ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (R-16-0806)
Title 9, Chapter 22, Article 7, Standards for Payments

Amend: R9-22-701; R9-22-712.35; R9-22-712.60; R9-22-712.61; R9-22-712.66; R9-22-712.67; R9-22-712.71; R9-22-712.75

GOVERNOR'S REGULATORY REVIEW COUNCIL
M E M O R A N D U M

MEETING DATE: August 2, 2016 **AGENDA ITEM: F-7**

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

FROM: Shama Thathi, Staff Attorney

DATE: July 15, 2016

SUBJECT: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (R-16-0806)**
Title 9, Chapter 22, Article 7, Standards for Payments

Amend: R9-22-701; R9-22-712.35; R9-22-712.60; R9-22-712.61; R9-22-712.66; R9-22-712.67; R9-22-712.71; R9-22-712.75

General Comments

Purpose of the Agency and Summary of What the Rulemaking Does

The Arizona Health Care Cost Containment System ("AHCCCS") is established "to promote a comprehensive health care system to eligible citizens of this state." Laws 2013, 1st S.S., Ch. 10, § 53. This system is managed by the Director of the AHCCCS Administration ("Administration"), which is established under A.R.S. § 36-2902(A). The Director has the powers and duties as outlined in A.R.S. §§ 36-2903 and 2903.01.

This rulemaking seeks to amend eight rules in A.A.C. Title 9, Chapter 22, Article 7, which contain rules related to standards for payments.

Article Contents, Including the Subject Matter of Each Rule Affected

Article 7 contains thirty rules, eight of which are affected by this rulemaking, and one exhibit. The rules address definitions; outpatient hospital reimbursement: adjustments to fees; diagnosis related group (DRG) payments, DRG payments: exceptions; DRG service policy adjustor; DRG reimbursement: transfers; final DRG payment; and DRG reimbursement: payment for administrative days.

Year that Each Rule was Last Amended or Newly Made

- November 1, 2007: R9-22-701

- October 1, 2011: R9-22-712.35
- August 1, 2014: R9-22-712.60, R9-22-712.61, R9-22-712.66, R9-22-712.67, R9-22-712.71, R9-22-712.75

Proposed Action

The following is a non-exhaustive summary of the actions being taken by the Administration in this rulemaking:

- R9-22-701: For clarity, definitions are being added and deleted from this section. Citations are also being updated.
- R9-22-712.35: A new subsection (E), which outlines payment requirements for services rendered between October 1, 2016 and September 30, 2017, is being added. Clarifying changes are also being made.
- R9-22-712.60: Clarifying changes are being made.
- R9-22-712.61: A new subsection (E) is being added to clarify hospitals that have contracts with the Administration for transplant services are paid for inpatient days in accordance with the terms of contract. Clarifying changes are also being made.
- R9-22-712.66: The rule is being amended to refine the service policy adjustor associated with claims for inpatient hospital services provided to children with different levels of illness
- R9-22-712.67: Clarifying change is being made.
- R9-22-712.71: A new subsection (4) is being added to outline the criteria for hospitals to qualify for the inpatient value based purchasing differential adjusted payment.
- R9-22-712.75: This rule is being amended to clarify the meaning of "administrative days," which occur when a patient must remain admitted or cannot be safely discharged due to the lack of an appropriate setting outside the hospital.

The Administration indicates that the proposed amendments improve clarity regarding payments to hospitals for inpatient and outpatient services. Specifically, this rulemaking is intended to reward hospitals that have implemented an effective system of electronic health records retention and exchange, with the goals of reducing the cost of health care and improving patient health outcomes.

Exemption or Request and Approval for Exception from the Moratorium

The Governor's Office granted an exception from Executive Order 2016-03 for this rulemaking on March 28, 2016.

Substantive or Procedural Concerns

None.

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

Yes. The Administration cites to A.R.S. § 36-2903.01(F) as general authority for the rules. Under A.R.S. § 36-2903.01(F), the director of the Administration "may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article." In addition, A.R.S. § 36-2903.01(G)(3) and (G)(12) grant specific authority to the Administration to make adjustments to the outpatient hospital rates and to establish the DRG methodology, respectively.

2. Are the rules written in a manner that is clear, concise, and understandable to the general public?

Yes. The rules are clear, concise, and understandable.

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

Yes. The Administration indicates that it received written comments on the rulemaking from four individuals. On pages 4-10 of the Notice of Final Rulemaking (NFR), the Administration summarizes the comments received, and provides responses for each comment. As a whole, the Administration adequately addressed, and responded to, comments on the proposed rules.

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

No. The Administration only made one technical change by removing the term "comprehensive" from the definition of sub-acute services. In addition, minor grammatical and style corrections were made at the request of Council's staff.

5. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely on in the agency's evaluation of or justification for the rules?

No. The Administration indicates that no study was reviewed or relied upon for the rules.

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

No. The Administration indicates that no federal laws directly correspond to the rules.

7. Do the rules require a permit or license and if so, does the agency use a general permit or is any exception applicable under A.R.S. § 41-1037?

No. The rules do not require a permit or license.

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

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

9. Conclusion

The Administration requests an effective date of October 1, 2016 for the rules to coincide with the beginning of the contract year with the contractors who make the hospital payments. This analyst recommends approval of the rules.

GOVERNOR'S REGULATORY REVIEW COUNCIL
M E M O R A N D U M

MEETING DATE: August 2, 2016 **AGENDA ITEM: F-7**

TO: Members of the Governor's Regulatory Review Council

FROM: GRRC Economist

DATE : July 15, 2016

SUBJECT: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (R-16-0806)**
Title 9, Chapter 22, Article 7, Standards for Payments

Amend: R9-22-701; R9-22-712.35; R9-22-712.60; R9-22-712.61; R9-22-712.66; R9-22-712.67; R9-22-712.71; R9-22-712.75

I reviewed the economic, small business, and consumer impact statement (hereafter referred to as EIS) and make the following comments. These comments are made to assist the Council in its review and may be used as the Council determines.

