15. Any known medical complication that resulted from the abortion, including at least one of the following:

(a) Shock.

(b) Uterine perforation.

(c) Cervical laceration requiring suture or repair.

(d) Heavy bleeding or hemorrhage with estimated blood loss of at least five hundred cubic centimeters.

(e) Aspiration or allergic response.

(f) Postprocedure infection.

(g) Sepsis.

(h) Incomplete abortion retaining part of the fetus requiring reevacuation.

(i) Damage to the uterus.

(j) Failed termination of pregnancy.

(k) Death of the patient.

(l) Other.

(m) None.

16. The basis for any medical judgment that a medical emergency existed that excused the physician from compliance with the requirements of this chapter.

17. The physician's statement if required pursuant to section 36-2301.01.

18. If applicable, the weight of the aborted fetus for any abortion performed pursuant to section 36-2301.01.

19. Whether a fetus or embryo was delivered alive as defined in section 36-2301 during or immediately after an attempted abortion and the efforts made to promote, preserve and maintain the life of the fetus or embryo pursuant to section 36-2301.

20. Statements by the physician and all clinical staff who observed the fetus or embryo during or immediately after the abortion certifying under penalty of perjury that, to the best of their knowledge, the aborted fetus or embryo was not delivered alive as defined in section 36-2301.

21. The medical specialty of the physician performing the abortion, including one of the following:

(a) Obstetrics-gynecology.

(b) General or family practice.

(c) Emergency medicine.

(d) Other.

22. The type of admission for the patient, including whether the abortion was performed:

(a) As an outpatient procedure in an abortion clinic.

(b) As an outpatient procedure at a hospital.

(c) As an inpatient procedure at a hospital.

(d) As an outpatient procedure at a health care institution other than an abortion clinic or hospital.

23. Whether anesthesia was administered to the mother.

24. Whether anesthesia was administered to the unborn child.

25. Whether any genetic abnormality of the unborn child was detected at or before the time of the abortion by genetic testing, such as maternal serum tests, or by ultrasound, such as nuchal translucency screening, or by other forms of testing.

26. If a surgical abortion was performed, the method of final disposition of bodily remains and whether the woman exercised her right to choose the final disposition of bodily remains.

B. The hospital or facility shall request the information specified in subsection A, paragraph 12 of this section at the same time the information pursuant to section 36-2153 is provided to the woman individually and in a private room to protect the woman's privacy. The information requested pursuant to subsection A, paragraph 12 of this section may be obtained on a medical form provided to the woman to complete if the woman completes the form individually and in a private room.

C. If the woman who is seeking the abortion discloses that the abortion is being sought because of a reason described in subsection A, paragraph 12, subdivision (d), (e), (f), (g) or (h) of this section, the hospital or facility shall provide the woman with information regarding the woman's right to report a crime to law enforcement and resources available for assistance and services, including a national human trafficking resource hotline.

D. The report must be signed by the physician who performed the abortion or, if a health professional other than a physician is authorized by law to prescribe or administer abortion medication, the signature and title of the person who prescribed or administered the abortion medication. The form may be signed electronically and shall indicate that the person who signs the report is attesting that the information in the report is correct to the best of the person's knowledge. The hospital or facility must transmit the report to the department within fifteen days after the last day of each reporting month.

E. Any report filed pursuant to this section shall be filed electronically at an internet website that is designated by the department unless the person required to file the report applies for a waiver from electronic reporting by submitting a written request to the department.

36-2901.08. Hospital assessment

(Conditionally Rpld.)

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.

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.

41-1074. Compliance with administrative completeness review time frame

A. An agency shall issue a written notice of administrative completeness or deficiencies to an applicant for a license within the administrative completeness review time frame.

B. If an agency determines that an application for a license is not administratively complete, the agency shall include a comprehensive list of the specific deficiencies in the written notice provided pursuant to subsection A of this section. If the agency issues a written notice of deficiencies within the administrative completeness time frame, the administrative completeness review time frame and the overall time frame are suspended from the date the notice is issued until the date that the agency receives the missing information from the applicant.

C. If an agency does not issue a written notice of administrative completeness or deficiencies within the administrative completeness review time frame, the application is deemed administratively complete. If an agency issues a timely written notice of deficiencies, an application is not complete until the agency receives all requested information.

D. Except for an application submitted to the department of water resources pursuant to title 45, a determination by an agency that an application is not administratively complete is an appealable agency action, which if timely initiated, entitles the applicant to an adjudication on the merits of the administrative completeness of the application.

41-1075. Compliance with substantive review time frame

A. During the substantive review time frame, an agency may make one comprehensive written request for additional information. The agency and applicant may mutually agree in writing to allow the agency to submit supplemental requests for additional information. If an agency issues a comprehensive written request or a supplemental request by mutual written agreement for additional information, the substantive review time frame and the overall time frame are suspended from the date the request is issued until the date that the agency receives the additional information from the applicant.

B. By mutual written agreement, an agency and an applicant for a license may extend the substantive review time frame and the overall time frame. An extension of the substantive review time frame and the overall time frame may not exceed twenty-five per cent of the overall time frame.

41-1076. Compliance with overall time frame

Unless an agency and an applicant for a license mutually agree to extend the substantive review time frame and the overall time frame pursuant to section 41-1075, an agency shall issue a written notice granting or denying a license within the overall time frame to an applicant. If an agency denies an application for a license, the agency shall include in the written notice at least the following information:

1. Justification for the denial with references to the statutes or rules on which the denial is based.

2. An explanation of the applicant's right to appeal the denial. The explanation shall include the number of days in which the applicant must file a protest challenging the denial and the name and telephone number of an agency contact person who can answer questions regarding the appeals process.

41-1079. Information required to be provided

A. An agency that issues licenses shall provide the following information to an applicant at the time the applicant obtains an application for a license:

1. A list of all of the steps the applicant is required to take in order to obtain the license.

2. The applicable licensing time frames.

3. The name and telephone number of an agency contact person who can answer questions or provide assistance throughout the application process.

B. This section does not apply to the Arizona peace officer standards and training board established by section 41-1821.

Gmail

Patricia Grant <patricia.grant@azdoa.gov>

Fwd: Additional question for DHS (D2) TITLE 9, CHAPTER 10, TITLE 1

1 message

Anakaren Lemus <anakaren.lemus@azdoa.gov> Mon, Jul 31, 2023 at 2:16 PM
To: Patricia Grant <patricia.grant@azdoa.gov>, Simon Larscheidt <simon.larscheidt@azdoa.gov>

FYI - DHS' response to Council Member Thorwald's questions.

Thanks.

Anakaren Lemus

Legislative Specialist | ADOA - Director's Office

100 North 15th Avenue, Suite 302, Phoenix, AZ 85007

Anakaren.Lemus@azdoa.gov | http://www.azdoa.gov

---------- Forwarded message ---------
From: **Emily Carey** <emily.carey@azdhs.gov>
Date: Mon, Jul 31, 2023 at 11:42 AM
Subject: Re: Additional question for DHS (D2) TITLE 9, CHAPTER 10, TITLE 1
To: Anakaren Lemus <anakaren.lemus@azdoa.gov>

Hi Anakaren,

Please see below ADHS response to Council Member Thorwald's inquiries on Chapter 10, Article 1-General.

Regarding the proposed five-year-review report for Title 9, Chapter 10 Health Care Institutions, Article 1, the Department of Health Services rules regarding medications referenced in R9-10-120 for Opioid Prescribing and Treatment are applicable to all articles, unless explicitly stated otherwise, and are an addition to the rules specified in each correlating Article. The Department has implemented rules for medication services in each Article of Chapter 10 that are specific to the type of facility, as specified in each Article. For example, 9 A.A.C. 10, Article 8 regarding Assisted Living Facilities, stipulates the medication services in R9-10-816 that each facility must comply with for policies and procedures relating to medication administration and storage. The Department will review our rules regarding medications, however, the Department believes the medication services component of each Article is adequate and sufficient for personnel and facilities to follow for proper drug management and appropriation of medications.

Concerning the topic of repurposing medication in accordance with A.R.S. § 32-1909, the Department intends to incorporate the requirements in A.R.S. § 32-1909 into our rules for each kind of health care institution type. The Department believes this reference should be included, for example in R9-10-816(F) on policies and procedures on tracking, dispensing, and storing medications. The rules in R9-10-816 are attached for your convenience. The Department appreciates Council Member Thorwald for bringing forward these questions. Please let us know if there are any more questions. Thank you.

Thank you,

Emily Carey, M.S.
Senior Rules Analyst, Administrative Counsel & Rules
Arizona Department of Health Services
150 N 18th Ave, Phoenix, AZ 85007
Direct - 602-542-5121
Email - emily.carey@azdhs.gov
Health and Wellness for all Arizonans

On Fri, Jul 28, 2023 at 7:28 AM Emily Carey <emily.carey@azdhs.gov> wrote:

> Thank you!
>
> **Emily Carey, M.S.**
> Senior Rules Analyst, Administrative Counsel & Rules
> Arizona Department of Health Services
> 150 N 18th Ave, Phoenix, AZ 85007
> Direct - 602-542-5121
> Email - emily.carey@azdhs.gov
> *Health and Wellness for all Arizonans*
>
> On Thu, Jul 27, 2023 at 8:52 AM Anakaren Lemus <anakaren.lemus@azdoa.gov> wrote:
>
> > Hi Emily -
> >
> > Please see the attached information sent me in regards to your questions.
> >
> > Thanks.
> >
> > **Anakaren Lemus**
> >
> > Paralegal Project Specialist | Governor's Regulatory Review Council
> >
> > Public Records Manager | ADOA - Director's Office
> >
> > 100 North 15th Avenue, Suite 302, Phoenix, AZ 85007
> > Office: 602.542.2058
> >
> > Anakaren.Lemus@azdoa.gov | http://www.azdoa.gov
> >
> > On Wed, Jul 26, 2023 at 12:24 PM Emily Carey <emily.carey@azdhs.gov> wrote:
> >
> > > Thank you very much!
> > >
> > > **Emily Carey, M.S.**
> > > Senior Rules Analyst, Administrative Counsel & Rules
> > > Arizona Department of Health Services
> > > 150 N 18th Ave, Phoenix, AZ 85007
> > > Direct - 602-542-5121
> > > Email - emily.carey@azdhs.gov
> > > *Health and Wellness for all Arizonans*
> > >
> > > On Wed, Jul 26, 2023 at 12:15 PM Anakaren Lemus <anakaren.lemus@azdoa.gov> wrote:
> > >
> > > > Yes - I have forwarded your questions to Council Member Thorwald.
> > > >
> > > > **Anakaren Lemus**
> > > >
> > > > Paralegal Project Specialist | Governor's Regulatory Review Council

Public Records Manager | ADOA - Director's Office

100 North 15th Avenue, Suite 302, Phoenix, AZ 85007
Office: 602.542.2058

Anakaren.Lemus@azdoa.gov | http://www.azdoa.gov

On Wed, Jul 26, 2023 at 12:02 PM Emily Carey <emily.carey@azdhs.gov> wrote:

Would it be possible to ask Council Member Thorwald if he could provide us any clarification on what he means by "repurposed medication" and the specific board of pharmacy rules he is referring to?

Thank you,

Emily Carey, M.S.
Senior Rules Analyst, Administrative Counsel & Rules
Arizona Department of Health Services
150 N 18th Ave, Phoenix, AZ 85007
Direct - 602-542-5121
Email - emily.carey@azdhs.gov
Health and Wellness for all Arizonans

On Wed, Jul 26, 2023 at 11:24 AM Emily Carey <emily.carey@azdhs.gov> wrote:

Thank you Anakaren. We will provide a written response prior to next week's meeting!

Emily Carey, M.S.
Senior Rules Analyst, Administrative Counsel & Rules
Arizona Department of Health Services
150 N 18th Ave, Phoenix, AZ 85007
Direct - 602-542-5121
Email - emily.carey@azdhs.gov
Health and Wellness for all Arizonans

On Wed, Jul 26, 2023 at 10:23 AM Anakaren Lemus <anakaren.lemus@azdoa.gov> wrote:

Hi Emily -

Please see below additional questions from Council Member Thorwald regarding the 5YRR heard yesterday.

Thank you.

Anakaren Lemus

Paralegal Project Specialist | Governor's Regulatory Review Council

Public Records Manager | ADOA - Director's Office

100 North 15th Avenue, Suite 302, Phoenix, AZ 85007
Office: 602.542.2058

Anakaren.Lemus@azdoa.gov | http://www.azdoa.gov

---------- Forwarded message ---------

---------- Forwarded message ---------
From: **Frank Thorwald** <FrankThorwald@thorwaldgroup.com>
Date: Tue, Jul 25, 2023 at 8:12 PM

Subject: Additional question for DHS (D2) TITLE 9, CHAPTER 10, TITLE 1
To: Simon Larscheidt <simon.larscheidt@azdoa.gov>
Cc: Frank Thorwald <FrankThorwald@thorwaldgroup.com>

Why are you not incorporating repurposed medication that unanimously approved by the legislature and rules established by the pharmacy board that may save the state millions?

Frank Thorwald
940-230-5840
Frank Thorwald@ThorwaldGroup.com

CONFIDENTIALITY NOTICE: This e-mail is the property of the Arizona Department of Health Services and contains information that may be PRIVILEGED, CONFIDENTIAL, or otherwise exempt from disclosure by applicable law. It is intended only for the person(s) to whom it is addressed. If you have received this communication in error, please do not retain or distribute it. Please notify the sender immediately by e-mail at the address shown above and delete the original message. Thank you.

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R9-10-816.pdf
750K

Historical Note

New Section renumbered from R9-10-811 and amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-815. Directed Care Services

A. A manager shall ensure that a resident's representative is designated for a resident who is unable to direct self-care.

B. A manager of an assisted living facility authorized to provide directed care services shall not accept or retain a resident who, except as provided in R9-10-814(B)(2):
1. Is confined to a bed or chair because of an inability to ambulate even with assistance; or
2. Has a stage 3 or stage 4 pressure sore, as determined by a registered nurse or medical practitioner.

C. In addition to the requirements in R9-10-808(A)(3), a manager shall ensure that the service plan for a resident receiving directed care services includes:
1. The requirements in R9-10-814(F)(1) through (3);
2. If applicable, the determination in R9-10-814(B)(2)(b)(iii);
3. Cognitive stimulation and activities to maximize functioning;
4. Strategies to ensure a resident's personal safety;
5. Encouragement to eat meals and snacks;
6. Documentation:
   a. Of the resident's weight, or
   b. From a medical practitioner stating that weighing the resident is contraindicated; and
7. Coordination of communications with the resident's representative, family members, and, if applicable, other individuals identified in the resident's service plan.

D. A manager shall ensure that an employee does not provide non-prescription medication to a resident receiving directed care services unless the resident has an order from a medical practitioner for the non-prescription medication.

E. A manager shall ensure that:
1. A bell, intercom, or other mechanical means to alert employees to a resident's needs or emergencies is available in a bedroom being used by a resident receiving directed care services; or
2. An assisted living facility has implemented another means to alert a caregiver or assistant caregiver to a resident's needs or emergencies.

F. A manager of an assisted living facility authorized to provide directed care services shall ensure that:
1. Policies and procedures are established, documented, and implemented that ensure the safety of a resident who may wander;
2. There is a means of exiting the facility for a resident who does not have a key, special knowledge for egress, or the ability to expend increased physical effort that meets one of the following:
   a. Provides access to an outside area that:
      i. Allows the resident to be at least 30 feet away from the facility, and
      ii. Controls or alerts employees of the egress of a resident from the facility;
   b. Provides access to an outside area:
      i. From which a resident may exit to a location at least 30 feet away from the facility, and
      ii. Controls or alerts employees of the egress of a resident from the facility; or
   c. Uses a mechanism that meets the Special Egress-Control Devices provisions in the International Building Code incorporated by reference in R9-10-104.01; and
3. A caregiver or an assistant caregiver complies with the requirements for incidents in R9-10-804 when a resident who is unable to direct self-care wanders into an area not designated by the governing authority for use by the resident.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

R9-10-816. Medication Services

A. A manager shall ensure that:
1. Policies and procedures for medication services include:
   a. Procedures for preventing, responding to, and reporting a medication error;
   b. Procedures for responding to and reporting an unexpected reaction to a medication;
   c. Procedures to ensure that a resident's medication regimen and method of administration is reviewed by a medical practitioner to ensure the medication regimen meets the resident's needs;
   d. Procedures for:
      i. Documenting, as applicable, medication administration and assistance in the self-administration of medication; and
      ii. Monitoring a resident who self-administers medication;
   e. Procedures for assisting a resident in procuring medication; and
   f. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
2. If a verbal order for a resident's medication is received from a medical practitioner by the assisted living facility:
   a. The manager or a caregiver takes the verbal order from the medical practitioner,
   b. The verbal order is documented in the resident's medical record, and
   c. A written order verifying the verbal order is obtained from the medical practitioner within 14 calendar days after receiving the verbal order.

B. If an assisted living facility provides medication administration, a manager shall ensure that:
1. Medication is stored by the assisted living facility;
2. Policies and procedures for medication administration:
   a. Are reviewed and approved by a medical practitioner, registered nurse, or pharmacist;
   b. Include a process for documenting an individual, authorized, according to the definition of "adminis-

ter" in A.R.S. § 32-1901, by a medical practitioner to administer medication under the direction of the medical practitioner;
c. Ensure that medication is administered to a resident only as prescribed; and
d. Cover the documentation of a resident's refusal to take prescribed medication in the resident's medical record; and
3. A medication administered to a resident:
a. Is administered by an individual under direction of a medical practitioner,
b. Is administered in compliance with a medication order, and
c. Is documented in the resident's medical record.

C. If an assisted living facility provides assistance in the self-administration of medication, a manager shall ensure that:
1. A resident's medication is stored by the assisted living facility;
2. The following assistance is provided to a resident:
a. A reminder when it is time to take the medication;
b. Opening the medication container or medication organizer for the resident;
c. Observing the resident while the resident removes the medication from the container or medication organizer;
d. Except when a resident uses a medication organizer, verifying that the medication is taken as ordered by the resident's medical practitioner by confirming that:
i. The resident taking the medication is the individual stated on the medication container label,
ii. The resident is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label, and
iii. The resident is taking the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label;
e. For a resident using a medication organizer, verifying that the resident is taking the medication in the medication organizer according to the schedule specified on the medical practitioner's order; or
f. Observing the resident while the resident takes the medication;
3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or nurse; and
4. Assistance in the self-administration of medication provided to a resident:
a. Is in compliance with an order, and
b. Is documented in the resident's medical record.

D. A manager shall ensure that:
1. A current drug reference guide is available for use by personnel members, and
2. A current toxicology reference guide is available for use by personnel members.

E. A manager shall ensure that a resident's medication organizer is only filled by:
1. The resident;
2. The resident's representative;
3. A family member of the resident;
4. A personnel member of a home health agency or hospice service agency; or
5. The manager or a caregiver who has been designated and is under the direction of a medical practitioner, according to subsection (B)(2)(b).

F. When medication is stored by an assisted living facility, a manager shall ensure that:
1. Medication is stored in a separate locked room, closet, cabinet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented for:
a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
c. A medication recall and notification of residents who received recalled medication; and
d. Storing, inventorying, and dispensing controlled substances.

G. A manager shall ensure that a caregiver immediately reports a medication error or a resident's unexpected reaction to a medication to the medical practitioner who ordered the medication or, if the medical practitioner who ordered the medication is not available, another medical practitioner.

H. If medication is stored by a resident in the resident's bedroom or residential unit, a manager shall ensure that:
1. The medication is stored according to the resident's service plan; or
2. If the medication is not being stored according to the resident's service plan, the resident's service plan is updated to include how the medication is being stored by the resident.

Historical Note
New Section made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-817. Food Services

A. A manager shall ensure that:
1. A food menu:
a. Is prepared at least one week in advance,
b. Includes the foods to be served each day,
c. Is conspicuously posted at least one calendar day before the first meal on the food menu is served,
d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
e. Is maintained for at least 60 calendar days after the last day included in the food menu;
2. Meals and snacks provided by the assisted living facility are served according to posted menus;
3. If the assisted living facility contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to pre-

OIL AND GAS CONSERVATION COMMISSION
Title 12, Chapter 7, Article 1

GOVERNOR'S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

MEETING DATE: August 1, 2023

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

FROM: Council Staff

DATE: July 14, 2023

SUBJECT: **OIL AND GAS CONSERVATION COMMISSION**
Title 12, Chapter 7, Article 1

Summary

This Five-Year Review Report (5YRR) from the Oil and Gas Conservation Commission (Commission) relates to fifty-five (55) rules in Title 12, Chapter 7, Article 1 regarding Oil, Gas, Helium, and Geothermal Resources.

In the prior 5YRR for these rules which was submitted in March 2017, the Commission proposed to amend thirty-two (32) rules to improve their clarity and consistency. The Commission indicates, for each of the proposed amendments, the Commission continued to assess the listed rulemaking priorities and, due to ongoing workload constraints, the proposed changes are still in process and the Commission plans to move forward with these changes and any newly acknowledged changes over approximately the next 12 months, contingent on the necessary statutory changes and rulemaking approvals.

Proposed Action

In the current report, the Commission is proposing to amend thirty-four (34) rules to improve clarity, consistency, and effectiveness. The Commission indicates it plans to amend these rules by August 2024, contingent on staff resources and the necessary statutory changes and rulemaking approvals.

1. Has the agency analyzed whether the rules are authorized by statute?

The Commission cites both general and specific statutory authority for these rules.

2. Summary of the agency's economic impact comparison and identification of stakeholders:

These rules directly impact the companies engaged in oil, gas, or geothermal exploration or development activities. In the opinion of the Commission, the rules are mostly procedural in nature and do not significantly impact the economy, small businesses, or consumers. The Commission has not identified any information that would alter the economic, small business, and consumer impact statements that were submitted with the rulemaking in 2007, 2005, 2002, 2000, 1998, 1997, 1993, and 1992. These economic, small business and consumer impact statements concluded that the rules would not significantly impact the economy or have a significant impact upon small businesses or consumers.