GRRC Economist comments:

As of June 1, 2016, 1,849,578 Arizona residents were enrolled with healthcare coverage through AHCCCS. Of those, 236,590 have their coverage through the fee-for-service program. A.R.S 36-2903.01 requires that AHCCCS adopt rules regarding how the Administration will reimburse inpatient and outpatient services for hospitals which participate in the AHCCCS system's fee-for-service coverage. These rules are made and clarified in Title 9, Chapter 22, Article 7.

The proposed rule amendments for these rules are intended to update the methodology for reimbursement for healthcare services provided by hospitals that have entered into participation agreements with the Administration. The rulemaking aims to "increase payments to hospitals that have implemented electronic medical records systems and that participate in a health information exchange (p. 6-7).

According to the Administration, this rulemaking will not affect the behavior and conduct of the public.

1. **Costs and Benefits for:**

   a. **The implementing agency:**

There is an anticipated increase of costs for the Administration as there will be "increased expenditures for hospital services under the terms of the contracts between hospitals and those managed care entities…" (p.5). According to the EIS, legislative funds have already been appropriated for the Administration to fund the cost of the increased payments to hospitals. These funding adjustments provided by the legislature are currently limited to the time period of 10/1/2016 to 9/30/17.

Specifically, the Administration anticipates making $3.6 million more in payments to 19 hospitals that participate in health information exchanges. The Administration anticipates making $19.4 million in payments annually to 53 hospitals that provide care to high-acuity pediatric patients. The Administration does not anticipate needing to hire full time employees as a result of this shift.

b. Political subdivisions:

The proposed rule amendments do not directly affect political subdivisions.

c. Businesses:

The Administration anticipates that businesses (hospitals) may need to modify their systems that emulate the claims payment systems of payers in order to estimate revenue. The Administration does not believe this will cause hospitals to incur costs outside usual operating expenditures.

d. Small businesses:

The Administration anticipates no fiscal impact on small businesses from the proposed rule amendments due to the Administration not conceptualizing hospitals as small businesses.

e. Consumers directly affected by the rulemaking:

Private persons, consumers, and AHCCCS members are not directly impacted by the proposed rule amendments.

2. <u>Do the probable benefits outweigh the probable costs?</u>

Based on the information provided above, the Administration indicates that there are only probable benefits to modifying the methodology of the rules for reimbursement.

3. <u>Analysis of methods to reduce the small business impact:</u>

The proposed rule amendments represent the most cost-effective and efficient method of fulfilling the Administration's responsibilities and impose only those requirements that are necessary to comply with federal law and state statute. However, the Administration

does not conceptualizing hospitals as small businesses; therefore these requirements do not apply.

4. <u>The probable effect on state revenues:</u>

The Administration anticipates the proposed rule amendments will have no impact on state revenues.

5. <u>Analysis of any less intrusive or less costly alternative methods:</u>

The Administration did not consider other alternatives, and state in the EIS that "the changes are the most cost effective and efficient method of complying with federal and state requirements" (p.8).

6. <u>Whether an analysis was submitted to the agency regarding the rule's impact on the competitiveness of businesses in this state as compared to the competitiveness of businesses in other states:</u>

The EIS does not mention any analysis comparing the rule's impact of the competiveness of businesses in this state to the impact on businesses in other states.

7. <u>A description of any data on which a rule is based with an explanation of how the data was obtained and why the data is acceptable data, and the methods used by the agency to evaluate the costs and benefits in the EIS.</u>

The Administration indicates that no data was used to base the rule upon.

8. <u>Conclusion:</u>

The submitted economic, small business and consumer impact statement is generally accurate, and contains the information required for compliance with A.R.S. §§ 41-1035, 41-1052(D)(1-3), and 41-1055. This analyst recommends that the proposed rule amendments be approved.

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

June 20, 2016

Ms. Nicole Ong, Chair
Governor's Regulatory Review Council
100 N. 15th Ave, Suite 402
Phoenix, AZ 85007

Dear Ms. Ong:

The Arizona Health care Cost Containment System (AHCCCS) Administration is submitting the attached regular rule package for your consideration:

- 9 A.A.C. 22, Article 7, Standard for Payments,

AHCCCS is providing the following information as required in A.A.C. R1-6-201:

a. The close of record date was 5p.m., May 9, 2016.

b. Definitions of terms contained in statute of other rules and used in the rule are either cross-referenced or attached.

c. The rulemaking does not relate to a 5-year-review.

d. The rulemaking contains no new fees.

e. The rulemaking contains no fee increase.

f. Documents enclosed:

   - Notice of Final Rulemaking, including the preamble, table of contents for the rule, and text of the rule;
   - Economic, small business, and consumer impact statement;
   - If applicable, copy of definitions of terms, contained in statutes or other rules, used in the rule.

g. All written comments submitted by the public concerning the proposed rule.

h. The adopted rules contain no materials incorporated by reference.

i. The adopted rules do not require a permit.

j. The rule is not more stringent than federal law and the citation to the statutory authority does not exceed the requirements of federal law.

k. A person has not submitted an analysis to the agency that compares the rule's impact of the competiveness of the businesses in this state to the impact on businesses in other states.

l. The AHCCCS Administration has not notified the Joint Legislative Budget Committee (JLBC) of a number of new full-time employees (FTE's) since none were required as a result of this rulemaking as required by A.R.S. § 41-1055.

m. The AHCCCS Administration has requested and received approval to proceed with this rulemaking from the Governor's Office in reference to the rulemaking moratorium described under Executive Order 2016-03.

I certify that the information provided in number 7 of the preamble is accurate. An immediate effective date is requested. I respectfully request that the Council consider and approve the adopted rules.

Sincerely,

Matthew Devlin
Assistant Director – Office of Administrative Legal Services

Attachments

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

PREAMBLE

1. Article, Part, or Section Affected (as applicable)	**Rulemaking Action:**
R9-22-701	Amend
R9-22-712.35	Amend
R9-22-712.60	Amend
R9-22-712.61	Amend
R9-22-712.66	Amend
R9-22-712.67	Amend
R9-22-712.71	Amend
R9-22-712.75	Amend

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

Authorizing statute: A.R.S. § 36-2903.01(F)

Implementing statute: A.R.S. §§ 36-2903.01(G)(3) and 36-2903.01(G)(12)

3. The effective date of the rule:

The agency selected an effective date of October 1, 2016 as specified in A.R.S. § 41-1032(B) to coincide with the start of the contract year between the AHCCCS Administration and managed care contractors that make the majority of hospital payments. Thus good cause exists for this effective date and the effective date will not harm the public interest.

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

Notice of Rulemaking Docket Opening: 22 A.A.R. 784, April 8, 2016

Notice of Proposed Rulemaking: 22 A.A.R. 761, April 8, 2016

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

Name:	James Maguire
Address:	701 E. Jefferson St.
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:

The proposed rulemaking will amend and clarify rules regarding payments to hospitals for inpatient and outpatient services. Specifically, this rulemaking increases payments for inpatient and outpatient services provided during a one year period to hospitals that participate in a qualifying health information exchange and have been certified as having achieved "meaningful use stage 2" with respect to the hospital's use of the health information exchange. The payment adjustments reward hospitals that have made the investment necessary to implement an effective system of electronic health records retention and exchange which actions are expected to improve patient health outcomes and reduce the cost of care. In addition, the proposed rulemaking refines the Service Policy Adjustor associated with claims for inpatient hospital services provided to certain high-acuity children; clarifies payments for inpatient hospital services after a patient is transferred to another hospital to receive sub-acute care; and clarifies reimbursement for inpatient hospital services designated as "administrative days" – that is, when a patient must be admitted or cannot be safely discharged due to the unavailability or an appropriate setting outside the hospital.

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 for.

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. The rulemaking will not diminish a previous grant of authority of a political subdivision.

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

The Administration anticipates a moderate economic impact on the implementing agency, small businesses and consumers for the rule changes:

- The Administration anticipates that the adjustments to payments for inpatient and outpatient hospital services due to Value Based Purchasing (VBP) will result in approximately $3.6 million of additional payments for the contract year October 1, 2016 through September 30, 2017 to about 19 qualifying hospitals that have met the criteria in the rule for implementation and use of electronic health records and health information exchange.
- The Administration amended rule to clarify the description of how DRG payments are made, including transplant services. The amended rule also clarifies how DRG payments are made for Administrative days and transfers. These changes are not expected to have an economic impact on any party since the changes are only for clarification and do not change a service or payment. The revisions to the rules will enhance the public's understanding.
- In addition, the Administration refined the high acuity pediatric policy adjustor for January 1, 2016 to recognize the higher cost of treating higher acuity pediatric patients. It is anticipated that the high acuity pediatric policy adjustor will result in annual additional payments of $19.4 million to 53 hospitals.

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

No changes were made between the proposed rulemaking and the final rulemaking, with exception of the technical change of removing the term "comprehensive" from the definition of subacute services as requested by a commenter.

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

The following comments were received as of the close of the comment period of May 9, 2016.

Item #	Rule Cite Line #	Comment From and Date rec'd.	Comment	Analysis/ Recommendation
1.	R9-22-701	William Timmons 05/04/16	The word "comprehensive" could mean different things to different individuals with their interpretation related to whether they work for a hospital or a health care plan. Thus, any attempt to define "comprehensive" would be difficult. For these reasons the word "comprehensive" adds no value to the definition and should be removed. The phrase "instead of" is key since it supports our pursuit of direct admissions to both hospitals so we don't have to rely just on transfers from tertiary care hospitals. The definition needs to include **what it is not, i**.e., it is not the type/level of care provided in a skilled nursing facility. The preferred definition is: **"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 but requires care at a level beyond that provided by a skilled nursing facility. Sub-acute care is rendered immediately after or instead of acute inpatient hospitalization.**	The Administration has agreed to remove the term "comprehensive", however, the Administration declines the suggestion to make other revisions to the definition of sub-acute services. Sub-acute services may include the level of services provided at a nursing facility, thus the recommendation to include care at a level beyond that provided by a skilled nursing facility will not be added. Nursing facilities are permitted to render sub-acute services. The federal description of nursing facility services in 42 CFR 440.155 provides that nursing facility services are services provided to persons who do not require hospital care but whose condition requires services above the level of room and board.
2.	R9-22-712.67 A	William Timmons 05/04/16	Add the following information from the payment policies manual that AHCCCS published on October 30, 2015, this would add clarity which is important since we want to make sure that tertiary care hospitals are incentivized to transfer patients to LNH and HCH. **"Clarification regarding transfers for sub-acute services: A recipient who no longer meets medical inpatient criteria may be discharged/transferred to another acute care facility without triggering a reduction to the transferring hospital via the 70 Discharge Status Code (Discharge/transfer to another type of health care institution not defined**	The Administration has noted your comment. Hospitals that participate in AHCCCS are required to sign provider participation agreements which agreement incorporates by reference several policy manuals. Those policy manuals provide clarification and detail regarding billing instructions. Billing instructions are generally delineated in policy. Therefore, additional language is not necessary.