At least seven companies (two publicly-owned businesses, two publicly-owned small businesses, and three privately-owned small businesses) are engaged in oil and gas exploration or development activity in Arizona; two operate 14 liquefied petroleum gas (LPG) storage wells, four operate 41 producing oil and gas wells, and one or more are currently drilling wells.

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?

According to the Commission, the rules are procedural in nature and the Commission believes that these rules impose the least burden and costs to regulated persons, including paperwork and other compliance costs, which are necessary to achieve the underlying regulatory and statutory objectives.

4. Has the agency received any written criticisms of the rules over the last five years?

The Commission indicates it has received numerous written criticisms regarding these rules in the last five years. Summaries of these criticisms are found in Section 7 of the Commission's report. The Commission indicates many of these criticisms provide support for its proposed course of action.

5. Has the agency analyzed the rules' clarity, conciseness, and understandability?

The Commission identifies twenty-one (21) rules that are not clear, concise, and understandable as outlined in more detail in Section 6 of the Commission's 5YRR.

6. Has the agency analyzed the rules' consistency with other rules and statutes?

The Commission indicates it judges the consistency of its rules in connection with its statutory declaration of policy (A.R.S. § 27-502), obligation to prevent physical waste (A.R.S. § 27-503), authorizing statutes (A.R.S. §§ 27-515, 27-516, and 27-656), and the Arizona Administrative Procedures Act (A.R.S. §§ 41-1001 et seq.). The Commission states Title 12, Chapter 7 is consistent with all applicable state and federal statutes and rules applicable to oil, gas, helium, and geothermal resources, with the possible exception of the EPA's Class II and V injection well requirements. As a result, the Commission indicates it may recommend amendments to the requirements under R12-7-175 through R12-7-179. The Commission plans to continue its working relationship with EPA and ADEQ, who is currently seeking Underground Injection Control (UIC) primacy from the EPA. The Commission plans to review and consider updates to its rules and associated statutes in order to better align with corresponding federal law. The Commission indicates it has been working closely with ADEQ's Aquifer Protection Program as they pursue UIC primacy and plans to amend the Commission's rules and statutes to better align with UIC requirements and prevent unnecessary burden and permitting redundancies.

7. Has the agency analyzed the rules' effectiveness in achieving its objectives?

The Commission indicates the rules are generally effective in achieving their objectives. The Commission is proposing minor revisions to rules R12-7-103, R12-7-121, and R12-7-175 as outlined in more detail in Section 3 of the Commission's report.

8. Has the agency analyzed the current enforcement status of the rules?

The Commission indicates the rules are currently 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 Commission indicates the oil and gas rules in Article 1 are consistent with, and not more stringent than, the federal regulations applicable to oil and gas conservation. However, the Commission indicates the one possible exception to this is the EPA Underground Injection Control requirements. In this case, the Commission indicates it may recommend amendments to the requirements under R12-7-175 through R12-7-179. The Commission plans to continue its working relationship with EPA and ADEQ, who is currently seeking UIC primacy from the EPA. The Commission plans to review and consider updates to its rules and associated statutes in order to better align with corresponding federal law. The Commission indicates it has been working closely with ADEQ's Aquifer Protection Program as they pursue UIC primacy and plans to amend Commission rules and statutes to better align with UIC requirements and prevent unnecessary burden and permitting redundancies.

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 Commission indicates the rules were originally adopted and any amendments were promulgated prior to July 29, 2010.

11. Conclusion

This 5YRR from the Commission relates to fifty-five (55) rules in Title 12, Chapter 7, Articles 1 regarding Oil, Gas, Helium, and Geothermal Resources. The Commission has identified numerous proposed amendments to these rules to make them more clear, concise, understandable, consistent, and effective. Specifically, the Commission is proposing to amend thirty-four (34) rules to improve clarity, consistency, and effectiveness. The Commission indicates it plans to amend these rules by August 2024, contingent on staff resources and the necessary statutory changes and rulemaking approvals.

Council staff recommends approval of this report.

ARIZONA DEPARTMENT
OF
ENVIRONMENTAL QUALITY

July 21, 2023
SENT VIA EMAIL ONLY

Nicole Sornsin, Chair
Governor's Regulatory Review Council
100 N. 15th Ave., #305
Phoenix, AZ 85007
grrc@azdoa.gov

Re: Submittal of Five-Year Review Report for A.A.C. Title 12, Chapter 7, Article 1

Dear Chair Sornsin:

I am pleased to submit to you, pursuant to A.R.S. § 41-1056 and A.A.C. R1-6-301, our agency's Five-Year Review Report for A.A.C. Title 12, Chapter 7, Article 1: Arizona Oil and Gas Conservation Commission – Oil, Gas, Helium, and Geothermal Resources.

Pursuant to A.R.S. § 41-1056(A), I certify that the Arizona Oil and Gas Conservation Commission (AZOGCC) is in compliance with A.R.S. § 41-1091 requirements for filing of notices of substantive policy statements and annual publication of a substantive policy statement directory.

Please contact me at 520-235-2579 or dalenations2@gmail.com if you have any

questions. Sincerely,

Jack Dale Nations
Vice Chairman

Enclosure

Arizona Oil and Gas Conservation Commission

Five-Year Review Report

Title 12. Natural Resources

Chapter 7. Oil and Gas Conservation Commission

ARTICLE 1. Oil, Gas, Helium, and Geothermal Resources

March 29, 2023

1. Authorization of the rule by existing statutes

The Arizona Oil and Gas Conservation Commission (AZOGCC) is granted authority to prevent the waste of oil and gas and non-hydrocarbon gasses in Arizona Revised Statutes (A.R.S.) § 27-503. The Commission is granted authority under A.R.S. §§ 27-516(A) and 27-656(A) to adopt the rules in 12 Arizona Administrative Code (A.A.C.) 7, Article 1.

2. The objective of each rule:

Rule	Objective
R12-7-101	The definition section defines unique terms and acronyms, words with uncommon meanings and technical terms used in the oil and gas industry as used in 12 A.A.C., Chapter 7, Article 1.
R12-7-102	Repealed.
R12-7-103	This section specifies the mandatory financial assurance to be posted by operators, prescribing performance bond amounts and terms for the purpose of the proper plugging and abandonment of the well. In addition, the performance bond shall cover well site reclamation (including ARS § 27- 516.18) and removal of equipment and debris and backfilling of all mud pits. The AZOGCC requires operators to fill out one of two notarized forms (cash or performance bond), which are available online for recording performance bond deposits with the state.
R12-7-104	This section specifies procedures, requirements and timeframes for permitting all wells under jurisdiction of the AZOGCC, including oil, gas, injection (R12-7-175 through 182) and geothermal wells. The AZOGCC must issue a permit before any such well can be drilled in the state. A fee of $25 per well is required.
R12-7-105	This section specifies the procedures an operator must follow if there is a change in the approved location before drilling. The emergency relief well situation overrides the normal routine of permitting simply because it is an emergency. The rule allows the Administrator and the Commission discretion to address the emergency first, then require a post-drilling permit and post a performance bond, if necessary.
R12-7-106	This section specifies the minimum requirements for identification that must be present in the field when drilling and signage that must identify wells, producing leases, tanks, refineries, buildings, and oil and gas related facilities.
R12-7-107	This rule specifies well spacing and acreage dedication requirements, which then become dedicated drilling units. If an operator wants to deviate from the standard requirement, the

	AZOGCC may grant a formal exception in a public hearing. The rule's intent is to protect adjoining landowners and other oil and gas interests, who may be damaged by drilling too close to their holdings. An operator must justify his request for a deviation from spacing and acreage requirements based on geological, geophysical, or other subsurface information. Such deviation may be allowed if the information defines a known geologic structure.
R12-7-108	This section specifies requirements for drilling mud and construction of reserve pits during drilling
R12-7-109	Repealed.
R12-7-110	This section specifies depth, size, cementing, and integrity requirements for surface casing.
R12-7-111	This section specifies size, depth, cementing, and integrity requirements of casing and tubing installed in a well.
R12-7-112	This section defines defective casing or cementing and standards for remediation.
R12-7-113	This section specifies blowout control equipment installation and testing requirements.
R12-7-114	This section specifies requirements for recovery of casing.
R12-7-115	This section specifies requirements for directional drilling and deviation surveys.
R12-7-116	This section specifies requirements for well completions with more than one production zone in a well.
R12-7-117	This section specifies requirements for artificial stimulation and chemical treatment of wells.
R12-7-118	This section specifies requirements to follow when drilling in hydrogen sulfide environments in order to protect human health.
R12-7-119	This section specifies requirements for wellheads and other lease equipment to prevent waste, protect the environment and ensure safety at the well site.
R12-7-120	This section specifies requirements operators must follow for preventing and reporting fires, spills, and blowouts at any drilling, producing, injection, disposal, transportation or storage facility.
R12-7-121	This section specifies completion and filing requirements for drilled wells and their compliance time frames for submission to the AZOGCC. The rule grants confidentiality to certain types of wells.
R12-7-122	This section specifies requirements on workovers, recompletions, or stimulation of wells.

R12-7-123; R12-7-124	Reserved.
R12-7-125	This section specifies requirements for operations that are suspended for 60 days or more.
R12-7-126	This section requires operators to submit plugging plans to the AZOGCC for review and approval.
R12-7-127	This section specifies plugging methods, procedures, and reporting requirements to prevent subsurface contamination by oil, gas, and geothermal drilling and production activities.
R12-7-128	This section specifies requirements for holes drilled to obtain stratigraphic or seismic information.
R12-7-129	This section specifies requirements for converting any well or exploratory hole to a water well for use by persons who need a potable water source.
R12-7-130 — R12-7-134	Reserved.
R12-7-135	This section requires operators to conduct specific tests for the purpose of measuring oil / gas ratios in producing oil fields. This prevents waste and protects adjoining leaseholders' shared interests in the oil and gas produced.
R12-7-136	This section specifies initial and periodic testing requirements for oil and gas wells to ensure prevention of waste of oil and gas resources.
R12-7-137	This section specifies requirements for accounting of production from separate pools to prevent waste and protect adjoining interests from being illegally drained. Protects all producers in a unitized pool by requiring a public hearing and AZOGCC approval.
R12-7-138	This section regulates the production, sale and transport and venting of all casinghead gas in order to prevent waste. Specifies measurement and reporting requirements to the AZOGCC for gas produced from oil wells.
R12-7-139	This section prohibits the use of vacuum pumps unless authorized by the AZOGCC in order to prevent waste and protect adjoining leaseholders from improper drainage of their interests. The Commission has statutory authority over all wells in A.R.S. § 27-516. Furthermore, the AZOGCC has broad discretionary authority to promulgate rules that address the overall production rate and the method of production, pursuant to A.R.S. § 27-515, A.R.S. §§ 27-524(A) and 525.
R12-7-140	This section requires operators to prevent surface/ subsurface pollution, surface damage, and minimize noise caused by drilling activity.
R12-7-141	Renumbered.
R12-7-142	This section requires precise measurement of oil produced, purchased or transported in order to minimize and/or prevent waste. Requires oil to be measured before transporting from a lease.

R12-7-143	This section specifies safety requirements for oil tanks, fire walls, and preventing fire hazards pursuant to the Declaration of Policy in A.R.S. 502(A)(6) "Safeguard the health, property and public welfare of citizens of the state and other interested persons."
R12-7-144 - R12-7-149	Reserved.
R12-7-150	This section requires capacity tests for wells in a certain timeframe.
R12-7-151	This section requires precise measurement by metering of gas produced, purchased or transported in order to minimize and/or prevent waste. Requires accurate measurement of geothermal resources produced.
R12-7-152	This section restricts and prohibits the use of gas from wells by well owners and operators to specific uses in order to prevent waste.
R12-7-153	This section expands the scope of this chapter to include non-hydrocarbon gasses ("helium, carbon dioxide, and any other non-hydrocarbon gas.").
R12-7-154 - R12-7-159	Reserved.
R12-7-160	This section gives the AZOGCC authority to limit, allocate or apportion oil, gas or geothermal production under specific conditions where waste is, or may be caused. The Commission's purpose is to promote the production of oil and gas in the state of Arizona, as stated in A.R.S. § 27-502.
R12-7-161	This section specifies that operators are required to report all oil, water, and gas produced from all wells regulated by the AZOGCC in the state. It also specifies what operators must report to the AZOGCC on production from each producing lease and the timeframe for submittal.
R12-7-162 - R12-7-169	Reserved.
R12-7-170 - R12-7-171	Renumbered.
R12-7-172 - R12-7-174	Reserved.
R12-7-175	This section identifies the types of injection wells that require a permit from the AZOGCC, pursuant to R12-7-104, and further specifies which types of wells are covered under specific sections of the rule.
R12-7-176	This section specifies special requirements for permitting injection wells before the AZOGCC will allow any substance to be injected into any geologic stratum.
R12-7-177	Repealed.

R12-7-178	This section requires operators to keep the AZOGCC informed of the operational status of all regulated injection wells in the state, including start-up, cessation, temporary abandonment, plugging and abandonment or transfer of injection wells.
R12-7-179	This section specifies testing, monitoring, and reporting requirements for operators of injection wells. The testing, monitoring and recordkeeping requirements are to ensure operators are in compliance with the AZOGCC rules on injection wells.
R12-7-180	This section specifies additional requirements an operator must include in any application for drilling storage (injection) wells to store liquid or gaseous hydrocarbons, or any other substances under the jurisdiction of the Commission.
R12-7-181	This section specifies minimum design, construction and maintenance requirements for underground storage of liquid or gaseous hydrocarbons, or any other substances under the jurisdiction of the Commission. This includes the storage wells that service these cavities to prevent waste, leakage or loss of product and/ or exposure of hazardous gasses to people, pursuant to the Declaration of Policy in A.R.S. 502(A)(6) "Safeguard the health, property and public welfare of citizens of the state and other interested persons."
R12-7-182	This section specifies operation, inspection, reporting and abandonment requirements for underground storage wells for natural gas to prevent waste, leakage or loss of product and/ or exposure of hazardous gasses to people. The information from required reports assists the AZOGCC in monitoring the operator's compliance with the oil and gas rules and the amount of product produced. The Commission is authorized to adopt this rule, pursuant to the Declaration of Policy in A.R.S. 502(A)(6) "Safeguard the health, property and public welfare of citizens of the state and other interested persons."
R12-7-183	This section specifies requirements to transport oil and gas from a lease. The AZOGCC issues a certificate, which authorizes an operator or producer to transport oil, gas, or geothermal resources from a lease for each well.
R12-7-184	This section specifies requirements for transport of load oil that is recovered from the well after treatment. The AZOGCC approves this activity by issuing a certificate of load oil credit and permit to transport.
R12-7-185	This section specifies requirements to track an oil transporter's stocks of oil and condensate on hand and all movements within the state of oil and condensate by pipeline, trucks, or other conveyances except railroads. This is done through a system of monthly reports submitted to the AZOGCC. The information assists the AZOGCC in monitoring the operator's compliance with the rules and the amount of product produced.
R12-7-186	This section requires purchasers of gas and geothermal products to report monthly on the acquisition and disposition of gas or geothermal resources produced from a well. The information assists the AZOGCC in monitoring the operator's compliance with the rules and the amount of product produced.
R12-7-187	This section requires injection well operators to submit monthly reports including locational data, operational parameters and production data. The information assists the AZOGCC in monitoring the operator's compliance with the rules and the amount of product produced.
R12-7-188	This section requires refinery operators to report monthly on oil, condensate and other hydrocarbon products and by-products produced at such a facility. The information assists the

	AZOGCC in monitoring the operator's compliance with the rules and the amount of product produced.
R12-7-189	Repealed.
R12-7-190	This section specifies reporting requirements of all operators of plants that extract any hydrocarbon liquids (*e.g.,* gasoline, kerosene, condensate, oil, etc.) from gas. The information assists the AZOGCC in monitoring the operator's compliance with the rules and the amount of product produced.
R12-7-191	Reserved.
R12-7-192	This section specifies requirements for books and records to verify data reported to the AZOGCC on prescribed forms. The rule gives the AZOGCC legal access to inspect/ audit production data for up to six years after a well is completed.
R12-7-193	Repealed.
R12-7-194	This section specifies information required in a legal document (organization report) that must be submitted with an application to drill or with a Sundry Notice when the operator name changes. It is a statement made under oath of who the operator/ applicant is and that the operator is a legitimate business/ person doing business in the state of Arizona.
R12-7-195	Repealed.
Appendix 1	Repealed.

3. <u>Are the rules effective in achieving their objectives?</u> **Yes _x_ No __**

The rules are generally effective in achieving their objectives, except for the rules found in the table below. Minor clarifications can be made as described in the proposed courses of action found in Section 14.

Rule	Explanation
R12-7-103	Performance bond amounts are inadequate to cover the current costs of properly plugging and abandoning a well.
R12-7-121	The AZOGCC reviewed well records and discovered that there may be confusion regarding the definition of a "completed well" and "the date the work is done" that has interfered with timely compliance for submitting completion data. The AZOGCC developed a specific form for compiling completion data, but the rule does not require operators to use it.
R12-7-175	Generally, the rule is effective in achieving the immediate objectives of the AZOGCC, but there remains the potential for overlap with competing rules adopted by USEPA and ADEQ, which also require permits for injection wells.

4. <u>Are the rules consistent with other rules and statutes?</u> **Yes _x_ No __**

The AZOGCC judges the consistency of its rules in connection with its statutory declaration of policy (A.R.S. § 27-502), obligation to prevent physical waste (A.R.S. § 27-503), authorizing statutes (A.R.S. §§ 27-515, 27-516, and 27-656), and the Arizona Administrative Procedures Act (A.R.S. §§ 41-1001 et seq.). A.A.C. Title 12, Chapter 7 is consistent with all applicable state and federal statutes and rules applicable to oil, gas, helium, and geothermal resources, with one possible exception. That exception is EPA's Class II and V injection well requirements. This issue is discussed below in Section #12 under the discussion of R12-7-175.

5. Are the rules enforced as written? **Yes _x_** **No __**

The rules are generally enforced as written. A statement of the Commission's general policy regarding enforcement of these rules is below.

Rule	Explanation
General Policy Statement	The Arizona Administrative Code sets forth rule requirements to drill and produce oil, gas and geothermal resources in a manner that conserves these resources. The AZOGCC enforces the rules by conducting inspections, reviewing numerous submitted forms and reports, and when necessary, referring enforcement actions to the Arizona Attorney General's Office.

6. Are the rules clear, concise, and understandable? **Yes _x__** **No __**

The rules are clear, concise, and understandable. Minor clarifications can be made as described in the table below.

Rule	Explanation
Generally	Generally, the rules are clear, concise, and understandable. They are consistent with the applicable statutes and rules, unless stated otherwise in the proposed courses of action or written criticisms. For consistency and to add clarity, one common recommendation throughout this report is to, "add clarifying language on a form approved by the Commission". Over time, the AZOGCC has created about twenty forms for operators to use. However, their use is inconsistent and the oil and gas program's reporting requirements could be met more timely and efficiently, if use of these forms were required in the rule. Only two places in the current rule refer to a form by a proper name: R12- 7-125(B) ("Sundry Notice") and R12-7-129(B) ("notarized water-well responsibility form"). This revision would reduce the regulatory burden while achieving the same regulatory objective, consistent with EO2017-02. Several AZOGCC actions to permit or otherwise authorize an operator action require the Commissioners to vote on approval at a public hearing. The rules could be improved by clearly stating in each instance the time frame for a public notice before the hearing. For example: R12-7- 176(A)(B), 15 days is specified for a hearing for an injection well permit; R12-7-107(E)(4) provides 10 days for change of a well classification; elsewhere, the time frame is unspecified. Currently, if the time frames are unspecified, the AZOGCC infers it to be 15 calendar days. The rules could be improved by a consistent time frame of 15 calendar days to give the public adequate notice and allow time for preparation. Rule language should be added where noted in the Section by Section Analysis. The AZOGCC recommends amendments to R12-7-107(E), 107(F), 107(G), 116, 137, 139 and 152(B) to clearly designate that 15 calendar days' notice is required before any public hearing.

R12-7-101	R12-7-153 expands the scope of this rule to include non-hydrocarbon gasses (helium, carbon dioxide, etc.). This was an amendment to the rule, effective February 23, 1993, but no other changes were made to harmonize other rules, such as the definition of "gas well," with this amendment. Also, to improve clarity of what constitutes a completed well, a definition for "completion operations" is needed in this section.
R12-7-107	Two issues in this section are vague and could benefit from more precise rule language. R12-7-107(B) and (E) require the operator to provide the Commission extra supporting information, such as subsurface geologic and seismic data, to be submitted with any drilling application (R12-7-104) when the applicant seeks a well spacing exception. The rule could be improved by clearly stating the extra requirements, in accordance with similar specifics that are found in R12-7-176(B) for injection wells. The second issue is that the rule is silent on the duration of the public notice period for a well *spacing exception*, although -107(E)(4) requires 10 days' notice for a hearing to change a well's *classification*. The AZOGCC has always required 15 days' notice for hearings on well spacing exceptions. R12-7-107 should be clarified and public notice requirements made consistent throughout the entire rule. The rule should clarify that a request for a spacing exception should be made at least 45 days in advance of an AZOGCC hearing.
R12-7-110	The rule could be improved by replacing "witness" with "observe" to improve the public's understanding of the rule's intent and replacing "corrective measures" and "remedial action" with "corrective actions" to improve clarity and conciseness. Cement requires a minimum of 12 hours curing time, which is the industry standard. No Commission authority is required for additional curing time for the cement.
R12-7-111	Replacing "corrective measures" and "remedial action" with "corrective actions" could improve clarity and conciseness. Replacing "witness" with "observe" could improve understandability.
R12-7-112	Wording about reporting to the Commission is awkward. Replacing "corrective measures" and "remedial action" with "corrective actions" in R12-7-112(B) could improve clarity and conciseness.
R12-7-116	The time frame for a hearing is not specified and should be consistent throughout the article. A new definition that differentiates "multiple zone completions" from "commingling production" could improve understandability. Alternatively, clarification language could be placed in section 116 and section 137 to differentiate the context of the two terms and improve conciseness. Replacing "witness" with "inspect" or "observe" could also improve understandability.
R12-7-121	The AZOGCC reviewed well records and discovered that there has been long-term confusion regarding the definition of a "completed well" and "the date the work is done" that has interfered with timely compliance for submitting completion data. The AZOGCC developed a specific form for compiling completion data, but the rule does not require operators to use it. SB 1530 transferred administrative responsibilities to the Arizona Department of Environmental Quality, effective August 6, 2016 and the mailing address must be updated in R12-7-121(B)(3).
R12-7-122	An operator who wants to re-enter an existing well shall file with the Commission an application for permit to drill or re-enter an existing well (Form #3) and pay the applicable fee. The rule language could be clarified by cross-referencing it with R12-7-104(A). "Zone" is an industry term with a common definition.