			elsewhere in the code list) for the provision of sub-acute services."	
3.	R9-22-712.75 A2	William Timmons 05/04/16	A2 use of the term "other" in this context would seem to imply that nursing facility provides sub-acute services as defined in R9-22-701. There is a difference between the levels of care provided by skilled nursing facilities and hospitals providing sub-acute services. To avoid possible confusion I suggest restating A2: **"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 post-acute care setting, such as a nursing facility or a hospital providing sub-acute services."**	The Administration declines to make the suggested change. Nursing facilities are not precluded from rendering sub-acute services. The federal description of nursing facility services in 42 CFR 440.155 provides that nursing facility services are services provided to persons who do not require hospital care but whose condition requires services above the level of room and board.
4.	R9-22-712.75E	William Timmons 05/04/16	For clarity purposes I suggest that R9-22-712.75E's example of "as nursing facility days" be **amended to include "as sub-acute facility days".** Also, I suggest that section E **include the phrase "Administrative days will be reimbursed using a negotiated per diem rate".** The reason is because a number of health plans have already established their own non-negotiated Administrative day rate for nursing facilities and want us to accept these much lower rates that are not commensurate with the sub-acute level of care we provide.	The rule specifies nursing facilities as an example and does not exclude days at other facilities offering sub-acute care. AHCCCS managed care organizations are permitted to establish their own rates through individually negotiated contracts with hospitals. Therefore, no changes will be made to the proposed language.
5.	General	William Timmons 05/04/16	This matter needs to be addressed: There is no financial incentive for hospitals to transfer patients to our hospitals either under the DRG system or the per diem system. Also there is no financial incentive for the health plans to authorize payment under the DRG system or the per diem system for patients transferred to our hospitals. **The result is that many infants, children and teens who no longer need care in a tertiary care hospital are not being transferred to our hospitals.**	The purpose of the rule is to establish an appropriate payment when patient is transferred from one hospital to another for sub-acute care. The rule is not intended to incentive such transfers or to incentives transfers to a particular hospital.
6.	VBP	Debbie Johnston 05/06/16	We also believe the second metric, participation in the state's health information exchange (HIE) network, will not be administratively burdensome for most hospital subtypes. However, it **will be cost-prohibitive for some hospitals.** This is particularly true for small hospitals that lack the capital resources to invest in connectivity at this time. While these facilities would like to participate in exchange, they are simply unable due to financial constraints.	The AHCCCS Administration is aware that some small hospital providers are already participating in the health information exchange. The purpose of this rulemaking is to recognize the improved health outcomes and health care costs savings expected from hospital participation in health information exchange. Alternate metrics for value based payments may be considered in future program years.

7.	VBP	Debbie Johnston 05/06/16	The proposal, however, falls short with respect to the principle that all hospitals should have an opportunity to qualify for the adjustment, regardless of subtype. As we mentioned in our December 30th letter, we are concerned that Psychiatric, Rehabilitation, and Long Term Acute Care (LTAC) hospitals will not be eligible for the differential adjustment because these hospital subtypes are currently excluded from federal MU Stage 2. We urged the Administration to adopt alternative metrics for these hospitals, which provide important transitional inpatient care to trauma and other medically complex patients on a post-acute care basis in order to restore medical and functional capacity that enable these patients to return to a community setting. Psychiatric hospitals are also critical in providing mental health and increasingly integrated services to the vast number of Medicaid recipients in need of inpatient behavioral health services**. We are disappointed that the Administration was unable to develop alternative metrics for these hospital subtypes for CYE 2017, and strongly urge their development for CYE 2018.**	Your suggestion has been noted. We will take it into consideration for CYE 2018.
8.	VBP	Debbie Johnston 05/06/16	Finally, we seek clarification on two issues related to the rulemaking. First, we would like to have a better understanding **of how the adjustment will be implemented within AHCCCS's managed care framework given rates are the product of provider-health plan negotiations.** The Preamble to the proposed rule states the differential adjustment will be made to hospitals that "satisfy specific criteria for receipt of VBP Differential Adjusted Payments by the AHCCCS Administration *as well as Managed Care Contractors*." (Emphasis added.) The Administration's criteria are set forth in the rulemaking. **Does the Administration also intend that AHCCCS health plans be permitted to set additional criteria as a prerequisite for "passing through" the payment adjustment?** We would strongly oppose such a proposal, as it could create uneven implementation of the VBP differential, increase confusion around the program, and reduce transparency. Second, we would like a better understanding of **how the adjustment is being funded.** Since the Legislature is not appropriating new funds for the adjustment, we assume funding is being reallocated from existing programs. In an effort to advance transparency, we believe it is important for the	This rule sets forth the fee-for-service payment methodology. MCO's are required by statute to use this payment methodology in the absence of a contract with a provider calling for a different methodology. This rule does not limit or restrict the ability of MCO's to contract for reimbursement on different terms. The AHCCCS Administration intends to address implementation of value-based purchasing incentives by managed care organizations through its contracts with the managed care organizations which is beyond the scope of this rule-making. The adjustment is supported by funds appropriated by the legislature. The AHCCCS Administration is not reducing payments to support the adjustment.