R12-7-126	The rule could be improved by adding language that the Sundry Notice is used for this purpose.
R12-7-127	The rule could be improved by replacing "witness" with "observe" to improve understandability.
R12-7-137	The time frame for a hearing is not specified. "Pool" is defined in A.R.S. § 27-501(16). The rule could be improved by adding a new definition, to differentiate "multiple zone completions" from "commingling production." Alternatively, clarifying language could be added to R12-7-116 and 137 to differentiate the context of the two terms to improve conciseness. Replacing "witness" with "inspect" or "observe" would also improve understandability.
R12-7-139	The rule is silent on the duration of the public notice period for an AZOGCC hearing on the use of a vacuum pump in a well.
R12-7-142	The term "measure" requires clarification.
R12-7-152	The time frame for a hearing is not specified.
R12-7-175	This rule is not clear on a few key issues, all of which are related to the Underground Injection Control (UIC) program administered by the US Environmental Protection Agency (USEPA) and the Arizona Department of Environmental Quality's (ADEQ) Aquifer Protection Program. The rule references "Class II" and "Class V" wells, which is assumed to be the UIC program, but these terms are not defined in R12-7-101. Furthermore, the rule may have overlapping authorities with the Aquifer Protection Program and UIC with respect to regulatory oversight and financial assurance requirements.
R12-7-176	The requirement in section 176(A)(B) for a 15 day notice before a public hearing conflicts with the requirement in section 107(E)(4), change of well classification, which is ten days. A single time frame of 15 calendar days is recommended for consistency and to give the public adequate notice.
R12-7-178	The rule could be improved by changing "1" to "one" in R12-7-178(3).
R12-7-181	Section 181(A) provides: "… applicant shall demonstrate to the Commission that …, etc." implies that the Commission must approve the applicant's demonstration that the proposed design will preserve the structural integrity of the host rock. However, the rule is not clear regarding what type of hearing is required or that approval can be administratively granted. In the past the AZOGCC has required this demonstration as part of the drilling application (R12-7-104). The rule is silent on any time frame the Commission must comply with, in accordance with R12-7-104(C). R12-7-181(D) preserves Arizona's two underground storage facilities, however, if it is determined that the AZOGCC has jurisdiction over the PHMSA Interim Rule in the state, these design and construction requirements may change.
R12-7-182	"Witness", "observe", "inspect" are used interchangeably in regards to AZOGCC activity at the site. For consistency, the AZOGCC may consider replacing "witness" with "observe".
R12-7-186	The rule needs more specificity on content for a typical geothermal report.
R12-7-190	Should a gasoline plant be constructed in Arizona, this rule would satisfy the basic requirements of reporting typical data from such a facility that would be of interest to the state. The rule may have to be amended in the future to accommodate factors applicable to a gasoline plant in this state. The rule should not be repealed.

7. <u>Has the agency received written criticisms of the rules within the last five years?</u> Yes _x__ No __

Rule	Explanation

R12-7-103	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding the performance bonding requirements in neighboring states as compared to Arizona: "*These are essential funds to ensure wells are safely plugged according to the statutes. The cost for this work has increased over the years.* A. 1. The bonds for individual wells, $10,000 or $20,000 should be increased by the amount of inflation since they were established, not any amount more. *The higher charge for deeper wells does not carry over to multiple wells, should be re considered.* A. 2. The number of wells included in multiple well bonds is too large. See recommendation below, note the Operator would specify a number of wells, for example 5 wells would be $37,500 and 8 wells would be $50,000; A. 2. a. $25,000 for 3 wells; A. 2. b. $50,000, or $7,500 per well for more than 3 but fewer than 10 wells, whichever is less; or A. 2. c. $250,000, or $5,500 per well for 10 or more wells, whichever is less." *"These amounts would also be adjusted for inflation as in A. 1."* The AZOGCC views this comment as additional support for its proposed course of action.
R12-7-104	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding the application for permit to drill: "*The language should support the change to electronic communication. Also suggest a new section to include the initial request for a deviated well or horizontal segment. Someday this should be routine.* A. 3. Also include plats for deviated wells and horizontal segments, if applicable. B. Every reference to "mail" and "written" should be modified to electronic communication. B. 2. As above B. 6. $25 should be increased by the amount of inflation since it was established, not any amount more. *Note R12-7-105 B. specifies the use of electronic communication for a change of drilling location, can use similar language in other sections.*" The AZOGCC views this comment as additional support for its proposed course of action.
R12-7-107	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding the spacing of wells: "*The spacing for oil and gas wells is generally too large. This can be addressed under sections E and F, but more flexibility for Operators up front is suggested. The use of larger or smaller spacing units, including other than 40 or 160 acres, should be at the discretion of the Commission, and can be requested by the Operator.* A. The initial drilling unit for oil wells should be approximately 40 contiguous surface acres, a single governmental quarter-quarter section.

A. 1. The last sentence should change to 38 acres and 1,500 feet

A. 2. Do not need the reference to 330 feet from center line, no center line like this with 40 acre spacing. A. 3. Not needed with 40 acre spacing.

B. The initial drilling unit for gas should be approximately 160 contiguous surface acres, a single governmental quarter section.

B. 1. The last sentence should change to 150 acres and 3,000 feet.

B. 2. For 160 acre spacing, this would be 660 feet.

D. This is too brief to really address horizontal drilling, but refer to "horizontal segments within a drilling unit"…

D. 2. For 160 acre spacing, this would be 660 feet.

Add D. 4. As approved or modified by the Commission in the case of horizontal segments involving two or more drilling units.

E. 2. and 4. These should be more consistent. Some changes may not affect anyone else. It could be a very large task to notify "all adjoining lessees" or operators "within a one mile radius", lots of potential complications. Proof is only mentioned in E4. I recommend that the requirement be to notify "affected offset operators, lease holders or mineral owners". It will be reviewed at the hearing.

Minor note, the reference to (C) in E and F is redundant, C has well spacing to be determined."

The AZOGCC received the following comment from Brittany Rothe, Myriad Resources, LLC, regarding the spacing of wells:

"The 1,660' minimum standard distance from a section line for any gas well seems excessive when compared to nearby states. However, the provision afforded in subpart E. that allows a variance to that distance, is appropriate in our eyes. The only alteration we would suggest would be altering the rules to allow for a private hearing with all necessary parties as opposed to a public hearing. This would allow confidential information to be maintained if the planned well is exploratory in nature."

The AZOGCC received the following comment from Clare Brophy Bellendir, Aztec Land and Cattle Company, Ltd., regarding the spacing of wells:

"The setback of 1,600' seems inconsistent and far too great in comparison to nearby states. However, at this time we would suggest altering the rules to allow for a private hearing with all necessary parties as opposed to a public hearing. This would allow confidential information to be maintained."

The AZOGCC received the following comment from Scott Sears, Nighthawk Resources, regarding the spacing of wells:

"Spacing of Wells for gas (1,660' from a section line). If this footage could be reasonably narrowed (similar to surrounding states), it would be immensely helpful for entities that are taking on considerable geologic risk in their drilling programs. Let me explain. As it stands today, in order for this setback to be to be narrowed, a geologic case must be made in a public hearing. In my experience (at Pinta Dome and Navajo Springs), the Commission has been very receptive and helpful with such requests. However, geologic information is highly proprietary and valuable. Sharing such information in a public forum allows for competitors to get a free look at valuable geologic profiles. Failing a confidential hearing for

	setback relief, the simplest way help this issue would be by reasonably narrowing this setback." The AZOGCC views this comment as additional support for its proposed course of action.
R12-7-110	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding the surface casing requirements: "*Just a few ideas here, need to directly compare this section with other State's regulations.* A. May want to incorporate a standard depth of 300 feet, or at a sufficient depth to protect… C. In addition to pressure testing, documentation of quality and quantity of cement used is standard practice. Part on cable drilling from surface is historic and should be dropped, if they can't pressure test, cable drilling should no longer be an option. D. This seems an unnecessary task for every well. The Administrator can make arrangements as needed." The AZOGCC views this comment as additional support for its proposed course of action.
R12-7-111	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding the intermediate and production casing requirements: "*As above, a few suggestions, need to compare to a standard or a review by a drilling engineer.* C. In addition to pressure testing, a bond log should be required to demonstrate integrity of cement job. C. 1. Drop this, if cable drilling is not on par as far as safety and environmental compliance is concerned, it should not be an option. D. Again, this seems an unnecessary task for every well. The Administrator can make arrangements as needed." The AZOGCC received the following comment from Brittany Rothe, Myriad Resources, LLC, regarding the intermediate and production casing requirements: "It may be appropriate to discuss altering the rules pertaining specifically to drilling with cable tools. In our experience, this method of drilling is no longer used." The AZOGCC received the following comment from Clare Brophy Bellendir, Aztec Land and Cattle Company, Ltd., regarding the intermediate and production casing requirements: "It may be appropriate to discuss altering the rules pertaining specifically to drilling with cable tools." The AZOGCC views this comment as additional support for its proposed course of action.

R12-7-114	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding the recovery of casing: "*This would be better located as part of R12-7-127, part of P&A, very unlikely to be approved."*
R12-7-115	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding deviation of hole and directional drilling: "B. This information should be with the original permit to drill, so it could be routinely approved if it was all within the appropriate spacing and maybe not the first one in the field. A hearing could be required for approval if necessary. C. D. and E. This is kind of a mess. Section E implies you are required to run a directional survey for every directionally drilled well. C and D list certain circumstances under which an operator may be required to run a directional survey. C and D are not needed."
R12-7-116	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding multiple zone completions: "*This appears cumbersome and overly detailed*. A. I see no reason the Commission should maintain a list. B. The specification of documents should go, what if the Commission wanted something in addition? Recommend the requirement be for "adequate documentation" B.3 and B.4 Should certainly go. Each individual completion must be at an approved spacing for that formation and oil versus gas, either standard or as approved by the Commission. Being a multiple completion does not have any special bearing on spacing infringement, which is addressed elsewhere. C.1, C.2 and C.3 should go, enough said the Commission may approve administratively. D. These are additions to the completion report. It could stay here or be in section 121. Completion reports are due in 30 days, there is no reason to make this 15 days. I don't think special notifications should be required. E. I suggest eliminating "and offset operators"
R12-7-117	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding the artificial stimulation of oil and gas wells: "This is really too brief to address artificial stimulation. In some cases, artificial stimulation can refer to routine acidizing, and it includes hydraulic fracturing. In the latter case, approval should be required in advance. A. This should go and be replaced with the approval process. With just a notification requirement, it implies that you just do it and then report it."
R12-7-121	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding the well completion and filing requirements: "A. and B. Instead of multiple due dates. The completion report, logs etc. and samples should all be due 30 days after the well is completed, temporarily abandoned or plugged and abandoned.

	C. 1. Suggest "drilled for oil and gas in unproven territory" be eliminated, also eliminate "unless the operator gives written permission to release the information at an earlier date" and substitute "at the operators request to the Commission". In the second sentence, eliminate "shall provide notice to the operator 60 days before confidential records become subject to public inspection and" and substitute "may". At the end of C. 1. Eliminate "with respect to unleased land in the vicinity of the well." C. 2. This is not needed if all wells included in C. 1. as recommended." The AZOGCC received the following comment from Brittany Rothe, Myriad Resources, LLC, regarding the well completion and filing requirements: "Would the AZOGCC consider making the requirement to catch samples every 30', rather than every 10', given the speeds of today's drilling? Should the address of where the cuttings are delivered be updated to where Myriad sent them? 400 W. Congress St., Suite 433, Tucson, AZ 85701?" The AZOGCC received the following comment from Clare Brophy Bellendir, Aztec Land and Cattle Company, Ltd., regarding the well completion and filing requirements: "Would the AZOGCC consider making the requirement to catch samples every 30', rather than every 10', given the speeds of today's drilling? And should the address of where the cutting are delivered be updated?" The AZOGCC received the following comment from Scott Sears, Nighthawk Resources, regarding the well completion and filing requirements: "I was recently involved (as a non-operating working interest owner) with a well drilled near Holbrook Arizona (Myriad Aztec SD 3-1 Fee. I was at the site for the drilling and the collection of drill samples at 10 ft. intervals was very difficult due to the fast drilling. Drill technology has greatly improved since (perhaps) this rule was crafted. I would suggest 30 ft. as a reasonable footage for catching samples. This would be very helpful."
R12-7-122	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding the well completion and filing requirements: "Between section 117 and 122 C. below, the Commission may currently have no approval process required for hydraulic fracturing in some circumstances. A. I believe the permit to drill/recomplete form is used for this now. "Written" and "in writing" should be modified to allow all this to happen electronically. B. As above, "written" and "writing" C. BETTER GET FRACTURING OUT OF THIS SECTION D. I think a sundry notice form is used for this. Again not "written", and why not 30 days?"
R12-7-125	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding temporarily abandoned and shut-in wells: "A. 60 days is too short, should not have to TA or SI wells so quickly, 120 days?

	B. Remove "if the operator demonstrates to a quorum of the Commission a future beneficial use of the well" and substitute "with approval of the Commission" A future beneficial use has shown to be too vague. It's their investment, obviously they want to get more out of it. Partly this has been a problem on new wells because the performance bonds are too low. But never the less, this should move toward more routine Administrative approval. D. Sundry notice, electronically, 30 days" The AZOGCC received the following comment from Carmon Decker Bonanno, Blackstone Exploration Inc., regarding the well completion and filing requirements: "It is different and not exploration company friendly. The State of Arizona, the ADEQ and AZ State Land department are anti oil, gas or helium exploration. For example, Kansas has a ten year temporarily abandoned rule and then you can re-apply."
R12-7-126	This section requires operators to submit plugging plans to the AZOGCC for review and approval.
R12-7-127	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding the plugging methods and procedures: "H. Notification should not be required on every well. I. Sundry notice, electronically, 30 days"
R12-7-135	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding the gas oil ratio and potential tests: "Sundry notice, electronically, 30 days"
R12-7-136	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding subsurface pressure tests and reservoir surveys: "Sundry notice, electronically, 30 days"
R12-7-139	The AZOGCC received the following comment from Jim Ballard, Retired Petroleum Geologist, regarding the use of vacuum pumps: "This is now referred to as gas compression"
R12-7-181	The AZOGCC received the following comment from Mike Olesko, Plains Midstream Canada, regarding the design and construction of storage wells and cavities: "C, 1.: "The final cemented casing string…shall be set a minimum of 200 feet into the formation to be used for the storage cavity.". Although the caverns at Bumstead, AZ comply with this criteria, due to abundant thickness of salt, it may be impractical elsewhere in Arizona where the storage formation does not have this thickness of salt in addition to the thickness of the intended storage cavity. Practically, a minimum of 40 feet would be appropriate."

R12-7-182	The AZOGCC received the following comment from Mike Olesko, Plains Midstream Canada, regarding the design and construction of storage wells and cavities: "D.: "A capacity determination for each storage cavity…shall be verified at least once every 5 years.". Industry Convention is typically every 10 years for capacity determinations, with the exception of certain states mandating a 5-year frequency, but only in some operating permits in fields with high potential for rapid cavern growth or geotechnical issues. While we can continue to conduct capacity determinations every 5 years, we have not seen large growth (<1%/yr.) or any geotechnical issues at Bumstead (such as roof falls, wall spalling or preferential solution mining). Consequently, conducting capacity determinations every 10 years, as is Industry Convention, would be the appropriate baseline, provided the Commission should have discretion to require capacity determinations every 5 years in instances where concerns over large growth or geotechnical issues have been historically observed or anticipated. F.: "Storage wells shall be plugged and abandoned in accordance with R12-7-126 and R12-7- 127". Plains disagrees that cavern storage should be treated the same as conventional wells in this section. Sections R12-7-126 and R12-7-127 were written for temporary abandonment or plugging for conventional wells and not specific to cavern wells. Cavern wells are not typically conductive to conventional oil and gas plugging methods or timelines because doing so could potentially lead to fracking to other caverns or formations. Plains recommends considerations be made for "nonconventional" storage wells to have a period of pressure/temperature monitoring until the cavern well can be abandoned safely, and abandonment methods suitable for the specific cavern well completion. It may be advisable for the Commission to simply state that a pre-abandonment and abandonment plan be submitted (for caverns) for review by the Commission."

8. <u>Economic, small business, and consumer impact comparison:</u>

At least seven companies (two publicly-owned businesses, two publicly-owned small businesses, and three privately-owned small businesses) are engaged in oil and gas exploration or development activity in Arizona; two operate 14 liquefied petroleum gas (LPG) storage wells, four operate 41 producing oil and gas wells, and one or more are currently drilling wells.

These rules directly impact the companies engaged in oil, gas, or geothermal exploration or development activities. In the opinion of the AZOGCC, the rules are mostly procedural in nature and do not significantly impact the economy, small businesses or consumers. The AZOGCC has not identified any information that would alter the economic, small business, and consumer impact statements that were submitted with the rulemakings in 2007, 2005, 2002, 2000, 1998, 1997, 1993, and 1992. These economic, small business and consumer impact statements concluded that the rules would not significantly impact the economy or have a significant impact upon small businesses or consumers.

9. <u>Has the agency received any business competitiveness analyses of the rules?</u> Yes ___ No _x_

10. <u>Has the agency completed the course of action indicated in the agency's previous five-year-review report?</u>

In its March 16, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to pursue a rulemaking moratorium exception to amend various rules for clarity and consistency. In each of the courses of action described below, since the last 5YRR, the AZOGCC continued to assess the listed rulemaking priorities. Unless otherwise noted below, due to ongoing workload constraints, the proposed changes are still in process and the AZOGCC plans to move forward with these changes and any newly acknowledged changes over approximately the next 12 months.

Rule	Objective
R12-7-101	In its March 16, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to revise the definition for "gas" to harmonize with R12-7-153. Many definitions are already covered in A.R.S. § 27-501, such as "completed well," "drilling unit," "drainage unit," "pool," and "well" apply everywhere. The Commission will consider adding other terms not defined in the current rule, such as "formation," "reservoir," and "source of supply" (or replacing these terms with one term) and moving other definitions within individual rules to this section. To reduce confusion and enhance clarity of what constitutes a well completion, the AZOGCC will add the statutory definition of well completion to the rule so that R12-7-101 is consistent with A.R.S. § 27- 551(2). For purposes of consistency and where applicable, definitions in A.R.S. § 27-551 will be incorporated into this rule where they are applicable on non-state land.
R12-7-102	Repealed.
R12-7-103	In its March 16, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to revise Arizona's performance bond amounts and determine what appropriate increases will meet current financial assurance needs. The Commission has reached out to operators and plugging vendors to determine the range of actual costs to plug and abandon a well in compliance with regulatory requirements as the basis for rule revisions. The Commission will revise the rule to allow adjustment of individual performance bonds, consider a base amount and a surcharge per foot of depth, and update performance bond amounts to reduce financial risk to the state for taking over improperly abandoned wells. The AZOGCC is still considering requiring a financial assurance demonstration by all operators to establish their financial capability of conducting oil and gas business in Arizona. A statutory change would be necessary to authorize the AZOGCC to make financial capability determinations. The AZOGCC plans to use the term "performance bond" consistently throughout the rules. Also, the Commission plans to add clarifying language, "on a form approved by the Commission" to direct operators to use clearly identified forms that must accompany a performance bond deposit (i.e., cash, cashier's check or surety bond).
R12-7-104	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to add clarifying language, "on a form approved by the Commission". The $25 permit fee, established both in statute and rule, has never been reviewed since its inception and is now too low to support the costs of administering the program. The Commission has reviewed other states' oil and gas fee programs and intends to propose adopting a higher rate that can cover at least some of the expenses of administering Arizona's program. The Commission will consider adding a definition of "commence" or adding detail to the action that must be commenced, for example, that "drilling" must commence.