			public and stakeholders to understand whether and how existing programs might be impacted.	
9.	R9-22-701	Debbie Johnston 05/06/16	We strongly support adding a definition of "sub-acute services" to the DRG regulations. We believe this definition will add much needed clarity, but recommend the following modifications: **1. The word "comprehensive" is subject to interpretation, and it is very likely providers and health plans will disagree over its meaning. Without further elaboration, we believe it adds little value to the definition. As such, we recommend eliminating the term.** **2. The definition should clarify that sub-acute services is a higher level of care than skilled nursing care provided by a SNF.** **3. We support the inclusion of the term "instead of" in the last sentence since patients may on occasion be directly admitted to these hospitals.**	The Administration has agreed to remove the term "comprehensive", however, no other revisions to the definition will be made. Sub-acute services may include the level of services provided at a nursing facility, thus the recommendation to include care at a level beyond that provided by a skilled nursing facility will not be added. Also see response to #3.
10.	R9-22-712.67	Debbie Johnston 05/06/16	**We support the definition of "transfer", but recommend the rules incorporate the following or substantially similar language from the October 30, 2015 Payment Policies Manual clarifying transfers for sub-acute services:** **"A recipient who no longer meets medical inpatient criteria may be discharged/transferred to another acute care facility without triggering a reduction to the transferring hospital via the 70 Discharge Status Code (Discharge/transfer to another type of health** **care institution not defined elsewhere in the code list) for the provision of sub-acute services."**	The Administration has noted your comment. Policy manual provisions incorporated by reference into the provider participation agreement between the hospital and the administration provide clarification and detail regarding billing instructions. Billing instructions are generally delineated in policy because details such as discharge status codes are subject to potential change by the professional organizations that establish those codes. Therefore, additional language will not be added to rule.
11.	R9-22-712.75 A2	Debbie Johnston 05/06/16	There is a difference between the levels of care provided by skilled nursing facilities and hospitals providing sub-acute or other post-acute care (e.g., rehabilitation). **To avoid possible confusion, we recommend restating R9-22-712(A)(2) as "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 post-acute care setting, such a nursing facility or hospital providing sub-acute services or other post-acute services."**	Please see the response to comment number 3.
12.	R9-22-712.75 A3	Debbie Johnston 05/06/16	**We recommend adding "or sub-acute facility days" after "nursing facility days" in subsection E. This would provide additional clarity by differentiating sub-acute services from skilled nursing services.**	The Administration has noted your comments. The rule specifies nursing facilities as an example.
13.	R9-22-712.75 A3	Debbie Johnston 05/06/16	**In addition, we recommend adding the phrase "Administrative days will be reimbursed using a negotiated per diem rate."** Hospitals providing	The rule sets forth the method by which the AHCCCS administration will reimburse hospitals on a fee-for-

			sub-acute care services report to us a number of AHCCCS health care plans have established non-negotiated Administrative day rates for nursing facilities and expect hospitals to accept these much lower rates, which are not commensurate with the sub-acute level of care hospitals provide. If the Administration chooses not to include this language in the rule, we urge such language be included in separate policy guidance.	services basis. AHCCCS managed care organizations are permitted to establish their own rates through individually negotiated contracts with hospitals. Therefore, no changes will be made to the proposed language.
14.	R9-22-712.66	Debbie Johnston 05/06/16	We do not question the high cost of treating high acuity pediatric patients. **However, we believe for the sake of transparency that the Administration should identify any data that it relied on in making this proposal.** While the Administration may not have relied on an external study, we would assume that Administration **staff reviewed internal or other data in making the policy determination** to establish and set a high acuity pediatric weight at 1.60. **We believe this data should be made available to the public**. In addition, we would like to have a better understanding of the funding source for this policy proposal, since the Administration is proposing and implementing it outside of the legislative appropriations process.	As the commenter noted, it is generally accepted that there is a higher cost to treating high acuity pediatric patients. No specific studies or data was reviewed to arrive at this conclusion.
15.	R9-22-712.35E 1	Steve Kaiser 05/09/16	Phoenix Children's Hospital has executed an agreement with a qualifying Health Information Exchange and currently is working through the process of exchanging data. Due to the complexity of the unique data flows in pediatrics, however, completing these processes may require more time than the proposed rule allows. Some of the challenges experienced in the pediatric context include obtaining appropriate parental consent when patients transfer in and out of foster care and the changing consent requirements as children get older. Furthermore, successful exchange of data requires all technology requirements be completed by both the Hospital and the HIE, and each Hospital is not in direct control of the timeline and priorities of a complex Health Information Exchange which must manage many clients. **We would propose that in the first year hospitals must have an executed agreement with a qualifying Health Information Exchange and be actively engaged with the on-boarding process with the HIE. By the second year hospitals should be electronically submitting admission, discharge, and transfer information.**	The purpose of this rulemaking is to recognize the improved health outcomes and health care costs savings expected from hospital that have already taken the necessary steps to participate in health information exchange. The rulemaking only impacts payments for hospital services during a one year period. Extension of an adjustment for participation in and health information exchange and/or alternate metrics for value based payments may be considered in future program years.

16.	R9-22-712.35E 2	Steve Kaiser 05/09/16	As an initial matter, there is currently no mechanism within AHCCCS to receive an attestation from an inpatient children's hospital, with the most recent direction from AHCCCS being that such a mechanism will be in place in May 2016 for submission of Program Year 2015 MU attestation. It also is unclear why attestation for program year 2015 would include data from January 2016 through April of 2016. The proposed rule also does not clarify whether a children's hospital must submit attestation of inpatient meaningful use or outpatient meaningful use. Phoenix Children's Hospital proposes that because of the lack of mechanism through which to submit an attestation for 2015, and since attestation for a program year cannot be filed until the following year, **that this rules criteria be based on successfully submitting a meaningful use attestation for Program Year 2015**	At the time of the proposed rule, April 30, 2016, was the deadline established by the federal government for the approval of an attestation to meaningful use. Since that time, CMS has announced that it will establish a new deadline, but, as of this date, has announced the new deadline. As a result, the Administration has modified the rule to reflect that the last date for an attestation for a children's hospital will be the date announced by CMS. In addition, the rule has been modified to clarify that the 2016 dates refer to the dates by which the attestation must be received and that the hospital must demonstrate implementation of Stage 2 Meaningful use during a reporting period in 2015.
17.	R9-22-712.66 (6)	Steve Kaiser 05/09/16	Phoenix Children's Hospital appreciates the support from AHCCCS in recognizing that higher acuity patients require more resources and care. This new ruling will allow Phoenix Children's Hospital to continue to provide the highest quality of care for patients with the most demanding needs.	Thank you for your support.
18.	R9-22-712.75 A	Steve Kaiser 05/09/16	Phoenix Children's Hospital supports the changes to R9-22-712.75 regarding DRG Reimbursement and Payment for Administrative Days.	Thank you for your support.
19.	General Prgh 2	Jennifer Carusetta 05/09/16	The Alliance would recommend that the Administration **utilize existing nationally recognized healthcare performance measures** when determining performance benchmarks and measuring hospital progress. As noted previously, hospitals already have systems in place to provide data in response to these measures.	Your suggestion has been noted. We will take it into consideration for CYE 2018.
20.	General Prgh 3	Jennifer Carusetta 05/09/16	It continues to be our understanding that the Value-Based Purchasing project is **intended to incentivize innovation and efficiency and shall not be used to penalize providers** who are unable to meet established benchmarks. The proposed framework establishes a good construct to continue to incentivize hospitals to transition from a payment system based on inputs, to a system based on outputs, without penalizing them for any of the infrastructure or implementation challenges they currently face.	Thank you for your support.

21.	General Prgh 4	Jennifer Carusetta 05/09/16	The proposed rules also clarify the circumstances under which hospitals may bill for Administrative Stays. We are actively engaged with Mercy Maricopa Integrated Care to identify collaborative solutions to address this issue, but very much appreciate the additional clarification on how systems may be reimbursed for these hospital stays.	Thank you for your support.
22.	General Prgh 5	Jennifer Carusetta 05/09/16	The proposed definition states that **sub-acute services** occur when the patient does not require acute inpatient hospitalization, but then goes on to state that sub-acute care shall take place immediately after an inpatient hospitalization. While we believe we understand the intent of this language, **it does appear to conflict and could lead to some confusion in its interpretation and application. For this reason, we would suggest additional clarification.**	The Administration has reviewed the definition and finds that where it states "does not require acute inpatient hospitalization" is sufficiently clear in addressing the present state of the patient's condition. Therefore no changes will be made.

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

No other matters are 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.

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

Not applicable.

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

Not applicable.

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

None

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

Not applicable.

15. The full text of the rules follows:

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-701. Definitions

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

R9-22-712.60. Diagnosis Related Group Payments

R9-22-712.61. DRG Payments: Exceptions

R9-22-712.66. DRG Service Policy Adjustor

R9-22-712.67. DRG Reimbursement: Transfers

R9-22-712.71. Final DRG Payment

R9-22-712.75. DRG Reimbursement: Payment for Administrative Days

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-701. Standard for Payments Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:

"Accommodation" means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is 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 413.20.29~~42 CFR 413.20.

"Copayment" means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.

"Cost-to-charge ratio" (CCR) means a hospital's costs for providing covered services divided by the hospital's charges for the same services. The CCR is the percentage derived from the cost and charge data for each revenue code provided to AHCCCS by each hospital.

"Covered charges" means billed charges that represent medically necessary, reasonable, and customary items of expense for covered services that meet medical review criteria of AHCCCS or a contractor.

"CPT" means Current Procedural Terminology, published and updated by the American Medical Association. CPT is a nationally-accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians that provide a uniform language to accurately designate medical, surgical, and diagnostic services.

"Critical Access Hospital" is a hospital certified by Medicare under 42 CFR 485 Subpart F and 42 CFR 440.170(g).

"Direct graduate medical education costs" or "direct program costs" means the costs that are incurred by a hospital for the education activities of an approved graduate medical education program that are the proximate result of training medical residents in the hospital, including resident salaries and fringe benefits, the portion of teaching physician salaries and fringe benefits that are related to the time spent in teaching and supervision of residents, and other related GME overhead costs.

"DRI inflation factor" means Global Insights Prospective Hospital Market Basket.

"Eligibility posting" means the date a member's eligibility information is entered into the AHCCCS Pre-paid Medical Management Information System (PMMIS).

"Encounter" means a record of a medically-related service rendered by an AHCCCS-registered provider to a member enrolled with a contractor on the date of service.

"Existing outpatient service" means a service provided by a hospital before the hospital files an increase in its charge master as defined in R9-22-712(G), regardless of whether the service was explicitly described in the hospital charge master before filing the increase or how the service was described in the charge master before filing the increase.

"Expansion funds" means funds appropriated to support GME program expansions as described under A.R.S. § ~~36-2903.01(H)(9)(b) and (c)(i)~~ 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 provide the majority of the hospital's services to children.

"GME program" means graduate medical education program as defined in ARS 36-2901(7).

"GME program approved by the Administration" or "approved GME program" means a graduate medical education program that has been approved by a national organization as described in 42 CFR 415.152.

~~"Graduate medical education (GME) program" means an approved residency program that prepares a physician for independent practice of medicine by providing didactic and clinical education in a medical environment to a medical student who has completed a recognized undergraduate medical education program.~~

"HCAC" means a health care acquired condition described under ~~42 U.S.C. 1395ww(d)(4)(D)(iv)~~ 42 CFR 447.26 but does not include Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

"HCPCS" means the Health Care Procedure Coding System, published and updated by Center for Medicare and Medicaid Services (CMS). HCPCS is a listing of codes and descriptive terminology used for reporting the provision of physician services, other health care services, and substances, equipment, supplies or other items used in health care services.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as specified under 45 CFR 162, that establishes standards and requirements for the electronic transmission of certain health information by defining code sets used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

"ICU" means the intensive care unit of a hospital.

“Indirect program costs” means the marginal increase in operating costs that a hospital experiences as a result of having an approved graduate medical education program and that is not accounted for by the hospital’s direct program costs.