R12-7-107	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to clarify the language that requires supplemental information to be submitted with all well spacing exceptions. Also, new language in R12-7-107(E), 107(F) and 107(G) must clearly specify that a 15 calendar day public notice period is required before holding a public hearing on well spacing exceptions or well re-classifications, and that exceptions need to be submitted at least 45 days prior to an AZOGCC hearing. The AZOGCC will add language that includes horizontal drilling in the category requiring public notice and hearing (R12-7-107(E)) and clarifying hearing requirements in 107(F). This request was first made in the last two five-year reports. The AZOGCC plans to consider revising the language that requires all operators to appear in a public hearing so that operators who control all contiguous acreage will no longer be bound by this requirement. The Commission would still require that operator to comply with all other application requirements in R12-7-104.
R12-7-110	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to replace "witness" with "observe" and also replace "corrective measures" and "remedial action" with "corrective actions." The Commission will review the sufficiency of the 1- hour minimum requirement in 110(C).
R12-7-111	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to consider replacing "witness" with "observe."
R12-7-112	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to rephrase existing rule language with either, "The operator shall report to the Commission in writing the corrective actions taken"; or, "The operator shall report in writing to the Commission the corrective actions taken" to improve consistency with similar language elsewhere in the rules.
R12-7-113	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to change the language in R12-7-113(A) to, "high pressures may be encountered that would result in safety or environmental hazards."
R12-7-116	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to include language in this section that clearly specifies a 15 calendar day public notice period is required before a public hearing on multiple zone completions. The AZOGCC has worked with the Interstate Oil and Gas Compact Commission (IOGCC) and other states' oil and gas commissions to determine the need for clarifying language for "multiple zone completions" and "commingling production" and revise this rule. In addition, the Commission intends to revise the rule to use one term uniformly throughout. The AZOGCC intends to replace "witness" with "observe."
R12-7-117	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to work with ADEQ to develop minimum requirements in the oil and gas rule that would meet the requirements of an aquifer protection permit to eliminate a duplicate permit burden, when the operator is performing artificial stimulation of a well under the oil and gas rules. The Commission intends to update the rules to current industry standards. The AZOGCC has been working with ADEQ's Aquifer Protection Program to understand permitting requirements for AZOGCC operators. We continue to work together to establish a framework for delineating regulatory responsibility in order to reduce the regulatory burden and eliminate the permitting redundancies. Further work is still needed to accomplish the proposed course of action expressed in the last review.
R12-7-121	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to update the mailing address of the Oil and Gas Program Administrator to 1110

	W. Washington St., Phoenix, Arizona 85007. Mail is no longer delivered to 416 W. Congress St., Tucson. To reduce confusion and enhance clarity of what constitutes a well completion, the AZOGCC will incorporate the definition in A.R.S. § 27-551(2) of "completion operations" into R12-7-101. To reduce confusion, enhance clarity and expedite reporting of well completion data, the AZOGCC will add clarifying language, "on a form approved by the Commission" and enforce the use of Form #4 by operators, and provide flexibility to require electronic submittals.
R12-7-122	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to consider adding language, "on a form approved by the Commission" and provide flexibility to require electronic submittals. The AZOGCC may need to work with the IOGCC on the intent of this rule in order to determine what form best serves this purpose. Since the last 5YRR, the AZOGCC continued to assess the necessary rulemaking priorities. The AZOGCC did establish a working relationship with the IOGCC to discuss the intent of this rule and determined it is consistent with other state regulations and no changes were suggested for the language.
R12-7-126	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to add clarifying language, "on a form approved by the Commission" and provide flexibility to require electronic submittals. The AZOGCC will consider more specific situations for the use of a Sundry Notice throughout the article.
R12-7-127	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to make the following revisions: change the wording from "witness" to "observe" where applicable; change "bore hole" to "borehole;" add requirements for a wellbore schematic diagram in the application; and require a photograph of the marker in place and its GPS coordinates with the plugging record.
R12-7-137	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to include language in this section that clearly specifies a 15-calendar day public notice period is required before a public hearing on commingling production from pools. Additionally, the AZOGCC intended to work with the Interstate Oil and Gas Compact Commission (IOGCC) and other states' oil and gas commissions to determine the need for clarifying language for "commingling production." The AZOGCC may consider replacing "witness" with "observe" where appropriate. Since the last 5YRR, the AZOGCC continued to assess the necessary rulemaking priorities and did establish a working relationship with the IOGCC to provide feedback on the language for "commingling production"
R12-7-139	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to include language in this section that clearly specifies a 15 calendar day public notice period is required before a public hearing on the use of a vacuum pump in a well. The AZOGCC plans to consult with the IOGCC as to the applicability of this rule in Arizona and revise the applicability language, if appropriate.
R12-7-142	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to update the rules to current industry standards.
R12-7-143	This section specifies safety requirements for oil tanks, fire walls, and preventing fire hazards pursuant to the Declaration of Policy in A.R.S. 502(A)(6) "Safeguard the health, property and public welfare of citizens of the state and other interested persons."
R12-7-151	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to update the rules to current industry standards.
R12-7-152	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to add language in section 152(B) that clearly specifies that a 15 calendar day public notice period is required before a public hearing on whether to approve the utilization of gas in the manufacture of carbon black.

R12-7-153	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to consider adding geothermal wells to the list, especially in the case of steam generation as a gas is produced in this process.
R12-7-161	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to add clarifying language, "on a form approved by the Commission." Since the last 5YRR, the AZOGCC continued to assess the necessary rulemaking priorities.
R12-7-175	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to work with USEPA and ADEQ to understand which permitting requirements are redundant and overlapping with the other programs to remove the conflicts and inconsistencies, streamline the permitting process and amend the oil and gas rules accordingly to reduce the regulatory burden while still achieving the same objectives, consistent with EO2017-02. Since the last 5YRR, the AZOGCC continued to assess the necessary rulemaking priorities. The AZOGCC has opened lines of communications with USEPA and ADEQ in order to develop an understanding of redundancies. We have been working with ADEQ's Water Quality Division's Aquifer Protection Program to understand permitting requirements for AZOGCC operators. We continue to work together to establish a framework for delineating regulatory responsibility in order to reduce the regulatory burden.
R12-7-176	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to amend the rule to designate that a 15 calendar day notice is required before a public hearing on permitting new injection wells and to change section 176(A) to, "… is prohibited unless ~~1st~~ first authorized by … "
R12-7-181	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to amend this section to refer to the application requirements in R12-7-104. Additionally, the AZOGCC proposed to make any necessary revisions to comply with the new PHMSA Interim Final Rule on underground natural gas storage, but the AZOGCC has since determined these changes are not necessary under AZOGCC regulation.
R12-7-182	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to change "Storage-well" to "Storage Well", as in R12-7-181 and replace "witness" and "observe" with "be present for the inspection."
R12-7-185	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to add clarifying language, "on a form approved by the Commission" and provide flexibility to require electronic submittals. Since the last 5YRR, the AZOGCC continued to assess the necessary rulemaking priorities.
R12-7-186	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to add clarifying language, "on a form approved by the Commission" and provide flexibility to require electronic submittals. Since the last 5YRR, the AZOGCC continued to assess the necessary rulemaking priorities.
R12-7-187	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to add clarifying language, "on a form approved by the Commission" and provide flexibility to require electronic submittals.
R12-7-188	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to add clarifying language, "on a form approved by the Commission" and provide flexibility to require electronic submittals. Since the last 5YRR, the AZOGCC continued to assess the necessary rulemaking priorities.
R12-7-190	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to add clarifying language, "on a form approved by the Commission" and provide flexibility to require electronic submittals.
R12-7-194	In its March 22, 2017 report to the Governor's Regulatory Review Council, the AZOGCC stated its intent to add clarifying language, "on a form approved by the Commission" and provide flexibility to require electronic submittals.

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 are procedural in nature and the AZOGCC believes that these rules impose the least burden and costs to regulated persons, including paperwork and other compliance costs, which are necessary to achieve the underlying regulatory and statutory objectives. The AZOGCC encourages exploration and development of oil and gas resources consistent with industry standards and requirements in surrounding states. In the long experience of the Commission, the issues that arise are of a technical nature, rather than legal, and do not lend themselves to retaining legal counsel.

12. Are the rules more stringent than corresponding federal laws? Yes ___ No _x_

The oil and gas rules in Article 12 are consistent with and not more stringent than the federal regulations applicable to oil and gas conservation. The one possible exception to this is the USEPA Underground Injection Control requirements. In this case, the AZOGCC may recommend amendments to the requirements under R12-7-175 through R12-7-179. The AZOGCC plans to continue its working relationship with EPA and ADEQ, who is currently seeking UIC primacy from the USEPA. The AZOGCC plans to review and consider updates to its rules and associated statutes in order to better align with corresponding federal law. The AZOGCC has been working closely with ADEQ's Aquifer Protection Program as they pursue UIC primacy and plans to amend AZOGCC rules and statutes to better align with UIC requirements and prevent unnecessary burden and permitting redundancies.

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 rules were originally adopted and any amendments were promulgated prior to July 29, 2010.

14. Proposed course of action

In each of the courses of action described below, since the last 5YRR, the AZOGCC continued to assess the committed rulemaking priorities. Due to ongoing workload constraints and staff turnover, the proposed changes are still in process and the AZOGCC plans to move forward with these changes and any newly acknowledged changes over approximately the next 12 months.

Rule	Objective
R12-7-101	The AZOGCC plans to revise the definition for "gas" to harmonize with R12-7-153. Many definitions are already covered in A.R.S. § 27-501, such as "completed well," "drilling unit," "drainage unit," "pool," and "well" apply everywhere. The Commission will consider adding other terms not defined in the current rule, such as "formation," "reservoir," and "source of

	supply" (or replacing these terms with one term) and moving other definitions within individual rules to this section. To reduce confusion and enhance clarity of what constitutes a well completion, the AZOGCC will develop consistency between the statutory definition A.R.S. § 27- 551(2) and rules about "completion operations" in R12-7-101. For purposes of consistency and where applicable, definitions in A.R.S. § 27-551 will be incorporated into this rule where they are applicable on non-state land.
R12-7-103	The AZOGCC will revise Arizona's performance bond amounts and determine what appropriate increases will meet current financial assurance needs. The Commission is conducting a survey to determine information on the range of actual costs to plug and abandon a well in compliance with regulatory requirements as the basis for rule revisions. The Commission will revise the rule to allow adjustment of individual performance bonds, consider a base amount and a surcharge per foot of depth, and update performance bond amounts to reduce financial risk to the state for taking over improperly abandoned wells. The AZOGCC will also consider requiring a financial assurance demonstration by all operators to establish their financial capability of conducting oil and gas business in Arizona. A statutory change would be necessary to authorize the AZOGCC to make financial capability determinations. The AZOGCC plans to use the term "performance bond" consistently throughout the rules. Also, the Commission plans to add clarifying language, "on a form approved by the Commission" to direct operators to use clearly identified forms that must accompany a performance bond deposit, either as cash, cashier's check or as a surety bond.
R12-7-104	The AZOGCC plans to add clarifying language, "on a form approved by the Commission" and allow flexibility for the use of electronic forms. The $25 permit fee, established both in statute and rule, has never been reviewed since its inception and is now too low to support the costs of administering the program. The Commission will review other states' oil and gas fee programs and propose adopting a higher rate that can cover at least some of the expenses of administering Arizona's program. The Commission will consider adding clarity about what must "commence."
R12-7-107	The AZOGCC plans to consider specifying additional potential spacing requirements for wells, as are found in rules of nearby states. This would expedite the process of changing a gas well from 640 acres to 160 acres, for example. Also clarify the language that requires supplemental information to be submitted with all well spacing exceptions. New language in R12-7-107(E), 107(F) and 107(G) must clearly specify that a 15 calendar day public notice period is required before holding a public hearing on well spacing exceptions or well re-classifications, and that spacing exemption requests must be submitted at least 45 days prior to the next hearing. The AZOGCC will add language that includes horizontal drilling in the category requiring public notice and hearing (R12-7-107(E)) and clarifying hearing requirements in 107(F). This request was first made in the previous five-year report. The AZOGCC plans to revise the language that requires all operators to appear in a public hearing so that operators who "control" all contiguous acreage will no longer be bound by this requirement. The Commission would still require that operator to comply with all other application requirements in R12-7-104. "Control" would also need to be defined to include ownership, royalties, etc.
R12-7-110	The AZOGCC will replace "witness" with "observe." The AZOGCC will also replace "corrective measures" and "remedial action" with "corrective actions." The Commission will review the sufficiency of the 1-hour minimum requirement in 110(C).

R12-7-111	The AZOGCC will replace "witness" with “observe.”
R12-7-112	The AZOGCC plans to rephrase existing rule language with "The operator shall report in writing to the Commission the corrective actions taken" to improve consistency with similar language elsewhere in the rules.
R12-7-113	The AZOGCC will change the language in R12-7-113(A) to, “high pressures may be encountered that would result in safety or environmental hazards.”
R12-7-116	The AZOGCC will include language in this section that clearly specifies a 15 calendar day public notice period is required before a public hearing on multiple zone completions. The AZOGCC will work with the Interstate Oil and Gas Compact Commission (IOGCC) and other states’ oil and gas commissions to determine the need for clarifying language for “multiple zone completions” and “commingling production” and revise this rule. In addition, the Commission will consider revising the rule to use one term uniformly throughout the rule. The AZOGCC will replace "witness" with “observe.”
R12-7-117	The AZOGCC will work with ADEQ to develop minimum requirements in the oil and gas rule that would meet the requirements of an aquifer protection permit to eliminate a duplicate permit burden, when the operator is performing artificial stimulation of a well under the oil and gas rules. The rules were consistent with industry standards at the time of adoption. If the governor extends the option to the AZOGCC to redraft the rules, the Commission will update the rules to current industry standards.
R12-7-121	At a minimum, the AZOGCC plans to update the mailing address of the Oil and Gas Program Administrator to 1110 W. Washington St., Phoenix, Arizona 85007. Mail is no longer delivered to 416 W. Congress St., Tucson. The AZOGCC is working on creating a new form for confidentiality demonstrations in conformance with A.R.S. § 44-1374, which allows operators to claim geologic and seismic data, submitted as part of a drilling application, as a trade secret and therefore be protected from public disclosure. The AZOGCC informs oil and gas operators that submit drill permit applications to the Commission to use the new form, requesting confidentiality. An update to the rule referencing the form will be helpful. To reduce confusion and enhance clarity of what constitutes a well completion, the AZOGCC will incorporate the definition in A.R.S. § 27-551(2) of “completion operations" into R12-7-101. To reduce confusion, enhance clarity and expedite reporting of well completion data, the AZOGCC will add clarifying language, “on a form approved by the Commission”, allow electronic submittal requirements, and enforce the use of Form #4 by operators.
R12-7-122	The AZOGCC will consider adding language, “on a form approved by the Commission” and allow electronic submittal requirements,. The AZOGCC may need to work with the IOGCC on the intent of this rule in order to determine what form best serves this purpose.
R12-7-126	The AZOGCC plans to add clarifying language, “on a form approved by the Commission” and allow electronic submittal requirements, The AZOGCC will consider more specific situations for the use of a Sundry Notice throughout the article.
R12-7-127	The AZOGCC will make the following revisions: change the wording from “witness” to “observe” where applicable; change “bore hole” to “borehole;” add requirements for a wellbore schematic diagram in the application; and require a photograph of the marker in place and its GPS coordinates with the plugging record.
R12-7-136	The AZOGCC plans to include language in this section that clearly specifies a 15-calendar day public notice period is required before a public hearing on commingling production from pools.

	The AZOGCC plans to work with the Interstate Oil and Gas Compact Commission (IOGCC) and other states' oil and gas commissions to determine the need for clarifying language for "commingling production." The AZOGCC will replace "witness" with "observe".
R12-7-137	This section specifies requirements for accounting of production from separate pools to prevent waste and protect adjoining interests from being illegally drained. Protects all producers in a unitized pool by requiring a public hearing and AZOGCC approval.
R12-7-138	This section regulates the production, sale and transport and venting of all casinghead gas in order to prevent waste. Specifies measurement and reporting requirements to the AZOGCC for gas produced from oil wells.
R12-7-139	The AZOGCC plans to include language in this section that clearly specifies a 15 calendar day public notice period is required before a public hearing on the use of a vacuum pump in a well. The AZOGCC plans to consult with the IOGCC as to the applicability of this rule in Arizona and revise the applicability language, if appropriate.
R12-7-142	If the governor extends the option to the AZOGCC to redraft the rules, the Commission will update the rules to current industry standards.
R12-7-151	The rules were consistent with industry standards at the time of adoption. If the governor extends the option to the AZOGCC to redraft the rules, the Commission will update the rules to current industry standards.
R12-7-152	The AZOGCC plans to add language in section 152(B) that clearly specifies that a 15 calendar day public notice period is required before a public hearing on whether to approve the utilization of gas in the manufacture of carbon black.
R12-7-153	The AZOGCC will add geothermal wells to the list, especially in the case of steam generation as a gas is produced in this process.
R12-7-161	The AZOGCC plans to add clarifying language, "on a form approved by the Commission" and allow electronic submittal requirements.
R12-7-175	The AZOGCC shall work with USEPA and ADEQ to understand which permitting requirements are redundant and overlapping with the other programs. The end result should be to remove the conflicts and inconsistencies, streamline the permitting process and amend the oil and gas rules accordingly to reduce the regulatory burden while still achieving the same objectives, consistent with the rulemaking moratorium.
R12-7-176	The AZOGCC plans to amend the rule to designate that a 15 calendar day notice is required before a public hearing on permitting new injection wells and to change section 176(A) to, "… is prohibited unless first authorized by …"
R12-7-178	The AZOGCC plans to change R12-7-178(3)(c) to, "The Commission shall return ~~1~~ one copy of the request for transfer to the operator and ~~1~~ one to the proposed new operator …" and to change 178(3)(c)(ii) to, "the Commission shall return ~~1~~ one copy of the request to the operator and ~~1~~ one copy to the proposed operator …"
R12-7-181	This section may need revision to comply with the new PHMSA Interim Final Rule on underground natural gas storage. Regardless of that outcome, this section should be amended to refer to the application requirements in R12-7-104.
R12-7-182	"Storage well" should not be hyphenated in the rule's title. The AZOGCC will change "Storage-well" to "Storage Well", as in R12-7-181 and replace "witness" with "observe".
R12-7-185	The AZOGCC plans to add clarifying language, "on a form approved by the Commission" and allow electronic submittals.
R12-7-186	The AZOGCC plans to add clarifying language, "on a form approved by the Commission" and allow electronic submittals.
R12-7-187	The AZOGCC plans to add clarifying language, "on a form approved by the Commission" and allow electronic submittals.

R12-7-188	The AZOGCC plans to add clarifying language, “on a form approved by the Commission” and allow electronic submittals.
R12-7-190	The AZOGCC plans to add clarifying language, “on a form approved by the Commission” and allow electronic submittals.
R12-7-194	The AZOGCC plans to add clarifying language, “on a form approved by the Commission” and allow electronic submittals.

R12-7-127	The AZOGCC will make the following revisions: change the wording from “witness” to “observe” where applicable; change “bore hole” to “borehole;” add requirements for a wellbore schematic diagram in the application; and require a photograph of the marker in place and its GPS coordinates with the plugging record.
R12-7-136	The AZOGCC plans to include language in this section that clearly specifies a 15-calendar day public notice period is required before a public hearing on commingling production from pools. The AZOGCC plans to work with the Interstate Oil and Gas Compact Commission (IOGCC) and other states’ oil and gas commissions to determine the need for clarifying language for “commingling production.” The AZOGCC will replace "witness" with “observe”.
R12-7-137	This section specifies requirements for accounting of production from separate pools to prevent waste and protect adjoining interests from being illegally drained. Protects all producers in a unitized pool by requiring a public hearing and AZOGCC approval.
R12-7-138	This section regulates the production, sale and transport and venting of all casinghead gas in order to prevent waste. Specifies measurement and reporting requirements to the AZOGCC for gas produced from oil wells.
R12-7-139	The AZOGCC plans to include language in this section that clearly specifies a 15 calendar day public notice period is required before a public hearing on the use of a vacuum pump in a well. The AZOGCC plans to consult with the IOGCC as to the applicability of this rule in Arizona and revise the applicability language, if appropriate.
R12-7-142	If the governor extends the option to the AZOGCC to redraft the rules, the Commission will update the rules to current industry standards.
R12-7-151	The rules were consistent with industry standards at the time of adoption. If the governor extends the option to the AZOGCC to redraft the rules, the Commission will update the rules to current industry standards.
R12-7-152	The AZOGCC plans to add language in section 152(B) that clearly specifies that a 15 calendar day public notice period is required before a public hearing on whether to approve the utilization of gas in the manufacture of carbon black.
R12-7-153	The AZOGCC will add geothermal wells to the list, especially in the case of steam generation as a gas is produced in this process.
R12-7-161	The AZOGCC plans to add clarifying language, “on a form approved by the Commission" and allow electronic submittal requirements.
R12-7-175	The AZOGCC shall work with USEPA and ADEQ to understand which permitting requirements are redundant and overlapping with the other programs. The end result should be to remove the conflicts and inconsistencies, streamline the permitting process and amend the oil and gas rules accordingly to reduce the regulatory burden while still achieving the same objectives, consistent with the rulemaking moratorium.

R12-7-176	The AZOGCC plans to amend the rule to designate that a 15 calendar day notice is required before a public hearing on permitting new injection wells and to change section 176(A) to, "… is prohibited unless first authorized by …"
R12-7-178	The AZOGCC plans to change R12-7-178(3)(c) to, "The Commission shall return ~~1~~ one copy of the request for transfer to the operator and ~~1~~ one to the proposed new operator …" and to change 178(3)(c)(ii) to, "the Commission shall return ~~1~~ one copy of the request to the operator and ~~1~~ one copy to the proposed operator …"
R12-7-181	This section may need revision to comply with the new PHMSA Interim Final Rule on underground natural gas storage. Regardless of that outcome, this section should be amended to refer to the application requirements in R12-7-104.
R12-7-182	"Storage well" should not be hyphenated in the rule's title. The AZOGCC will change "Storage-well" to "Storage Well", as in R12-7-181 and replace "witness" with "observe".
R12-7-185	The AZOGCC plans to add clarifying language, "on a form approved by the Commission" and allow electronic submittals.
R12-7-186	The AZOGCC plans to add clarifying language, "on a form approved by the Commission" and allow electronic submittals.
R12-7-187	The AZOGCC plans to add clarifying language, "on a form approved by the Commission" and allow electronic submittals.
R12-7-188	The AZOGCC plans to add clarifying language, "on a form approved by the Commission" and allow electronic submittals.
R12-7-190	The AZOGCC plans to add clarifying language, "on a form approved by the Commission" and allow electronic submittals.
R12-7-194	The AZOGCC plans to add clarifying language, "on a form approved by the Commission" and allow electronic submittals.