“Intern and Resident Information System” means a software program used by teaching hospitals and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

“Medical education costs” means direct hospital costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, as described in the Medicare Provider Reimbursement Manual.

“Medical review” means a clinical evaluation of documentation conducted by AHCCCS or a contractor for purposes of prior authorization, concurrent review, post-payment review, or determining medical necessity. The criteria for medical review are established by AHCCCS or a contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

“Medicare Urban or Rural Cost-to-Charge Ratio (CCR)” means statewide average capital cost-to-charge ratio published annually by CMS added to the urban or rural statewide average operating cost-to-charge ratio published annually by CMS.

“National Standard code sets” means codes that are accepted nationally in accordance with federal requirements under 45 CFR 160 and 45 CFR 164.

“New hospital” means a hospital for which Medicare Cost Report claim and encounter data are not available for the fiscal year used for initial rate setting or rebasing.

“NICU” means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

“Non-IHS Acute Hospital” means a hospital that is not run by Indian Health Services, is not a free-standing psychiatric hospital, such as an IMD, and is paid under ADHS rates.

“Observation day” means a physician-ordered evaluation period of less than 24 hours to determine whether a person needs treatment or needs to be admitted as an inpatient. Each observation day consists of a period of 24 hours or less.

“Operating costs” means AHCCCS-allowable accommodation costs and ancillary department hospital costs excluding capital and medical education costs.

"OPPC" means an Other Provider Preventable Condition that is: (1) a wrong surgical or other invasive procedure performed on a patient, (2) a surgical or other invasive procedure performed on the wrong body part, or (3) a surgical or other invasive procedure performed on the wrong patient.

"Organized health care delivery system" means a public or private organization that delivers health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

"Outlier" means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described under this Article and A.R.S. § ~~36-2903.01(H)~~ 36-2903.01(G).

"Outpatient hospital service" means a service provided in an outpatient hospital setting that does not result in an admission.

"Ownership change" means a change in a hospital's owner, lessor, or operator under 42 CFR 489.18(a).

"Participating institution" means an institution at which portions of a graduate medical education program are regularly conducted and to which residents rotate for an educational experience for at least one month.

"Peer group" means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services, including specialty hospitals that limit the provision of services to specific patient populations, such as rehabilitative patients or children.

"PPC" means prior period coverage. PPC is the period of time, prior to the member's enrollment, during which a member is eligible for covered services. The time-frame is the first day of the month of application or the first eligible month, whichever is later, until the day a member is enrolled with a contractor.

"PPS bed" means Medicare-approved Prospective Payment beds for inpatient services as reported in the Medicare cost reports for the most recent fiscal year for which the Administration has a complete set of Medicare cost reports for every rural hospital as determined as of the first of February of each year.

"Procedure code" means the numeric or alphanumeric code listed in the CPT or HCPCS manual by which a procedure or service is identified.

"Prospective rates" means inpatient or outpatient hospital rates set by AHCCCS in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-party payments regardless of billed charges or individual hospital costs.

"Public hospital" means a hospital that is owned and operated by county, state, or hospital health care district.

"Qualifying health information exchange organization" means a non-profit health information organization as defined in A.R.S. § 36-3801 that provides the statewide exchange of patient health information among disparate health care organizations and providers not owned, operated, or controlled by the health information exchange. A qualifying health information exchange organization must include representation by the Administration on its board of directors, and have a significant number of health care participants, including hospitals, laboratories, payers, community physicians and Federally Qualified Health Centers.

"Rebase" means the process by which the most currently available and complete Medicare Cost Report data for a year and AHCCCS claim and encounter data for the same year are collected and analyzed to reset the Inpatient Hospital Tiered per diem rates, or the Outpatient Hospital Capped Fee-For-Service Schedule.

"Reinsurance" means a risk-sharing program provided by AHCCCS to contractors for the reimbursement of specified contract service costs incurred by a member beyond a certain monetary threshold.

"Remittance advice" means an electronic or paper document submitted to an AHCCCS-registered provider by AHCCCS to explain the disposition of a claim.

"Resident" means a physician engaged in postdoctoral training in an accredited graduate medical education program, including an intern and a physician who has completed the requirements for the physician's eligibility for board certification.

"Revenue code" means a numeric code, that identifies a specific accommodation, ancillary service, or billing calculation, as defined by the National Uniform Billing committee for UB-04 forms.

"Sub-acute services" means inpatient care for a patient with an acute illness, injury or exacerbation of a disease process when the patient does not require acute inpatient hospitalization. Sub-acute care is rendered immediately after, or instead of, acute inpatient hospitalization.

"Specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.

"Sponsoring institution" means the institution or entity that is recognized by the GME accrediting organization and designated as having ultimate responsibility for the assurance of academic quality and compliance with the terms of accreditation.

"Tier" means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure, or revenue codes, peer group, NICU classification level, or any combination of these items.

"Tiered per diem" means an AHCCCS capped fee schedule in which payment is made on a per-day basis depending upon the tier (or tiers) into which an AHCCCS inpatient hospital day of care is assigned.

"Trip" means a one-way transport each time a taxi is called. If the taxi waits for the member then the transport continues to be part of the one-way trip. If the taxi leaves and is called to pick up the member, that is considered a new one-way trip.

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 u~~U~~niversity a~~A~~ffiliated h~~H~~ospital; ~~which~~ that 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 u~~U~~niversity a~~A~~ffiliated h~~H~~ospital; ~~which~~ that 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, 2016 through September 30, 2017, 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, 2016. To qualify, a hospital providing outpatient hospital services must meet the following criteria:

1. By June 1, 2016, the hospital must have executed an agreement with and electronically submitted admission, discharge, and transfer information, as well as data from the hospital emergency department, to a qualifying health information exchange organization, and
2. No sooner than January 4, 2016, and no later than February 29, 2016, CMS must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015; or, for a children's hospital that does not participate in the medicare electronic health record incentive program, no sooner than January 4, 2016, and no later than the date established by CMS, the administration must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015.