TITLE 12. NATURAL RESOURCES

CHAPTER 7. OIL AND GAS CONSERVATION COMMISSION

(Authority: A.R.S. § 27-514 et seq.)

ARTICLE 1. OIL, GAS, HELIUM, AND GEOTHERMAL RESOURCES

Section

ARTICLE 2. REPEALED

Article 2, consisting of R12-7-201 through R12-7-221, R12-7-231 through R12-7-234, R12-7-241 through R12-7-246, R12-7-251, R12-7-252, R12-7-261 through R12-7-264, R12-7-271, R12-7-272, R12-7-281, R12-7-291 through R12-7-294, and Appendix 1, repealed effective January 2, 1996 (Supp. 96-1).

ARTICLE 1. OIL, GAS, HELIUM, AND GEOTHERMAL RESOURCES

R12-7-101. Definitions

In this Chapter, unless the context otherwise requires:

"API" means American Petroleum Institute.

"Barrel" means 42 (US) gallons measured at 60° F and atmospheric pressure at sea level.

"BTU" means British thermal unit and represents the quantity of heat required to raise the temperature of 1 pound of water 1° F at or near 39.2° F.

"Condensate" means liquid hydrocarbons recovered at the earth's surface as a result of condensation due to reduced pressure or temperature of petroleum hydrocarbons that exist in a gaseous phase in subsurface reservoir rocks.

"Cubic foot of gas" means the volume of gas contained in 1 cubic foot of space at a standard pressure base of 14.73 pounds per square inch absolute and a standard temperature base of 60° F.

"Gas well" means a well that produces with a gas-oil ratio in excess of 50,000 cubic feet of gas per barrel of oil.

"Injection well" means a well used to inject air, gas, water, or other substance into an underground stratum.

"Mcf" means 1000 cubic feet of gas reported at a pressure base of 14.73 pounds per square inch absolute and a standard temperature base of 60° F.

"Oil well" means a well that produces with a gas-oil ratio less than 50,000 cubic feet of gas per barrel of oil.

"Operator" means any person authorized by an owner to control the day-to-day activities of a well or production or refining facility.

"Shut-in well" means a well that is capable of production in paying quantities, is completed as a producing well, and is not presently being operated.

"Stratigraphic test or core hole test" means drilling a hole for the sole purpose of obtaining geological information.

"Temporarily abandoned well" means a well that is not capable of production in paying quantities and is not presently being operated.

Historical Note

Former B; Former Section R12-7-101 renumbered and amended as Section R12-7-102, former Section R12-7-100 renumbered and amended as Section R12-7-101 effective September 29, 1982 (Supp. 82-5). Amended effective January 2, 1996 (Supp. 96-1). Amended by final rulemaking at 6 A.A.R. 4827, effective December 7, 2000 (Supp. 00-4).

R12-7-102. Repealed

Historical Note

Former 101; Former Section R12-7-102 renumbered and amended as Section R12-7-103, former Section R12-7-101 renumbered and amended as Section R12-7-102 effective September 29, 1982 (Supp. 82-5). Repealed effective January 19, 1994 (Supp. 94-1).

R12-7-103. Bond

A. An operator shall file a performance bond with the Commission before drilling a new well, re-entering an abandoned well, or assuming responsibility as the operator of an existing well. Choosing one of the following options, an operator shall provide a performance bond for each well or a blanket performance bond payable to the Oil and Gas Conservation Commission, State of Arizona and conditioned upon the faithful performance by the operator of the duty to drill each well, plug each dry or abandoned well, repair each well causing waste or pollution, maintain and restore each well site and otherwise act in a manner that is consistent with A.R.S. Title 27 Chapter 4 and this Chapter:

1. For individual wells, an operator shall provide a $10,000 bond for each well drilled to a total depth of 10,000 feet or less or a $20,000 bond for each well drilled deeper than 10,000 feet, or
2. For multiple wells, an operator shall provide one of the following blanket bonds to cover all wells:
   a. $25,000 for 10 or fewer wells;
   b. $50,000 for more than 10 but fewer than 50 wells; or
   c. $250,000 for 50 or more wells.

B. An operator shall provide a bond in the form of a surety bond, executed by the operator as principal and a corporate surety, authorized to do business in Arizona; a certified check; or a certificate of deposit at a federally insured bank, authorized to do business in Arizona.

C. Transfer of property does not release the bond. If an operator plans to transfer a property and desires release from the bond, the following rules apply:

1. The operator shall notify the Commission in writing of the proposed transfer, providing the location of each well, the date and number of each permit to drill, and the name, address, and telephone number of the proposed transferee;
2. The operator shall obtain from the proposed transferee a declaration to the Commission in writing, accepting the transfer and responsibility for each well. As the new operator, the proposed transferee shall submit a new bond or bonds unless the transferee has previously provided a blanket bond that complies with subsection (A)(2);
3. If the Commission approves the transfer, the transferor is released from all responsibility with respect to the well or wells, and the Commission shall notify the transferor and the bonding company in writing of the release.

Historical Note

Former Rule 102; Former Section R12-7-103 renumbered and amended as Section R12-7-104, former Section R12-7-102 renumbered and amended as Section R12-7-103 effective September 29, 1982 (Supp. 82-5). Amended effective January 19, 1994 (Supp. 94-1). Amended by final rulemaking at 11 A.A.R. 2948, effective September 10, 2005 (Supp. 05-3).

R12-7-104. Application for Permit to Drill

A. Before drilling or re-entering any well or conducting any surface disturbance associated with such activity, the operator shall submit to the Commission an application for permit to drill or re-enter and obtain approval. The complete application package shall contain:

1. An application for permit to drill on a form provided by the Commission, which shall include the operator's name, address, and phone number, and a description of the proposed well and its location;
2. A well and well-site construction plan that meets the requirements of R12-7-108 through R12-7-118;
3. A plat, prepared and certified by a registered surveyor bearing the surveyor's certificate number, on which is shown the exact acreage or legal subdivision allotted to the well as required by R12-7-107, the well's exact location, and its ground-level elevation;
4. An organization report as required by R12-7-194;

5. A performance bond, as required by R12-7-103; and
6. A fee of $25.00 per well.

B. The Commission shall mail to the applicant, within 30 days of receipt of the application required in subsection (A), written notice of administrative completeness or a detailed list of deficiencies. Within 30 days of receipt of all items required in subsection (A), the Commission shall review the application and:
1. Issue a permit to drill, or
2. Provide a written explanation in compliance with A.R.S. § 41-1076 to the applicant if the application is not approved.

C. Time-frames
1. The administrative review period is 30 days. The substantive review period is 30 days. The overall time-frame is 60 days.
2. For the purpose of this subsection, intermediate Saturdays, Sundays, and legal holidays shall be included in the time-frame computation. The last day of the notice period shall be included in the computation unless it is a Saturday, Sunday, or legal holiday.

D. Unless operations are commenced within 180 days after date of approval, the permit to drill shall become null and void unless an extension in writing is granted by the Commission.

E. In case of imminent danger to public safety or of contamination of the environment, the Commission may authorize the drilling of an emergency relief or offset well to reduce the danger or hazard. Within 10 days of commencing an emergency relief or offset well, the operator shall file an application as required in subsection (A). No well drilled under this subsection shall be used for production unless it conforms to the provisions of R12-7-107.

Historical Note

Former Rule 103; Former Section R12-7-104 renumbered and amended as Section R12-7-105, former Section R12-7-103 renumbered and amended as Section R12-7-104 effective September 29, 1982 (Supp. 82-5). Amended effective January 19, 1994 (Supp. 94-1). Amended effective June 6, 1997 (Supp. 97-2).

R12-7-105. Change of Location

A. No operator shall drill a well in a location other than that authorized by the permit issued pursuant to R12-7-104 until the following requirements have been met:
1. If the operator decides to change the location before drilling the well, an amended application for permit to drill shall be filed showing the new location.
2. If it is determined that the location is erroneously described on the permit after drilling has begun, the operator shall obtain a new permit showing the correct location.

B. If the new location is at an authorized point in the approved drilling unit as provided in the initial permit, the application may be made by electronic communication and the Commission may by electronic communication authorize the commencement or continuance of drilling operations. Within ten days after obtaining such authorization, the operator shall file an amended application showing the new location. An amended permit may be issued and the old permit cancelled without payment of additional fee.

C. If the new location is located outside the approved drilling unit covered by the initial permit, no drilling shall be commenced or continued until a new application for permit to drill is filed and approved as required by R12-7-104, including payment of an additional fee.

Historical Note

Former Rule 104; Former Section R12-7-105 renumbered and amended as Section R12-7-106, former Section R12-7-104 renumbered and amended as Section R12-7-105 effective September 29, 1982 (Supp. 82-5). Amended effective January 19, 1994 (Supp. 94-1).

R12-7-106. Identification of Wells, Producing Leases, Tanks, Refineries, Buildings, and Facilities

A. The operator shall mark each drilling, producing, injection, or shut-in well in a conspicuous place with the operator's name, lease name or number, well number, and the legal description of the well's location.

B. The operator shall mark each abandoned well as required in R12-7-127(F).

C. The operator shall mark all tank batteries, gasoline plants, structures, storage buildings, compressors, and compressor buildings, and all other storage or transportation equipment with the operator's name, address, telephone number, lease name or number, and location. All structures within a fenced yard may be identified by a single sign at the principal outside entrance to the yard.

D. The operator of a storage-well facility shall clearly mark each well with the operator's name, lease name or number, and well number. Each outside entrance to the facility shall be marked with the operator's name, address, and one or more emergency response telephone numbers.

E. The operator of a refinery shall mark each facility at each outside entrance with the operator's name, address, and one or more emergency response telephone numbers.

F. Sign lettering shall contrast strongly with the background and be large enough to be legible under normal conditions at a distance of 25 feet. The operator shall preserve these markings and keep them legible and up to date.

Historical Note

Former Rule 105; Former Section R12-7-106 renumbered and amended as Section R12-7-107, former Section R12-7-105 renumbered and amended as Section R12-7-106 effective September 29, 1982 (Supp. 82-5). Amended effective January 19, 1994 (Supp. 94-1).

R12-7-107. Spacing of Wells

A. Every well drilled for oil shall be located on a drilling unit consisting of approximately 80 contiguous surface acres within two governmental quarter-quarter sections or lots having one side in common, upon which there is not located, and of which no part is attributed to, any other well completed in or drilling to, the same pool.
1. In areas not covered by United States Public Land Surveys, the oil drilling unit shall consist of an area bounded by four sides intersecting at angles of not less than 85 degrees or more than 95 degrees. The unit shall contain at least 76 contiguous surface acres and its maximum dimension shall not exceed 3,000 feet.
2. No well drilled for oil shall be located closer than 330 feet to any boundary of the drilling unit or closer than 330 feet to the shortest center line of the drilling unit.
3. No well drilled for oil shall be located within a quarter-quarter section or lot having one side in common with another quarter-quarter section or lot upon which there is located a well completed in or drilling to the same pool.

B. Every well drilled for gas shall be located on a drilling unit consisting of approximately 640 but not less than 600 contiguous surface acres within one governmental section upon which there is not located, and of which no part is attributed to, any other well completed in or drilling to the same pool.

1. In areas not covered by United States Public Land Surveys, the gas drilling unit shall consist of an area bounded by four sides intersecting at angles of not less than 85 degrees or more than 95 degrees. The unit shall contain at least 600 contiguous surface acres and its maximum dimension shall not exceed 8,500 feet.
2. No well drilled for gas shall be located closer than 1,660 feet from any boundary of the drilling unit.

C. Every well drilled for geothermal resources shall be located on a drilling unit approved or as modified by the Commission. The Commission may require modification to minimize well interference and provide the necessary volume of geothermal resources for the intended use, to protect correlative rights, and to protect the environment.

D. If the operator drills a horizontal segment, that horizontal segment shall be located:
1. At least 330 feet from the boundary of the spacing unit in the case of an oil well;
2. At least 1,660 feet from the boundary of the spacing unit in the case of a gas well; and
3. As approved or modified by the Commission in the case of a geothermal well.

E. The Commission may grant exceptions to the regular locations specified in subsections (A), (B), and (C) only after notice and hearing.
1. Applications for exception shall fully state the reasons why the exception is necessary and shall include a plat prepared and certified by a registered surveyor bearing the surveyor's certificate number showing all other completed, drilling, and permitted wells on the property and all adjoining surrounding properties and wells.
2. Exceptions shall be granted only after the operator provides by certified mail a copy of the application to all adjoining lessees, and only after the Commission deter mines in a duly noted public hearing that the application is valid.
3. The Commission may grant an exception location without notice or hearing when topography prohibits drilling at a regular location on the drilling unit.
4. If an existing well's classification changes due to its recompletion or due to a change in the nature of the product being produced, the Commission may approve an irregular location application with supporting data and ten days' notice and hearing, provided that the operator furnish the Commission with proof of mailing of a copy of the application to all operators within a one-mile radius of the acreage to be dedicated.

F. In order to prevent waste, the Commission may, after notice and hearing, fix different spacing requirements and require lesser or greater acreage for drilling units in any specific oil, gas, or geothermal resource pool notwithstanding the provisions of subsections (A), (B), and (C).

G. The Commission may order pooling and integration of interests pursuant to A.R.S. §§ 27-505 and 27-666.

Historical Note

Former Rule 106; Former Section R12-7-107 renumbered and amended as Section R12-7-108, former Section R12-7-106 renumbered and amended as Section R12-7-107 effective September 29, 1982 (Supp. 82-5). Correction, paragraph (1) "No well drilled for oil shall be located within the bounds of a quarter-quarter section or lot . . ." (Supp. 82-6). Amended effective January 19, 1994 (Supp. 94-1).

R12-7-108. Pit for Drilling Mud and Drill Cuttings

A. Each operator shall maintain an adequate supply of drilling mud to confine oil, gas, or water to its native stratum during the drilling of any well and shall provide, before drilling is commenced, an adequate pit, either earthen or portable, for the drilling mud or the accumulation of drill cuttings.

B. An earthen pit used for drilling, deepening, testing, reworking, or fracturing shall be constructed of or sealed with an impervious material and shall be maintained to prevent escape of any contained substance. Earthen pits shall be fenced on all sides at all times.

C. Earthen pits shall be constructed and maintained to prevent the entrance of outside runoff water and the fluid level in earthen pits shall be kept at all times at least 18 inches below the lowest point of the embankment.

D. Any mud contained in an earthen pit shall be water-based and contain no more than one pound per barrel of thinner for each 25 pounds per barrel of barite or hematite. Mud containing chromium lignosulfonate, ferrochrome lignosulfonate or other chromium compounds shall not be used.

E. Drilling mud shall be disposed of by either recycling or commercial off-site disposal. Mud described in subsection (D) may be disposed of by evaporation and subsequent leveling of the pits.

Historical Note

Former Rule 107; Former Section R12-7-108 renumbered and amended as Section R12-7-109, former Section R12-7-107 renumbered and amended as Section R12-7-108 effective September 29, 1982 (Supp. 82-5). Amended effective January 19, 1994 (Supp. 94-1).

R12-7-109. Repealed

Historical Note

Former Rule 108; Former Section R12-7-109 renumbered and amended as Section R12-7-110, former Section R12-7-108 renumbered and amended as Section R12-7-109 effective September 29, 1982 (Supp. 82-5). Repealed effective January 19, 1994 (Supp. 94-1).

R12-7-110. Surface Casing Requirements

A. Surface casing shall be set at a sufficient depth to protect and isolate all known or reasonably estimated freshwater zones and to prevent blowouts or uncontrolled flows. The surface casing shall:
1. Be of sufficient size to permit the use of an intermediate string or strings of casing;
2. Be set in or through an impervious formation and shall be cemented by the pump and plug, displacement, or other method approved by the Commission;
3. Be cemented back to surface either during the primary cement job or by remedial action; and
4. Have API-approved centralizers on the bottom three joints as a minimum.

B. Cement shall be allowed to set a minimum of 12 hours under the lowest necessary pressure before drilling the cementing plugs or initiating tests.

C. Surface casing shall be pressure tested for at least 30 minutes to 70% of internal yield pressure or one psi per foot of casing depth, whichever is less. If a drop of more than 10% of the test pressure should occur, the casing shall be considered defective and corrective measures shall be applied. In wells drilled with cable tools, casing may be tested by bailing the well dry. The hole shall remain satisfactorily dry for one hour before commencing further operations. Results of the above test and any remedial action shall be reported in writing to the Commission within 15 days following the test.

D. The operator of a well shall notify the Commission at least 48 hours before setting surface casing so that a representative of the Commission may witness all or a part of the operations required in this Section.

Historical Note
Former Rule 109; Former Section R12-7-110 renumbered and amended as Section R12-7-111, former Section R12-7-109 renumbered and amended as Section R12-7-110 effective September 29, 1982 (Supp. 82-5). Amended effective January 19, 1994 (Supp. 94-1).

R12-7-111. Intermediate and Production Casing and Tubing Requirements

A. All producing wells shall be completed with production casing set directly above or through the producing interval and cemented by the pump and plug method, or other method approved by the Commission, to protect the zones to be produced. An intermediate string of casing may be required to seal off all potentially productive, lost circulation, and abnormally pressured zones that may be encountered in the well, except those to be produced. The Commission may require casing strings to be cemented from the maximum depth of the casing to at least 50 feet inside the previously run string of casing. For liners, a minimum of 100 feet of overlap between a string of casing and the next larger casing is required.

B. Strings of casing shall stand cemented for at least 12 hours before drilling out the cementing plugs or initiating such tests as the Commission may require.

C. Strings of intermediate and production casing shall be pressure tested to 70% of the manufacturer's rated internal yield pressure or one psi per foot of casing depth, whichever is less. In cases where combination strings utilizing casing of varied grades and weights are used, the above test pressures shall apply to the lowest pressure rated component used. If pressure declines more than 10% in 30 minutes, the casing shall be considered defective and corrective measures shall be applied.
1. In wells drilled with cable tools, casing may be tested by bailing the well dry, in which case the hole shall remain satisfactorily dry for at least one hour before commencing further operations on the well. Results of the above test and any remedial action shall be reported in writing to the Commission within 15 days following the test.

D. All flowing oil wells shall have tubing set as near the bottom as practical with tubing perforations not more than 250 feet above the top of the zone to be produced. Wells may be completed with small-diameter casing, which is generally understood in the industry to be "slim hole" or "tubingless" completions, in lieu of tubing.

E. The operator shall notify the Commission at least 48 hours before setting any casing string so that a representative of the Commission may witness all or a part of the operations required in this Section.

Historical Note
Former Rule 110; Former Section R12-7-111 renumbered and amended as Section R12-7-112, former Section R12-7-110 renumbered and amended as Section R12-7-111 effective September 29, 1982 (Supp. 82-5). Amended effective January 19, 1994 (Supp. 94-1).

R12-7-112. Defective Casing or Cementing

A. The operator shall take immediate steps to correct the casing condition of any well that may cause, or is causing, underground waste of oil, gas, or geothermal resources or contamination of fresh waters. These steps shall restore the integrity of the casing to the standards set in R12-7-110(C) and R12-7-111(C).

B. The operator shall report the corrective actions taken in writing to the Commission within 15 days of the completion of the work. If the condition of the casing cannot be corrected, the well shall be plugged and abandoned in compliance with R12-7-127.

Historical Note
Former Rule 111; Former Section R12-7-112 renumbered and amended as Section R12-7-113, former Section R12-7-111 renumbered and amended as Section R12-7-112 effective September 29, 1982 (Supp. 82-5). Amended effective January 19, 1994 (Supp. 94-1).

R12-7-113. Blowout Prevention and Related Well-control Equipment

A. When drilling in areas where pressures are unknown or high pressures do or are likely to exist, a blowout preventer, control head and related lines, and connections necessary to control the pressures and to keep the well under control at all times shall be installed as soon as the surface casing is set.

B. Upon installation, all ram-type blowout preventers and related equipment shall be pressure tested to the lesser of the manufacturer's full working pressure rating of the equipment, 70% of the minimum internal yield pressure of any casing subject to test, or one psi per foot of the last casing string depth. Annular or bag-type preventers shall be tested to the lesser of 1000 psi or 50% of full working pressure on installation. The blowout preventer and related equipment shall be tested:
1. After each string of casing is set in the well,
2. Not less than once each 14 days from each control station, and
3. Following repairs that require disconnection of any pressure seal in the assembly. Only the component repaired or replaced needs be tested unless alteration or repair occurs at a normal full blowout preventer test period.

C. The operator shall maintain records of the tests required in this Section until the well is completed and shall submit copies of these records to the Commission if required.

Historical Note
Former Rule 112; Former Section R12-7-113 renumbered and amended as Section R12-7-114, former Section R12-7-112 renumbered and amended as Section R12-7-113 effective September 29, 1982 (Supp. 82-5). Amended effective January 19, 1994 (Supp. 94-1).

R12-7-114. Recovery of Casing

Recovery of inside or outside strings of casing is prohibited unless written approval is obtained from the Commission. Approval shall be given only for wells where mudding and plugging operations can be carried out safely and the well abandoned in compliance with R12-7-127.

Historical Note
Former Rule 113; Former Section R12-7-114 renumbered and amended as Section R12-7-115, former Section R12-7-113 renumbered and amended as Section R12-7-114 effective September 29, 1982 (Supp. 82-5). Section repealed, new Section adopted effective January 19, 1994 (Supp. 94-1).

R12-7-115. Deviation of Hole and Directional Drilling

A. An operator drilling a well shall not intentionally deviate from the normal vertical course of the well unless the operator first files an application and obtains approval from the Commission after notice and hearing. The normal vertical course of a well is defined by an average deviation from vertical of not more than five degrees in any 500-foot interval. The operator shall test any vertical or deviated well that is drilled or deepened at

least once each 500 feet or at the first bit change succeeding 500 feet. The operator shall tabulate all deviation tests run and file the tabulation with the Commission within 30 days after drilling is completed. Deviation from the vertical for short distances is permitted in the drilling of a well without special approval only to straighten the hole, sidetrack junk, or correct other mechanical difficulties.

B. An application for directional drilling shall include:
1. The name, address, and telephone number of the operator;
2. The field name, lease name, well number, state permit number, reservoir name, and county where the proposed well is located;
3. A plat or sketch showing the distance from the surface location to section and lease lines and to the target location within the intended producing interval;
4. The reason for the intentional deviation; and
5. The signature of the operator.

C. The operator of any well capable of production and whose producing interval or any portion of the producing interval is located 330 feet or less in the case of an oil well or 1,660 feet or less in the case of a gas well from the boundary of any drilling unit shall run a directional survey before running the production casing.

D. In order to ensure compliance with this Section, the Commission may require the operator to run a directional survey of any hole at the operator's expense. The Commission may require an operator to run a directional survey of any hole at the request of an offset operator at the expense and risk of the offset operator unless the survey shows that the well is completed at a point outside the drilling unit or at an unauthorized point.

E. Within 30 days following the completion of drilling a directionally-drilled well, the operator shall file with the Commission a complete angular deviation and directional survey of the well, obtained by a well survey company.

F. An operator shall not drill a well in a manner that results in the well crossing drilling unit lines, except by approval obtained from the Commission after notice and hearing.

Historical Note

Former Rule 114; Former Section R12-7-115 renumbered and amended as Section R12-7-116, former Section R12-7-114 renumbered and amended as Section R12-7-115 effective September 29, 1982 (Supp. 82-5). Amended effective January 19, 1994 (Supp. 94-1). Amended by final rulemaking at 13 A.A.R. 4596, effective February 2, 2008 (Supp. 07-4).

R12-7-116. Multiple Zone Completions

A. Completions to include production from more than one common source of supply from a single well are prohibited except as authorized by the Commission after notice and hearing. After notice and hearing, the Commission shall maintain a list of zones or reservoirs, by fields, for which multiple completions have been authorized.

B. Operators shall file an application for multiple completion with the Commission and shall demonstrate the method to be used to keep the production streams separate. The application shall be accompanied by:
1. An electrical log or other acceptable log with tops and bottoms of formations or producing zones and perforated intervals shown and marked;
2. A diagrammatic sketch of the multiple completion installation indicating make, type, and setting depths of packer or packers;
3. A plat showing the location of the well and all offset wells and the names and addresses of operators of all leases offsetting acreage dedicated to applicant's well; and
4. Proof of mailing of application for multiple completion to all offset operators.

C. The Commission may approve subsequent applications for multiple completion of the same zones or reservoirs in a field administratively without a hearing, provided that:
1. The applicant can show that the Commission has approved and listed the zones or reservoirs as required in subsection (A);
2. The subsequent application is filed as required in subsection (B); and
3. The Commission receives no protest to the application after a 15-day holding period. A hearing shall be called if a protest is received.

D. Within 15 days of setting the final packer or packers, the operator shall file a report with the Commission identifying the well and its location showing the make, type, and depth set of each packer and the signature of the supervisor of the work. This report shall include the results of a packer leakage test and detail for each separate common source of supply, its stabilized shut-in pressure, producing pressure, and the simultaneous shut-in pressure on each other separate common source of supply. The operator shall notify the Commission at least 48 hours in advance of performing the tests required in this subsection.

E. Every operator of a multi-completed well shall operate, produce, and maintain the well to prevent commingling of production from the separate sources of supply. The Commission may require any multi-completed well to be tested at any time to demonstrate the effectiveness of the separation of sources of supply. These tests may be witnessed by representatives of the Commission and by offset operators.

Historical Note

Former Rule 115; Former Section R12-7-116 renumbered and amended as Section R12-7-117, former Section R12-7-115 renumbered and amended as Section R12-7-116 effective September 29, 1982 (Supp. 82-5). Amended effective January 19, 1994 (Supp. 94-1).

R12-7-117. Artificial Stimulation of Oil and Gas Wells

A. An operator shall report the artificial stimulation of any well to the Commission in writing within 15 days of the stimulation showing the type of stimulation, the amounts and types of materials used, stimulation pressures applied, and the flow and pressure results before and after stimulation.

B. If the artificial stimulation of a well results in any damage to the producing formation, a freshwater formation, casing, or casingseat that permits communication between fluid-bearing zones, the operator shall immediately notify the Commission and proceed with diligence to correct the damage. If the artificial stimulation results in irreparable damage to the well, the operator shall plug and abandon the well pursuant to R12-7-127.

Historical Note

Former Rule 116; Former Section R12-7-117 renumbered and amended as Section R12-7-118, former Section R12-7-116 renumbered and amended as Section R12-7-117 effective September 29, 1982 (Supp. 82-5). Amended effective January 19, 1994 (Supp. 94-1). Amended effective June 5, 1998 (Supp. 98-2).

R12-7-118. Operations in Hydrogen Sulfide Environments

A. When drilling, redrilling, deepening, or plugging back operations in areas where the formations to be penetrated are known to contain or are expected to contain hydrogen sulfide gas

(H_2S) in excess of 10 ppm and in areas where the presence or absence or H_2S is unknown, the operator shall contract the services of an approved H_2S safety company to be on location at the known or expected depths.

B. A written contingency plan providing details of actions to be taken to alert and protect operating personnel and members of the public in the event of an accidental release of H_2S gas shall be submitted to the Commission as part of the initial application for a permit to drill or as a sundry notice.

Historical Note

Former Rule 117; Former Section R12-7-118 renumbered and amended as Section R12-7-119, former Section R12-7-117 renumbered and amended as Section R12-7-118 effective September 29, 1982 (Supp. 82-5). Amended effective January 19, 1994 (Supp. 94-1).

R12-7-119. Wellhead and Lease Equipment

A. The operator shall install and maintain valves, fittings, and wellhead connections that
1. Have a rated working pressure equivalent to at least 100% of the calculated or known surface pressure to which they may be subjected from the producing zone;
2. Allow well production, productivity, deliverability, and transient pressure tests;
3. Permit pressures to be obtained on both casing and tubing; and
4. Control the flow of the oil, gas, or geothermal resources on a flowing well.

B. The operator shall produce flowing oil wells into tanks equipped with high-low pressure and high-low level shut-in controls and shall install a safety valve that automatically closes on the wellhead in the event of surface production equipment malfunctions.

C. The operator shall equip artificial lift wells with wellhead safety sensors to shut off the source of power in the event of abnormally high or low flowline pressures.

Historical Note

Former Rule 118; Former Section R12-7-119 renumbered and amended as Section R12-7-120, former Section R12-7-118 renumbered and amended as Section R12-7-119 effective September 29, 1982 (Supp. 82-5). Amended effective January 2, 1996 (Supp. 96-1).

R12-7-120. Notification of Fire, Leaks, Spills, and Blowouts

A. Each operator shall notify the Commission within 24 hours of any fire, break, leak, spill, overflow, or blowout that occurs at any oil, gas, or geothermal drilling, producing, or transportation facility, or at any injection, disposal, or storage facility.

B. Each operator shall file a final written report within 15 days of resolving incidents described in subsection (A) giving the location by quarter-quarter section, township, and range; date and time of occurrence; specific nature and cause of the incident; resultant damage; action taken to correct the situation and prevent its reoccurrence; and losses of hydrocarbons or geothermal resources.

Historical Note

Former Rule 119; Former Section R12-7-120 renumbered and amended as Section R12-7-121, former Section R12-7-119 renumbered and amended as Section R12-7-120 effective September 29, 1982 (Supp. 82-5). Amended effective January 2, 1996 (Supp. 96-1).

R12-7-121. Well Completion and Filing Requirements

A. An operator shall file a completion report with the Commission within 30 days after a well is completed. The completion report shall contain a description of the well and lease, the casing, tubing, liner, perforation, stimulation, and cement squeeze records, and data on the initial production. The operator shall submit other well data to the Commission within 30 days of the date the work is done, including any:
1. Lithologic, mud, or wireline log;
2. Directional survey;
3. Core description and analysis;
4. Stratigraphic or faunal determination;
5. Formation or drill-stem test;
6. Formation fluid analysis; or
7. Other similar information or survey.

B. An operator shall furnish samples of drilled cuttings, at a maximum interval of 10 feet, to the Commission within 30 days after drilling is completed. The operator may furnish samples of continuous core in chips at 1-foot intervals. The operator shall:
1. Wash and dry all samples;
2. For each sample, place approximately 3 tablespoons of the sample in an envelope with the following identifying information: the well from which the sample originates, the location of the well, the Commission's permit number for the well, and the depth at which the sample is taken; and
3. Package sample envelopes in protective boxes and ship prepaid to:
   Oil and Gas Administrator
   Arizona Geological Survey
   416 W. Congress, Ste. 100
   Tucson, AZ 85701

C. Confidential records:
1. The Commission shall keep the completion report and all well information required by this Section for any well drilled for oil and gas in unproven territory confidential for one year after the drilling is completed unless the operator gives written permission to release the information at an earlier date. The Commission shall provide notice to the operator 60 days before confidential records become subject to public inspection and, at the operator's request, extend the confidential period for six months to two years from the date of the request if the Commission finds that the operator has provided credible evidence that disclosure of the information is likely to cause harm to the operator's competitive position with respect to unleased land in the vicinity of the well.
2. The Commission shall keep the completion report and all well information required by this Section for any well drilled in search of geothermal resources confidential for one year after drilling is completed upon operator request.

Historical Note

Former Rule 120; Former Section R12-7-121 renumbered and amended as Section R12-7-122, former Section R12-7-120 renumbered and amended as Section R12-7-121 effective September 29, 1982 (Supp. 82-5). Amended effective January 2, 1996 (Supp. 96-1). Amended by final rulemaking at 6 A.A.R. 4827, effective December 7, 2000 (Supp. 00-4). Amended by final rulemaking at 13 A.A.R. 4596, effective February 2, 2008 (Supp. 07-4).

R12-7-122. Recompletion and Routine Maintenance Operations

A. After a well has been completed, it shall not be deepened, redrilled, plugged back, reworked, or recompleted in a different zone, without prior approval by the Commission of a written application showing the character of the proposed work and the time it will begin. The Commission shall notify the

applicant in writing whether the proposed work is approved or disapproved.

B. In the case of an emergency, an application may be made by electronic communication, and the Commission may by electronic communication authorize the work; however, written application required in subsection (A) shall be filed with the Commission within 10 days after emergency authorization is given, even though the work has already been commenced or completed. The Commission shall confirm the emergency authorization in writing upon receipt of the written application.

C. Written approval from the Commission is not required on acidizing, fracturing, and reperforating, or other routine well operations designed to restore or maintain production.

D. Within 15 days following the completion of any work described in this Section, the operator shall file a written report with the Commission identifying the well and fully describing the work performed. If the well is recompleted, a completion report shall be filed as required by R12-7-121.

Historical Note
Former Section R12-7-121 renumbered and amended as Section R12-7-122 effective September 29, 1982 (Supp. 82-5). Amended effective January 2, 1996 (Supp. 96-1).

R12-7-123. Reserved

R12-7-124. Reserved

R12-7-125. Temporarily Abandoned and Shut-in Wells

A. If drilling, injection, or production operations at a well are suspended, or have been suspended for 60 days, an operator shall plug the well under R12-7-127 unless the Commission permits the well to be temporarily abandoned or shut-in. The Commission shall not classify a well as shut-in until the operator submits a completion report under R12-7-121.

B. An operator may temporarily abandon or shut-in a well for up to 5 years if the operator demonstrates to a quorum of the Commission a future beneficial use of the well and submits a Sundry Notice to the Commission containing the following information:

1. Evidence of casing integrity as required in R12-7-112 including a complete description of the current casing, cementing, and perforation record of the well;
2. The stimulation and cement squeeze record and complete data on the results of any well tests performed to date; and
3. All other well data required in R12-7-121(A).

C. Before an approved time-frame for a temporarily abandoned or shut-in well expires, the operator shall return the well to beneficial use under a plan approved by the Commission, permanently plug and abandon the well, or apply for an extension to temporarily abandon or shut-in the well. If the integrity of the well casing is in question, the Commission may require the operator to:

1. Prove casing integrity in accordance with R12-7-112;
2. Plug any well that fails to meet the casing integrity required by R12-7-112; and
3. Re-test the well in accordance with R12-7-150 to continue shut-in status.

D. An operator shall ensure that no work begins on a temporarily abandoned or shut-in well until approved by the Commission. The operator shall give at least 24 hours' notice to the Commission before any work begins. Within 15 days of completing the proposed work, the operator shall file a written report with the Commission fully describing the work performed including a copy of all test rates, pressures, and fluid analyses.

Historical Note
Adopted effective January 2, 1996 (Supp. 96-1). Amended by final rulemaking at 6 A.A.R. 4827, effective December 7, 2000 (Supp. 00-4).

R12-7-126. Application to Plug and Abandon

A. Before abandoning any well, the operator shall submit an application to plug and abandon to the Commission and obtain approval. The application shall set forth the name and location of the well, the mechanical condition of the well, the productive zone and latest production, and a complete description of the proposed work. The plan shall provide for the protection of all formations containing usable-quality water, oil, gas, or geothermal resources.

B. In the case of a drilling well or an emergency, the application may be made by electronic communication, and the Commission may by electronic communication authorize the work; however, the operator shall file a written application within 10 days after the emergency authorization is given even though the work has already been commenced or completed. The Commission shall confirm the emergency authorization in writing upon receipt of the written application.

Historical Note
Former Rule 201; Amended effective September 29, 1982 (Supp. 82-5). Amended effective January 2, 1996 (Supp. 96-1).

R12-7-127. Plugging Methods and Procedures

A. Before abandoning any well, the operator shall submit an application to plug and abandon to the Commission for approval as required in R12-7-126. All down-hole plugging shall be conducted through drill pipe or tubing, unless otherwise approved by the Commission.

B. Open hole

1. A cement plug shall be placed to extend at least 50 feet below the bottom, except as limited by total depth or plugged back total depth, to 50 feet above the top of any zone containing fluid with a potential to migrate, any zone of lost circulation, and any zone containing potentially valuable minerals, including noncommercial hydrocarbons, coal, and oil shale.
2. All freshwater zones shall be plugged with a continuous cement plug which shall extend from at least 50 feet below to at least 50 feet above the freshwater zone, or a 100-foot plug shall be centered across the base of the freshwater zone and a 100-foot plug shall be centered across the top of the freshwater zone.
3. Open hole below the shoe of cemented casing shall be plugged with cement which shall extend from at least 50 feet below to at least 50 feet above the shoe.

C. Cased hole

1. A cement plug shall be placed opposite all open perforations and extend to a minimum of 50 feet below, except as limited by total depth or plugged back total depth, to 50 feet above the perforated interval. In lieu of the cement plug, a bridge plug may be placed within 50 to 100 feet above the open perforations and followed by at least 50 feet of cement.
2. If any casing is cut and recovered, a cement plug shall be placed to extend at least 50 feet above and below the stub.
3. No annular space that extends to the surface shall be left open to the drilled hole below. If this condition exists, a minimum of the top 100 feet of each annulus shall be plugged with cement.

D. Plugging mud having the proper weight and consistency to prevent movement of other fluids into or within the bore hole shall be placed across all intervals not plugged with cement. In

the absence of other information at the time plugging is approved, plugging mud shall be made up with a minimum of 15 pounds per barrel of sodium bentonite and a nonfermenting polymer, have a minimum consistency of 9 pounds per gallon, a minimum viscosity of 50 seconds per quart, and mixed with fresh water.

E. A cement surface plug of at least 50 feet shall be placed in the smallest casing which extends to the surface. The top of this plug shall be placed as near the eventual casing cut-off point as possible.

F. The abandoned well shall be marked by a piece of metal pipe not less than 4 inches in diameter securely set in cement and extending at least 4 feet above the general ground level. The well location and identity shall be permanently inscribed as required in R12-7-106(A). An abandoned well location on tilled or otherwise unique land shall be marked in a manner approved by the Commission.

G. The drill site of an abandoned well shall be restored as nearly as possible to its natural state, to the satisfaction of the Commission. All pits shall be filled and all equipment and debris shall be removed from the location.

H. The operator shall notify the Commission at least 48 hours before starting abandonment operations to allow a representative of the Commission to witness the operations required in this Section. To ensure the integrity or placement of any plug, the representative may order the plug to be tested.

I. Within 15 days after the plugging of any well, the operator shall file with the Commission a plugging record setting forth in detail the method used in plugging the well, including the casing record; the size, kind, and depth of plugs used; and the name and depth interval of each formation containing fresh water, oil, gas, or geothermal resources.

J. Seismic shot holes
1. All seismic shot holes shall be plugged and abandoned within 30 days of firing.
2. Seismic shot holes which do not encounter freshwater zones shall be filled with a high-grade bentonite slurry or some other comparable plugging material as approved by the Commission.
3. Seismic shot holes which do encounter freshwater zones shall be plugged with cement in accordance with the applicable provisions of subsections (B) and (D).
4. Seismic shot-hole locations shall be restored in accordance with subsection (G) and the operator shall file a plugging record in accordance with subsection (I).

Historical Note
Former Rule 202; Amended effective September 29, 1982 (Supp. 82-5). Amended effective January 2, 1996 (Supp. 96-1).

R12-7-128. Stratigraphic, Core, and Seismic Holes

A. Any hole drilled for stratigraphic, core, or seismic purposes shall comply with all rules in this Chapter pertaining to the drilling of a well except the spacing provisions of R12-7-107.

B. Each hole drilled for stratigraphic, core, or seismic purposes shall be plugged in accordance with R12-7-126 and R12-7-127. The operator of a stratigraphic or core hole shall submit samples and cores and file a completion report in accordance with R12-7-121.

Historical Note
Former Rule 203; Amended effective September 29, 1982 (Supp. 82-5). Amended effective January 2, 1996 (Supp. 96-1).

R12-7-129. Wells to be Used as Water Wells

A. The landowner, landowner's agent, or lessee may use any well or exploratory hole as a water well provided that:
1. Written approval is obtained from the Arizona Department of Water Resources;
2. The operator plugs the well in accordance with R12-7-127 to a point immediately below the freshwater strata; and
3. The landowner, landowner's agent, or lessee assumes responsibility for the well and compliance with the provisions of A.R.S. Title 45, Chapter 2 in a signed and notarized water-well responsibility form provided by and filed with the Commission.

B. After filing the notarized water-well responsibility form with the Commission, the landowner, landowner's agent, or lessee shall comply with A.R.S. Title 45, Chapter 2 before modification or abandonment of the well.

C. Upon filing the notarized water-well responsibility form with the Commission, the Commission shall notify the bonding company and operator in writing so that the bond may be cancelled or made no longer effective with respect to that well.

Historical Note
Former Rule 204; Amended effective September 29, 1982 (Supp. 82-5). Amended effective January 2, 1996 (Supp. 96-1). Amended by final rulemaking at 8 A.A.R. 3363, effective July 15, 2002 (Supp. 02-3).

R12-7-130. Reserved

R12-7-131. Reserved

R12-7-132. Reserved

R12-7-133. Reserved

R12-7-134. Reserved

R12-7-135. Gas-oil Ratio and Potential Tests

A. Each operator shall conduct a gas-oil ratio test between 5 and 15 days after the completion or recompletion of any well located in a pool which contains both oil and gas. The average daily oil production, the average daily gas production, and the average gas-oil ratio shall be recorded.

B. The results of the gas-oil ratio test shall be reported in writing to the Commission within 15 days after completion of the test.

C. Each operator shall conduct a potential test within 30 days following the completion or recompletion of any well for the production of oil. The results of this test shall be reported in writing to the Commission within 15 days after completion of the test.

Historical Note
Former Rule 301; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-136. Subsurface Pressure Tests and Reservoir Surveys

A. Each operator shall conduct a test, within 30 days after completion, to determine the reservoir pressure on the discovery well of any new pool. The test shall be made after the well has been shut-in for at least 24 hours, and the results shall be reported in writing to the Commission within 15 days after the completion of the test.

B. The Commission may require subsurface pressure measurements on a number of wells in any pool to provide data to determine reservoir characteristics. The survey shall be made by the operator and shall provide a description of the test method and results including fluids, temperature, and pressure data and may require supervision by a qualified agent of the

Commission. The results shall be reported in writing to the Commission within 15 days of the completion of the survey.

Historical Note
Former Rule 302; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-137. Commingling of Production from Pools

A. Unless authorized by the Commission, each pool shall be produced as a single common reservoir, with the wells completed, cased, maintained, and operated as the producing media for that pool. Oil production from each pool shall at all times be segregated into separate, identified tanks. The commingling of production from different pools is prohibited, unless authorized by order of the Commission after notice and hearing.

B. The Commission may approve commingling of production upon demonstration by the applicant that such commingling shall not cause waste of reservoir energy or diminish recovery of the resource. Application for approval of commingling shall include the following:

1. Electric or porosity log with tops and bottoms of formations or producing zones and perforated intervals shown and marked;
2. Diagrammatic sketch of the proposed well structure, including make, type and setting depths of packers;
3. The reservoir pressure for each zone or formation pro posed for commingling, the specific gravity and BTU content of the gas if the zone produces gas, and the API gravity and gas-oil ratio of the oil if the zone produces oil;
4. Plat showing the location of the well and all offset wells, and a list of the names and addresses of operators of all leases offsetting the acreage dedicated to the applicant's well;
5. Waiver consenting to the proposed commingling from each offset operator, or in lieu thereof, copies of letters requesting such waiver; and
6. Proof of mailing of notice of application for commingling to all offset operators.

C. The first application for commingling of pools in a field shall be approved by the Commission only after notice and hearing. Subsequent applications, completed as required in subsection (B), for commingling of the same zones in the same field may be approved administratively if, after a 15-day holding period, there are no protests from offsetting operators.

Historical Note
Former Rule 303; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-138. Casinghead Gas

A. All casinghead gas produced and sold or transported away from a lease, except amounts of flare gas, shall be metered and reported monthly in writing to the Commission in standard Mcf and gallons of liquids per Mcf. If the casinghead gas is sold as supply stock for a gasoline plant, the gallons of liquids per Mcf shall be reported. The operator of a lease shall not be required to measure the exact amount of casinghead gas produced and used for fuel purposes in the development and normal operation of the lease.

B. Pending arrangements for disposition of some useful purpose, all casinghead gas that is authorized to be vented shall be burned, and the estimated volume reported monthly as required by R12-7-161.

Historical Note
Former Rule 304; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-139. Use of Vacuum Pumps

A. The use of any device for the purpose of putting a vacuum on any stratum containing oil, gas, or geothermal resources is prohibited unless authorized by the Commission.

B. The Commission may, after notice and hearing, authorize the use of vacuum pumps if the applicant can show that use of the vacuum will not create waste or infringe on correlative rights.

Historical Note
Former Rule 305. Amended effective February 23, 1993 (Supp. 93-1).

R12-7-140. Pollution, Surface Damage, and Noise Abatement

A. An operator of a well, production facility, gasoline plant, gas plant, or pipeline shall conduct operations in a manner that prevents surface or subsurface pollution.

B. An operator shall conduct operations in a manner that prevents oil, gas, salt water, fracturing fluid or any other substance from polluting any surface or subsurface waters.

C. During swabbing and bailing operations or when purging a well, all substances removed from the bore hole shall be placed in a pit or tank and shall not be allowed to pollute any surface or subsurface waters.

D. An operator shall maintain all wellhead connections, surface equipment, lease flow lines, and tank batteries at all times to prevent the escape of oil, gas, produced water, or any other substance.

E. An operator shall report any fire, leak, or blowout to the Commission in accordance with R12-7-120. An operator shall ensure that any pit is constructed and operated in accordance with R12-7-108.

F. An operator shall minimize noise when conducting air drilling operations or when the well is allowed to produce while drilling. An operator shall ensure that the welfare of the operating personnel and the public is not negatively affected by the noise created by the expanding gases.

Historical Note
Former Rule 306. Amended effective February 23, 1993 (Supp. 93-1). Amended by final rulemaking at 8 A.A.R. 3363, effective July 15, 2002 (Supp. 02-3).

R12-7-141. Renumbered

Historical Note
Former Rule 307; Language transferred and amended, see Section R12-7-176 (Supp. 82-5).

R12-7-142. Measurement of Oil

Oil or condensate shall not be transported from a lease until it has been measured. Each transporter shall file a monthly report of the amount of oil or condensate transported from the lease as required by R12-7-185.

Historical Note
Former Rule 308; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-143. Oil Tanks, Fire Walls, and Fire Hazards

A. Oil shall not be stored or retained in an earthen reservoir or an open receptacle. The Commission may require dikes or fire walls to protect life, health, or property. All dikes or fire walls shall be erected and continuously maintained around all permanent oil tanks or batteries that are within the corporate limits of any city, town or village, or where such tanks are closer

than 150 feet to any highway or inhabited dwelling, or closer than 1,000 feet to any school or church. The capacity of the dike or firewall shall be 1 1/2 times the capacity of the tank or tanks that it surrounds. The reservoir so formed within the dike shall be kept free from vegetation, water and oil.

B. Anything that might constitute a fire hazard, including potentially flammable items and reckless behavior such as smoking, shall be moved at least 150 feet from the well, tanks, separator, or other equipment.

Historical Note
Former Rule 309. Amended effective February 23, 1993 (Supp. 93-1).

R12-7-144. Reserved

R12-7-145. Reserved

R12-7-146. Reserved

R12-7-147. Reserved

R12-7-148. Reserved

R12-7-149. Reserved

R12-7-150. Capacity Tests of Gas Wells and Geothermal Wells

A. The operator of a producing gas well shall determine its open-flow capacity within 30 days following completion. Additional tests shall be taken as requested by the Commission. When a pipeline connection is available, gas wells shall not be tested by open-flow method, but the open-flow capacity shall be determined by the multipoint or single-point back-pressure test method.

B. The Commission may require tests to determine the quantity and quality of geothermal resources or reservoir energy.

C. The results of the tests required in this Section shall be reported in writing to the Commission within 15 days after the completion of the test.

Historical Note
Former Rule 401; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-151. Measurement of Gas from Gas Wells and Geothermal Resources

A. All gas produced for whatever purpose in gaseous form from gas wells shall be accounted for by metering as approved by the Commission. If the gas is sold, the purchaser shall report the volume purchased as required by R12-7-186. If the gas is delivered to a transportation facility, the transporter shall report the volume transported as required by R12-7-185. The operator shall report the volume produced as required by R12-7-161.

B. Each operator of a geothermal lease shall measure the quantity and quality of all production in accordance with the standard practices, procedures, and specifications generally used in the industry. The operator shall report the production as required in R12-7-161 and the purchaser shall file a report as required in R12-7-186.

Historical Note
Former Rule 402; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-152. Utilization of Gas

A. No gas from any completed gas well shall be:
1. Permitted to escape into the air except for testing when no pipeline connection is available.
2. Used expansively in engines or pumps and then vented, or
3. Used to gas-lift in oil wells unless all gas produced from such gas-lift operations is processed in a gasoline plant, and the residue gas is used in the manufacture of carbon black or for some other profitable use.

B. Utilization of gas in the manufacture of carbon black may be made only if approved by the Commission, after notice and hearing, based on a finding that a more profitable use is not available or will not be available in a reasonable time.

Historical Note
Former Rule 403. Amended effective February 23, 1993 (Supp. 93-1).

R12-7-153. Non-hydrocarbon Gas

The rules of this Chapter shall also apply to helium, carbon dioxide, and any other non-hydrocarbon gas.

Historical Note
Former Rule 404. Amended effective February 23, 1993 (Supp. 93-1).

R12-7-154. Reserved

R12-7-155. Reserved

R12-7-156. Reserved

R12-7-157. Reserved

R12-7-158. Reserved

R12-7-159. Reserved

R12-7-160. Regulation of Production

If the Commission determines that oil, gas, or geothermal resources production in the state is causing waste, the Commission shall limit, allocate, and apportion the total amount of oil, gas, or geothermal resources which may be produced.

Historical Note
Former Rule 501; Amended effective September 29, 1982. See also Section R12-7-170 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-161. Producer's Monthly Report

A. Each operator shall file a producer's monthly report for each producing lease for each calendar month, setting forth the operator's name, each well's lease name or number, well number, state permit number, the actual amounts of oil, gas, water, or geothermal resources produced, the number of days each well produced, and the disposition of the produced oil, gas, water, or geothermal resources. The report shall be filed on or before the 25th day of the next succeeding month.

B. If a well is off production for a period exceeding 30 days, the Commission shall be notified in writing with the reasons given.

Historical Note
Former Rule 502; Amended effective September 29, 1982. See also Section R12-7-171 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-162. Reserved

R12-7-163. Reserved

R12-7-164. Reserved

R12-7-165. Reserved

R12-7-166. Reserved

R12-7-167. Reserved

R12-7-168. Reserved

R12-7-169. Reserved

R12-7-170. Renumbered

Historical Note
Former Rule 601; Language transferred and amended, see Section R12-7-160 (Supp. 82-5).

R12-7-171. Renumbered

Historical Note
Former Rule 602; Language transferred and amended, see Section R12-7-161 (Supp. 82-5).

R12-7-172. Reserved

R12-7-173. Reserved

R12-7-174. Reserved

R12-7-175. Injection Wells Including Enhanced Recovery, Disposal, and Storage Wells

A. The following injection wells used for enhanced recovery, disposal, or storage shall require a permit from the Commission:
1. Class II injection wells
   a. Saltwater disposal wells: wells used to return salt water associated with oil and gas production to the subsurface.
   b. Enhanced oil recovery wells: wells used to inject salt water, gases, enhanced waters, and steam in order to maintain and extend oil production;
   c. Hydrocarbon storage wells: wells used for the underground storage of crude oil, liquified petroleum gas (LPG), and other liquid hydrocarbon products in naturally occurring rock formations.
2. Other injection wells
   a. Geothermal injection wells: Class V wells used to reinject groundwater or geothermal fluids that are used in or are associated with the production of geothermal energy;
   b. Other wells: wells used for the underground storage of any hydrocarbons or nonhydrocarbons that are gaseous at standard temperature and pressure, wells used to dissolve salt to create a cavity to be used for underground storage, and wells used to dispose of brine produced in the course of creating a solution-mined salt cavity.

B. In addition to being subject to the applicable provisions of this Chapter, the wells listed in subsection (A) shall be subject to the following specific regulation:
1. Injection wells listed in subsections (A)(1)(a) and (b) and (A)(2)(a) shall be regulated by R12-7-176, R12-7-178, and R12-7-179.
2. Injection wells listed in subsections (A)(1)(c) and (A)(2)(b) shall be regulated by R12-7-176, R12-7-178, R12-7-179, R12-7-180, R12-7-181, and R12-7-182.

C. No permits for injection wells other than those described in this Section shall be issued by the Commission.

Historical Note
Adopted effective January 2, 1996 (Supp. 96-1).

R12-7-176. Permits for Injection Wells

A. The injection of any substance into any geologic formation is prohibited unless 1st authorized by the Commission after notice and hearing. The Commission shall give at least 15 days' notice before a hearing is held for drilling a new injection well or for converting an existing well into an injection well. A permit shall not be required for routine well operations pursuant to R12-7-122(C) whose physical effects are confined to the area near the well bore.

B. The application for a permit for an injection well as defined in R12-7-175 shall be prepared in accordance with R12-7-104, shall meet all the applicable requirements of this Chapter, and shall contain the following requirements, where applicable:
1. A plat showing the location of each proposed injection well and the location and status of all wells, including drilling wells and dry holes, within 1/2 mile of the proposed well. The plat shall include the lease boundary lines, the names of the surface and subsurface lessees and owners within 1/2 mile of the injection well or wells, and the name of each offset operator.
2. A geologic study, including:
   a. A contour map drawn on a geologic marker at or near the top of each injection zone in the project area;
   b. A thickness map of each injection zone in the project area;
   c. A geologic cross-section drawn through the site of an injection well in the project area showing structural details, any wells that may be affected by the project, and the location of the base of any freshwater strata, defined as water having 10,000 ppm or less of total dissolved solids, or a statement that no fresh water exists; and
   d. A representative electric log to a depth below the deepest producing zone identifying all geologic units including the injection and confining zones, freshwater aquifers, and oil, gas, or geothermal zones.
3. An engineering study, including:
   a. A statement of the primary purpose of the project;
   b. The characteristics of the injection and confining zones including porosity, permeability, thickness, areal extent, fracture gradient, original and present temperature and pressure, and residual oil, gas, and water saturations;
   c. The reservoir fluid data for each injection zone including oil gravity and viscosity, water quality, and specific gravity of gas;
   d. A description of each injection well's casing, or the proposed casing and cementing program, and the proposed method of testing the casing before use of the injection well. The casing shall be designed and tested in accordance with R12-7-181(C) with respect to the injection zone;
   e. A diagram of the proposed wellhead;
   f. A casing diagram, including cement plugs, and the actual or calculated cement fill behind the casing of all wells within the area affected by the project, including abandoned wells, showing that they will not cause damage to life, health, property, or natural resources;
   g. The well stimulation program if stimulation is planned; and
   h. The planned well-drilling and abandonment program to complete the project, including a flood-pattern map showing all injection, production, and abandoned wells, and unit boundaries.
4. An injection plan, including:
   a. A diagram and plan of the injection facilities;
   b. The maximum surface injection pressure expected during the life of the project and the estimated daily rate of fluid injection, by well. The operator shall provide calculations showing that the maximum

injection pressure will not initiate fractures in the confining zone;

c. A description of the area affected by the volumetric method and by the pressure-buildup method and the radius affected during the life of the project;

d. The monitoring system or method to be used to ensure that no damage is occurring and that the injection fluid is confined to the permitted injection zone and to the area controlled by the operator;

e. The method of injection such as casing, tubing, tubing with packer, between strings;

f. The protective methods to be used on each injection line and well and a contingency plan for well failure or a shut-in period, including a plan for disposition of fluids not injected as a consequence of well failure;

g. The source and chemical analysis of the injection fluid, and chemical analysis of the water in the injection zone. If the water in the injection zone has 10,000 ppm or less of total dissolved solids, the applicant shall provide evidence of commercial oil or gas producibility of the zone by means of historical production in the field or by log information, core data, and values for the porosity and permeability of the zone; and

h. The location and depth of each water-source well that will be used in conjunction with the project.

5. Proof of notification to neighboring operators and surface owners within 1/2 mile of the proposed well.
6. Supplementary data as required in R12-7-180 for storage-well projects.
7. Any additional information that the Commission may determine is necessary to adequately clarify the information submitted pursuant to R12-7-176(B)(1) through (B)(6).
8. All maps, diagrams, and exhibits required in this subsection shall be clearly labeled as to scale and purpose and shall clearly identify wells, boundaries, zones, contacts, and other relevant data.

C. Permits may be issued for a period up to the operating life of the well with review once every 5 years. Permits may be modified or terminated during their term if the Commission determines that the operator is not in compliance with the requirements of this Chapter.

Historical Note
Former Rule 701; Amended effective September 29, 1982. See also Section R12-7-141 (Supp. 82-5). Amended effective January 2, 1996 (Supp. 96-1).

R12-7-177. Repealed

Historical Note
Former Rule 702; Amended effective September 29, 1982 (Supp. 82-5). Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-178. Notice of Commencement, Discontinuance, and Transfer of Injection Operations

The following provisions apply to all injection projects defined in R12-7-175:

1. The operator shall notify the Commission of the date that injection operations will begin.
2. The operator shall notify the Commission of the date that injection operations will cease and provide the reasons for discontinuing the injection operations.
   a. The temporary abandonment of any injection well shall be in accordance with R12-7-125. Temporarily abandoned injection wells shall meet the testing requirements of R12-7-179(D).
   b. All injection wells shall be plugged and abandoned, in accordance with R12-7-126 and R12-7-127.
3. An injection well shall not be transferred from 1 operator to another without the written approval of the Commission.
   a. The operator shall file the request for transfer of ownership of an injection well in triplicate with the Commission at least 45 days before the proposed transfer date. The request shall include the name, address, and telephone number of the proposed new operator and provide the location and status of each well involved.
   b. The proposed new operator shall file with the Commission an organization report as required in R12-7-194 and bond as required in R12-7-103 before the request for transfer will be considered.
   c. The Commission shall return 1 copy of the request for transfer to the operator and 1 to the proposed new operator within 30 days after receipt of the information required in subsections (3)(a) and (b), designating approval or denial of the transfer of authority to inject for the subject well.
      i. If the proposed transfer is approved, a copy of the order authorizing injection shall be attached to the approved request for transfer.
      ii. If the proposed transfer is denied, the Commission shall return 1 copy of the request to the operator and 1 copy to the proposed operator together with the reasons for the denial and the steps necessary for its approval.

Historical Note
Former Rule 703; Amended effective September 29, 1982 (Supp. 82-5). Amended effective January 2, 1996 (Supp. 96-2).

R12-7-179. Testing and Monitoring of Injection Wells

A. The operator of an injection well shall file a weekly sundry report with the Commission on all drilling, completion, recompletion, and workover operations.

B. The operator of an injection well shall monitor operations to ensure that injection pressure at the wellhead does not exceed the maximum pressure authorized in the permit, and that no injection shall cause movement of injection or formation fluids into an underground source of drinking water.

C. The operator shall keep accurate records of the amount of oil, gas, water, or geothermal resources produced, the volume of substances injected, the average and maximum pressure used for injection, and the nature of the injected fluid. The operator of an enhanced recovery or disposal well shall submit a report as required in R12-7-187. The operator of a storage well shall submit a report as required in R12-7-185.

D. The operator shall run the following pressure or monitoring tests on new injection wells to establish the mechanical integrity of the tubing, casing, and packer. Existing wells being converted to an injection well shall be tested in the same manner and shall maintain the same mechanical integrity as a new well.

1. The casing-tubing annulus above the packer shall be tested upon completion and at least once every 5 years, under the supervision of the Commission, at a pressure equal to the lesser of the maximum authorized injection pressure or 1,000 psi, provided that no testing pressure shall be less than 300 psi. Documentation of the test shall be submitted to the Commission. Test pressures shall be

applied for a period of 30 minutes. If a drop of more than 10% of the test pressure should occur, corrective measures shall be applied. If the tubing, casing, or packer cannot be brought up to standard, the well shall be plugged and abandoned in accordance with R12-7-126 and R12-7-127.

2. The Commission may require the operator to run a tracer survey, a temperature log, or a noise log to demonstrate the absence of fluid movement in vertical channels adjacent to the injection well.

E. Mechanical failure or downhole problems which indicate an injection well is not, or may not be, directing the injected fluid into the permitted injection zone may be cause to shut in the well. The operator shall notify the Commission within 24 hours of any such failure or problem. A written notice shall be filed within 5 days of the occurrence, with a plan for testing and repairing the well. If the well cannot be brought up to the standard required in subsection (D), it shall be plugged and abandoned in accordance with R12-7-126 and R12-7-127.

Historical Note
Former Rule 704; Amended effective September 29, 1982 (Supp. 82-5). Amended effective January 2, 1996 (Supp. 96-1).

R12-7-180. Supplementary Requirements for Storage Wells

The application for a storage well as defined in R12-7-175(B)(2) shall be prepared in accordance with R12-7-176 and shall contain the following, where applicable:

1. Information on any oil or gas production within 5 miles of each proposed well;
2. Information on the oil and gas reserves of each storage zone before starting injection, including calculations;
3. A comprehensive plan for disposition of brine and salt produced in the course of creating a solution-mined salt cavity. Cavities shall be designed and constructed in accordance with R12-7-181;
   a. Surface disposition shall be subject to the rules of the Department of Water Resources and the Department of Environmental Quality;
   b. Saltwater disposal wells shall be permitted in accordance with R12-7-176;
   c. Surface brine reservoirs used in the operation of the storage system and disposal reservoirs shall be designed to prevent the contamination of air, fresh water, and soil;
4. A list of proposed surface and subsurface safety devices, tests, and precautions to be taken to ensure safety of the project. The operator shall install a flare or other safety system acceptable to the Commission at or near each brine pit or any other location where escape of gases is likely to occur.

Historical Note
Former Rule 705; Amended effective September 29, 1982 (Supp. 82-5). Amended effective January 2, 1996 (Supp. 96-1).

R12-7-181. Design and Construction of Storage Wells and Cavities

A. Before drilling a storage well for storing liquid or gaseous hydrocarbons, or any other substances under the jurisdiction of the Commission, in an underground cavity, the applicant shall demonstrate to the Commission that the proposed storage will preserve the structural integrity of the host rock, including halite, and the overlying sediments. The evidence presented shall include:

1. An investigation to determine the feasibility of a storage system at the particular site; and
2. An assessment of the stability of each proposed cavity design, particularly with regard to the size, shape and depth of the storage cavity, the amount of separation between storage cavities, and the amount of separation between the storage cavity and the periphery of the host rock.

B. The design of a solution-mined storage system shall be based on site-specific geologic and engineering parameters including type of storage use, location of each cavity, number of cavities, cavity capacity, and maximum development diameter of each cavity. The design shall ensure that project development can be conducted in a reasonable, prudent, and systematic manner and shall stress physical and environmental safety and the prevention of waste. The design and solution mining shall be continually reviewed throughout the construction phase to account for any new subsurface information and shall include provisions for protection from damage caused by hydraulic shock. The original development and operational plans shall be modified, as necessary, to conform with good engineering practice. The design shall incorporate the standards outlined below:

1. The minimum separation between the nearest outer walls of adjacent storage cavities as measured in any direction shall be established considering:
   a. The properties of the host rock;
   b. The elevation of the top and bottom of the adjacent cavities;
   c. Their maximum development diameter relative to the spacing of the cavities; and
   d. Other considerations deemed appropriate for the specific site; however, in no case shall such separation at any time during the storage project be less than 200 feet.
2. The walls of a storage cavity shall be no less than 200 feet from the boundary of the lands included in the storage project on which the chambers are located.
3. If the design involves the intentional subsurface connection between 2 adjacent storage cavities under 1 property (that is, a "U"-tube storage-cavity system), the minimum separation between cavities specified in subsection (B)(1)(d) shall not apply.

C. The borehole shall be dually cased from the surface into the cavity in accordance with R12-7-110 and R12-7-111. At least 2 strings of casing shall be fully cemented from the surface into the host rock either during the primary cement job or by remedial action. The Commission may administratively grant an exception to the requirement for 2 strings of cemented casing if the applicant can show that the exception is reasonable, justified by site-specific geologic or engineering parameters, is no less stringent, and consistent with the intent of these rules regarding physical and environmental safety, conservation of the resource, and the prevention of waste.

1. The final cemented casing string shall have tensile and collapse strengths, as approved by the Commission, for the setting depth and shall be set a minimum of 200 feet into the formation to be used for the storage cavity.
2. The casing seat of the final cemented casing string shall be pressure-tested after drilling at least 10 feet into the formation below the casing seat. The test pressure calculated at the casing seat shall equal the proposed maximum operating pressure at that point and shall not exceed 0.9 psi per foot of depth.
3. After the wellhead has been installed and before products are stored, the system shall be pressure-tested as a unit.

4. All tests required in this subsection shall meet the integrity standards set in R12-7-179(D).

D. Storage facilities in existence prior to June 1, 1978, shall not be required to meet the planning and construction requirements of subsections (B) and (C), except for future expansions or additions.

Historical Note
Adopted effective August 31, 1978 (Supp. 78-4). Amended effective September 29, 1982 (Supp. 82-5). Amended (and subsections (A)(1)(h) through (m) moved to Section R12-7-182) effective January 2, 1996 (Supp. 96-1)

R12-7-182. Operation, Inspection, and Closure of Storage-well Systems

A. The maximum and minimum operating pressures of a storage system shall be determined in consideration of the lithologic characteristics of the host rock. The maximum operating pressure at the shallower of the casing seat or cavity ceiling shall not exceed 0.9 psi per foot of depth.
1. The storage system shall not be subjected to pressures exceeding the maximum operating pressure even for short periods of time, including pressure pulsation peaks and abnormal operating conditions.
2. The wellhead, flowlines, valves, and all related connections shall have a test pressure rating equivalent to 125% of the maximum pressure which could be exerted at the surface. All valves shall be periodically inspected and maintained in good working order.
3. The wellhead and storage system shall be protected with safety devices to prevent pressures exceeding the maximum operating pressure from being exerted on the storage system and to prevent backflow of stored products in the event of flowline rupture.
4. Personnel shall be at either the well or other control sites for the well during injection or withdrawal from any storage well.

B. The flare, as required in R12-7-180(4), shall be burned continuously when a liquified gas or other flammable substance is being injected into a cavern.

C. Each operator of a storage well shall conduct semiannual safety inspections of the operator's facility and file with the Commission a written report on the inspection procedures and results within 5 days following the inspection. The operator shall notify the Commission at least 5 days before an inspection to allow a representative of the Commission to witness the inspection. Inspections shall include, the following:
1. Operation of all manual valves;
2. Operation of all automatic shut-in safety valves, including sounding or alarm devices;
3. Examination of flare system or other safety system installation;
4. Examination of earthen brine pits, tanks, firewalls, and related equipment;
5. Examination of flowlines, manifolds, and related equipment;
6. Examination of warning signs and safety fences;
7. Examination of housekeeping practices including the removal of weeds, used equipment, and debris from the area of operations;
8. The Commission may require additional inspections at any time during regular working hours and upon reasonable notice to the operator.

D. A capacity determination for each storage cavity shall be made and filed with the Commission upon completion of the storage cavity. These determinations shall be verified at least once every 5 years.

E. Safety precaution signs shall be displayed and unauthorized personnel kept out of the storage area. Each storage wellhead shall be visibly marked in accordance with R12-7-106(D). Guard rails shall be installed where the Commission determines it is necessary to ensure safety.

F. Storage wells shall be plugged and abandoned in accordance with R12-7-126 and R12-7-127.

G. If the Commission determines that the continued operation of a storage well or associated facilities, including valves, brine tanks or pits, flares, dehydrators, and loading and docking facilities, would cause unsafe operating conditions, waste, pollution, or contamination of air, fresh water, or soil, or encroachment on adjacent property, the Commission shall order discontinuance of operations of the storage facility or any part thereof until the Commission determines that the project can and will be conducted in a physically and environmentally safe manner.

H. The operator shall notify the Commission within 24 hours of every accident or equipment malfunction which causes loss of life or requires hospitalization of personnel; threatens the public health and safety; pollutes the air, soil, or fresh water; or causes loss of the stored substance. A final written report shall be filed with the Commission in accordance with R12-7-120(B).

I. The Commission may administratively grant exceptions to the guidelines and requirements of this Section if the applicant can show that the exception is reasonable, justified by site-specific geologic or engineering parameters, are no less stringent, and consistent with the intent of these rules regarding physical and environmental safety, conservation of the resource, and the prevention of waste. An applicant may request a hearing pursuant to A.R.S. § 27-517.

Historical Note
Adopted by moving subsections (A)(1)(h) through (m) of R12-7-181 and amending the text effective January 2, 1996 (Supp. 96-1).

R12-7-183. Certificate of Compliance and Authorization to Transport

A. Each producer or operator of any well shall execute under oath and file with the Commission an operator's certificate of compliance and authorization to transport oil, gas, or geothermal resources from lease provided by the Commission for each well.

B. The certificate, when properly executed and approved by the Commission, shall constitute authorization to the pipeline or other transporter to transport oil, gas or geothermal resources from the developed unit named. The Commission may provide written permission for the transportation of production in order to prevent waste, pending execution and approval of the certificate.

C. The certificate shall remain in full force and effect until:
1. The operating ownership of the developed unit changes, or
2. The transporter changes, or
3. The certificate is cancelled by the Commission.

D. When a change occurs in operating ownership of any developed unit, or when a change occurs in the transporter from any developed unit, the operator shall file a new certificate with the Commission within 10 days of the change. With respect to a temporary change in transporter which involves less than the production of one month, the producer may, in lieu of filing a new certificate, notify the Commission and the transporter in writing of the estimated amount of oil, gas, or geothermal

resources to be moved by the temporary transporter, and the name of the temporary transporter. The operator shall furnish a copy of the notice to the temporary transporter.

E. The temporary transporter shall not move any greater quantity of oil, gas, or geothermal resources than the estimated amount shown in the notice.

F. Time-frames

1. The Commission shall mail to the producer or operator, within 10 days of receipt of the certificate required in subsection (A), written notice of administrative completeness or a detailed list of deficiencies. Within 10 days of receipt of an administratively complete certificate, the Commission shall approve the certificate or provide a written explanation in compliance with A.R.S. § 41-1076 to the producer or operator if the certificate is not approved. The overall time-frame is 20 days.
2. For the purpose of this subsection, intermediate Saturdays, Sundays, and legal holidays are not included in the time-frame computation.

Historical Note
Former Rule 801; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1). Amended effective June 6, 1997 (Supp. 97-2).

R12-7-184. Recovered Load Oil

Recovered load oil may be run from a lease on which it is recovered only upon approval by the Commission of a certificate for load oil credit and permit to transport recovered load oil showing the source and amount of the load oil. Upon approval, the Commission shall forward one copy to the designated transporter as authority to transport the oil. This rule applies only to oil obtained from a source other than the lease on which it is used.

Historical Note
Former Rule 802; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-185. Transporter's and Storer's Monthly Report

A. Each transporter of oil and condensate shall furnish for each calendar month a report containing information and data respecting stocks of oil and condensate on hand and all movements within the state of oil and condensate by pipeline, trucks, or other conveyances except railroad, from leases to storers or refiners; movements between transporters within the state; movements between storers within the state; movements between refiners within the state; and movements between storers and refiners within the state.

B. Each storer of oil and condensate shall furnish for each calendar month a report containing information and data respecting the storage of oil and condensate within the state.

C. Each storer of natural gas, liquified petroleum gas, or other hydrocarbon or nonhydrocarbon gases in storage wells shall furnish for each calendar month a report containing information and data respecting the storage, including receipts and deliveries, of such products within the state.

D. Transporters and storers shall file reports required in this Section with the Commission on or before the 25th day of the next succeeding month.

Historical Note
Former Rule 803; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-186. Gas or Geothermal Purchaser's Monthly Report

A. Each purchaser or taker of gas in gaseous form or geothermal resources from any well, lease, pool or proration unit shall file for each calendar month a report detailing acquisition and disposition of all gas in gaseous form or geothermal resources purchased or taken during that month.

B. Purchasers and takers shall file reports required in this Section with the Commission on or before the 25th day of the next succeeding month.

Historical Note
Former Rule 804; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-187. Injection Project Report

A. Each operator of an injection project shall furnish for each injection well for each calendar month a report of injection project containing information and data including the lease and well number, the well's state permit number, average injection pressure during the month, amount of fluid in barrels injected during the month, the total amount of fluid injected to date, the source of the injected fluid, and the number of days the injection well was operated during the month.

B. Operators of injection projects shall file reports required in this Section with the Commission on or before the 25th day of the next succeeding month.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).

R12-7-188. Refinery Reports

A. Each refiner of oil or condensate shall furnish for each calendar month a refinery monthly report containing information and data respecting oil, condensate and products involved in the refiner's operations during each month.

B. Refiners shall file reports required in this Section with the Commission on or before the 25th day of the next succeeding month.

Historical Note
Former Rule 901; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-189. Repealed

Historical Note
Former Rule 902; Amended effective September 29, 1982 (Supp. 82-5). Repealed effective February 23, 1993 (Supp. 93-1).

R12-7-190. Gasoline Plant Reports

A. Each operator of a gasoline plant, cycling plant, or any other plant at which gasoline, butane, propane, condensate, kerosene, oil or other liquid products are extracted from gas shall furnish for each calendar month a gasoline plant or pressure maintenance plant monthly report containing information and data respecting gas and products involved in the operation of each plant during each month.

B. Operators shall file reports required by this Section with the Commission on or before the 25th day of the next succeeding month.

Historical Note
Former Rule 903; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-191. Reserved

R12-7-192. Books and Records to Substantiate Reports

A. Each operator, producer, transporter, storer, refiner, processor, gasoline or extraction or geothermal generating plant operator, and initial purchaser of oil, gas, or geothermal resources shall make and keep books and records covering operations in Arizona, from which are made and which will substantiate all reports required by the Commission.

B. Books and records required in this Section shall be available for inspection by the Commission for at least a six-year period.

Historical Note
Former Rule 1001; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1).

R12-7-193. Repealed

Historical Note
Former Rule 1002. Amended effective February 23, 1993 (Supp. 93-1). Repealed effective September 22, 1993 (Supp. 93-3).

R12-7-194. Organization Reports

A. Before any person shall engage in any activity covered by this Chapter, that person shall file with the Commission an organization report that includes a statement under oath giving the following information:

1. The name under which the business is being operated or conducted;
2. The name and post office address of the person and the business or businesses engaged in;
3. The plan or organization, and, if a reorganization, the name and address of the previous organization;
4. The state where incorporated, if a foreign corporation, and the name and post office address of the Arizona agent, together with the date of permit to do business in Arizona; and
5. The names and addresses of the principal officers or partners and the names and addresses of the directors.

B. When a change occurs, as to facts stated in the report filed, a new organization report shall be filed with the Commission within ten days of the change.

Historical Note
Former Rule 1003. Amended effective February 23, 1993 (Supp. 93-1).

R12-7-195. Repealed

Historical Note
Former Rule 1004; Amended effective September 29, 1982 (Supp. 82-5). Amended effective February 23, 1993 (Supp. 93-1). Repealed effective September 22, 1993 (Supp. 93-3).

Appendix 1. Repealed

Historical Note
(For the convenience of the operator, the forms and reports in common use by the United States Geological Survey, and for the purpose for which each form was designed, may be submitted in lieu of similar Commission forms. Commission forms No. 1, 2, 3, 4, and 27 must be used for their designated purpose and no substitutes will be acceptable.) Repealed effective January 2, 1996 (Supp. 96-1).

ARTICLE 2. REPEALED

R12-7-201. Repealed

Historical Note
Former A. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-202. Repealed

Historical Note
Former B. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-203. Repealed

Historical Note
Former Rule G-101. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-204. Repealed

Historical Note
Former Rule G-102. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-205. Repealed

Historical Note
Former Rule G-103. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-206. Repealed

Historical Note
Former Rule G-104. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-207. Repealed

Historical Note
Former Rule G-105. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-208. Repealed

Historical Note
Former Rule G-106. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-209. Repealed

Historical Note
Former Rule G-107. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-210. Repealed

Historical Note
Former Rule G-108. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-211. Repealed

Historical Note
Former Rule G-109. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-212. Repealed

Historical Note
Former Rule G-110. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-213. Repealed

Historical Note
Former Rule G-111. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-214. Repealed

Historical Note
Former Rule G-112. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-215. Repealed

Historical Note
Former Rule G-113. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-216. Repealed

Historical Note
Former Rule G-114. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-217. Repealed

Historical Note
Former Rule G-115. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-218. Repealed

Historical Note
Former Rule G-116. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-219. Repealed

Historical Note
Former Rule G-117. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-220. Repealed

Historical Note
Former Rule G-118. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-221. Repealed

Historical Note
Former Rule G-119. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-222. Reserved

R12-7-223. Reserved

R12-7-224. Reserved

R12-7-225. Reserved

R12-7-226. Reserved

R12-7-227. Reserved

R12-7-228. Reserved

R12-7-229. Reserved

R12-7-230. Reserved

R12-7-231. Repealed

Historical Note
Former Rule G-201. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-232. Repealed

Historical Note
Former Rule G-202. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-233. Repealed

Historical Note
Former Rule G-203. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-234. Repealed

Historical Note
Former Rule G-204. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-235. Reserved

R12-7-236. Reserved

R12-7-237. Reserved

R12-7-238. Reserved

R12-7-239. Reserved

R12-7-240. Reserved

R12-7-241. Repealed

Historical Note
Former Rule G-301. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-242. Repealed

Historical Note
Former Rule G-302. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-243. Repealed

Historical Note
Former Rule G-303. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-244. Repealed

Historical Note
Former Rule G-304. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-245. Repealed

Historical Note
Former Rule G-305. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-246. Repealed

Historical Note
Former Rule G-306. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-247. Reserved

R12-7-248. Reserved

R12-7-249. Reserved

R12-7-250. Reserved

R12-7-251. Repealed

Historical Note
Former Rule G-401. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-252. Repealed

Historical Note
Former Rule G-402. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-253. Reserved

R12-7-254. Reserved

R12-7-255. Reserved

R12-7-256. Reserved

R12-7-257. Reserved

R12-7-258. Reserved

R12-7-259. Reserved

R12-7-260. Reserved

R12-7-261. Repealed

Historical Note
Former Rule G-501. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-262. Repealed

Historical Note
Former Rule G-502. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-263. Repealed

Historical Note
Former Rule G-503. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-264. Repealed

Historical Note
Former Rule G-504. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-265. Reserved

R12-7-266. Reserved

R12-7-267. Reserved

R12-7-268. Reserved

R12-7-269. Reserved

R12-7-270. Reserved

R12-7-271. Repealed

Historical Note
Former Rule G-601. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-272. Repealed

Historical Note
Former Rule G-602. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-273. Reserved

R12-7-274. Reserved

R12-7-275. Reserved

R12-7-276. Reserved

R12-7-277. Reserved

R12-7-278. Reserved

R12-7-279. Reserved

R12-7-280. Reserved

R12-7-281. Repealed

Historical Note
Former Rule G-701. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-282. Reserved

R12-7-283. Reserved

R12-7-284. Reserved

R12-7-285. Reserved

R12-7-286. Reserved

R12-7-287. Reserved

R12-7-288. Reserved

R12-7-289. Reserved

R12-7-290. Reserved

R12-7-291. Repealed

Historical Note
Former Rule G-801. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-292. Repealed

Historical Note
Former Rule G-802. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-293. Repealed

Historical Note
Former Rule G-803. Repealed effective January 2, 1996 (Supp. 96-1).

R12-7-294. Repealed

Historical Note
Former Rule G-804. Repealed effective January 2, 1996 (Supp. 96-1).

Appendix 1. Repealed

Historical Note
Repealed effective January 2, 1996 (Supp. 96-1).

27-503. Waste of oil or gas prohibited; powers of commissioner to prevent waste

A. Waste of oil or gas is unlawful and is prohibited.

B. The commissioner shall make inquiries he deems proper to determine whether waste exists or is imminent. In the exercise of such power the commissioner may:

1. Collect data.

2. Make investigations and inspections.

3. Examine property, leases, papers, books and records, including drilling records and logs.

4. Examine, check, test and gauge oil and gas wells, tanks, refineries and modes of transportation.

5. Hold hearings.

6. Require keeping of records and making of reports.

7. Take action he deems necessary to enforce and effectuate the provisions of this article.

C. The commissioner may in order to prevent waste and avoid drilling unnecessary wells, permit the cycling of gas in any pool or portion thereof or the introduction of gas or other substance into an oil or gas reservoir for the purpose of repressuring the reservoir, maintaining pressure or carrying on secondary recovery operations of any type. The commissioner shall permit the pooling or integration of separate tracts when reasonably necessary in connection with the operations.

27-516. Rules

A. The commission shall make rules and amend them as deemed necessary for the proper administration and enforcement of this article, including the following rules and orders:

1. Requiring the drilling, casing and plugging of wells in a manner to prevent:

(a) Escape of oil and gas from one stratum to another.

(b) Intrusion of water into an oil or gas stratum from a separate stratum.

(c) Pollution of fresh water supplies by oil, gas or salt water.

(d) Waste.

2. Requiring reports showing the location of oil and gas wells and requiring filing of logs and drilling records within thirty days after drilling is completed for a well drilled for oil or gas.

3. Requiring a reasonable bond with good and sufficient surety conditioned on the performance of the duties prescribed in paragraphs 1 and 2 of this subsection including the obligation to plug each dry or abandoned well.

4. Preventing drowning by water of any stratum or part capable of producing oil or gas in paying quantities and preventing the premature and irregular encroachment of water which reduces or tends to reduce the total ultimate recovery of oil or gas from any pool.

5. Requiring the operation of wells with efficient gas-oil ratio and fixing the limits of such ratios.

6. Preventing blowouts, caving and seepage.

7. Preventing creation of unnecessary fire hazards.

8. Requiring identification of ownership of oil and gas wells, producing leases, refineries, tanks, plants, structures and storage and transportation equipment and facilities.

9. Regulating shooting, perforating and chemical treatment of wells.

10. Regulating gas cycling operations.

11. Regulating secondary recovery methods, including introduction of gas, air, water or any other substances into producing formations.

12. Regulating spacing of wells and establishing drilling units.

13. Limiting, allocating and apportioning production of oil and gas from a pool or field for prevention of waste, and allocating production between tracts of land under separate ownership in a pool on a fair and equitable basis so that each tract will be permitted to produce not more than its just and equitable share from such pool.

14. Preventing, so far as practicable, reasonably avoidable drainage from each developed unit, not equalized by counterdrainage.

15. Requiring a producer of oil or gas to submit for each oil or gas well operated, on a form prescribed by the commission, a monthly report of actual production from each oil or gas well. Such report shall be submitted on or before the twenty-fifth day of the next succeeding month.

16. Requiring persons making settlement with the owner of oil or gas interests to render statements to the owner showing the quantity and gravity purchased and the price per barrel of oil or the price per one thousand cubic

feet of gas.

17. Requiring, either generally or in a particular area, a certificate of clearance for transportation or delivery of oil, gas or any product.

18. Requiring the applicant for a drilling permit, if the surface of the land is owned by another not in a contractual relationship with the applicant, to post bond in a reasonable sum with good and sufficient surety conditioned on payment of just compensation to the landowner for actual damages to the surface of or improvements on the land caused by the drilling permittee's operations.

19. Requiring all forms and reports requested by the commission to be submitted to the commission on or before the twentieth day of the next succeeding month for monthly reports or within twenty days following the completion of the action requiring the report, except as otherwise provided by the commission.

20. Requiring the permitting of all wells and the approval of all equipment and methods:

(a) To create or use existing storage space for the underground storage of hydrocarbon substances, whether liquid or gaseous.

(b) Used for the injection of any substance into geological strata for the purpose of pressure maintenance or for the purpose of increasing ultimate recovery.

(c) Used for the purpose of secondary and tertiary recovery.

(d) Used for the disposal of any substance.

B. No rule or order, or change, renewal or extension, except as otherwise provided by this article, shall, in the absence of an emergency, be made by the commission under the provisions of this article except after a public hearing of which not less than ten days' notice has been given. The public hearing shall be held at such time and place as may be prescribed by the commission, and any interested person shall be entitled to be heard. Notice shall be given by personal service, by publication or by United States mail addressed, postage prepaid, to the last known mailing address of the person or persons affected. The date of service shall be the date on which service was made in the case of personal service, the date of first publication in the case of notice by publication and the date of mailing in the case of notice by mailing. The notice shall issue in the name of the state, shall be signed by a member of the commission or its deputy, shall specify the style and number of the proceeding and the time and place of the hearing and shall briefly state the purpose of the proceeding. If the commission gives notice by personal service, such service may be made by an officer authorized to serve process or by the commission in the same manner as is provided by law for the service of process in civil actions in the courts of this state. Proof of service by the commission shall be by the affidavit of the commission or its authorized representative making personal service. If service is made by the sheriff, the proof of service shall be as required by law for service of process in civil actions. If the matter to be heard concerns the adoption, amendment or repeal of a rule of general applicability, notice shall be by publication.

C. If an emergency is found by the commission to exist, which in its judgment requires making, changing, renewing or extending a rule or order without first having a hearing, the emergency rule or order shall have the same validity as if a hearing had been held after due notice. The emergency rule or order shall remain in force for not to exceed thirty days from its effective date but shall expire when a rule or order with respect to the subject matter of the emergency rule or order becomes effective after due notice and hearing.

27-656. Rules and orders; hearing

A. The commission shall adopt rules necessary for the proper administration and enforcement of this article.

B. The commission shall comply with title 41, chapter 6 in adopting, modifying, renewing or extending rules under this article.

C. Any order, or change, renewal or extension of an order, except as otherwise provided by this article, shall be made in compliance with title 41, chapter 6, article 10.

D. If the commission makes a finding that an order is necessary as an emergency measure, the order may be made without first complying with the notice and hearing requirements prescribed by title 41, chapter 6, article 10. All affected persons shall be notified of the emergency order. If oral notice is given, it shall be followed by immediate written notice. The emergency order shall be valid for thirty days from its effective date. The effective date is the date affected persons receive the order by oral or written communication, whichever occurs first. The commission shall hold a hearing within ten days after the effective date of the emergency order. Unless otherwise provided in this section, the hearing shall be conducted in compliance with title 41, chapter 6, article 10. Any order made at the hearing shall expressly repeal the emergency order. For purposes of this subsection, "emergency" means a situation which requires an order without compliance with the notice provisions prescribed in title 41, chapter 6, article 10 because the order is necessary for immediate preservation of the public safety, welfare, natural resources or property and the notice and hearing requirements are impracticable.