~~**E.**~~**F.** Fee adjustments made under subsection (A), (B), (C), ~~and~~ (D), and (E) are on file with AHCCCS and current adjustments are posted on AHCCCS' web site.

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 that is described in this section and sections R9-22-712.61 through R9-22-712.81.

~~**B.**~~ Payments made using the DRG methodology shall be the sole reimbursement to the hospital for all inpatient hospital services and related supplies provided by the hospital. Services provided in the emergency room, observation area, or other outpatient departments that are directly followed by an inpatient admission to the same hospital are not reimbursed separately. ~~Are reimbursed through the DRG methodology and not reimbursed separately.~~

C. Each claim for an inpatient hospital stay shall be assigned a DRG code and a DRG relative weight based on version 31 of the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. If version 31 of the APR-DRG classification system will no longer support assigning DRG codes and relative weights to claims, and 3M Health Information Systems issues a newer version of the APR-DRG classification system using updated DRG codes and/or updated relative weights, then ~~the more current version~~ an updated version established by 3M Health Information Systems will be used; however, if the ~~newer~~ version employs updated relative weights, those weights will be adjusted using a single adjustment factor applied to all relative weights to ensure that the statewide weighted average of the updated relative weights does not increase or decrease from the statewide weighted average of the relative weights used under version 31.

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 version 31 of 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.

R9-22-712.61. DRG Payments: Exceptions.

A. Notwithstanding section R9-22-712.60, claims for inpatient services from the following hospitals shall be paid on a per diem basis, including provisions for outlier payments, where rates and outlier thresholds are included in the capped fee schedule published by the

Administration on its website and available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The outlier CCR will be the sum of the urban or rural default operating CCR appropriate to the location of the hospital and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. The resulting amount will be the total reimbursement for the claim. There is no provision for outlier payments for hospitals described under subsection (A)(3).

1. Hospitals designated as type: hospital, subtype; rehabilitation in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website in March of each year;
2. Hospitals designated as type: hospital, subtype: long term in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
3. Hospitals designated as type: hospital, subtype; psychiatric in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
4. ~~Transplant facilities to the extent the inpatient days associated with the transplant exceed the terms of the contract.~~

B. Notwithstanding section R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the ~~primary~~ principal diagnosis on the claim is a behavioral health diagnosis, shall be reimbursed as prescribed by ~~ADHS~~ a per diem rate described by a fee schedule established by the Administration; however, if the ~~primary~~ principal diagnosis is a ~~medical~~ 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~~ ~~a~~Administration and the transplant facility.

D. Notwithstanding section R9-22-712.60, claims from an ~~IHS facility or from a hospital operated as a 638 facility~~ 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. ~~A 638 facility is a hospital operated by an Indian tribe or tribal organization, as defined in 25 USC 1603, funded, in whole or part, by the IHS as provided for in a contract or compact with IHS under 25 U.S.C. §§ 450 through 458aaa-18.~~

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.

R9-22-712.66. DRG Service Policy Adjustor

In addition to subsection 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 following service policy adjustors:

1. Normal newborn DRG codes: 1.55
2. Neonates DRG codes: 1.10
3. Obstetrics DRG codes: 1.55
4. Psychiatric DRG codes: 1.65
5. Rehabilitation DRG codes: 1.65
6. ~~Claims for members under age 19 assigned DRG codes other than listed above: 1.25~~ Claims for members under age 19 assigned DRG codes other than listed above:
   a. 1.25 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. 1.25 for dates of discharge on or after January 1, 2016 for severity of illness levels 1 and 2,
   c. 1.60 for dates of discharge on or after January 1, 2016 for severity of illness levels 3 and 4.

R9-22-712.67. DRG Reimbursement: Transfers.

A. For purposes of this ~~subsection~~ Section a "transfer" means the transfer of a member from a hospital to a short-term general hospital for inpatient care, ~~to~~ a designated cancer center, ~~or~~

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.

R9-22-712.71. Final DRG Payment.

The final DRG payment is the sum of the final DRG base payment, ~~and~~ the final DRG outlier add-on payment, and the Inpatient Value Based Purchasing (VBP) Differential Adjusted Payment.

~~**A.**~~ 1. The final DRG base payment is an amount equal to the product of the covered day adjusted DRG base payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

~~**B.**~~ 2. The final DRG outlier add-on payment is an amount equal to the product of the covered day adjusted DRG outlier add-on payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

~~C.~~ 3. The factor for each hospital and for each federal fiscal year is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS administration's website and is on file for public inspection at the AHCCCS administration located at 701 E Jefferson Street, Phoenix, Arizona.

4. For inpatient services with a date of discharge from October 1, 2016 through September 30, 2017, the Inpatient VBP 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, 2016. To qualify for the Inpatient VBP Differential Adjusted Payment, a hospital providing inpatient hospital services must meet the following criteria:

   a. By June 1, 2016, the hospital must have executed an agreement with and electronically submitted admission, discharge, and transfer information, as well as data from the hospital emergency department, to a qualifying health information exchange organization, and
   b. No sooner than January 4, 2016, and no later than February 29, 2016, CMS must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015; or for a children's hospital that does not participate in the medicare electronic health record incentive program, no sooner than January 4, 2016, and no later than the date established by CMS, the Aministration must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015.

R9-22-712.75. DRG Reimbursement: Payment for Administrative Days.

~~**A.** Administrative days are days of a hospital stay in which a member does not meet criteria for an acute inpatient stay, but is not discharged because an appropriate placement outside the hospital is not available, the Administration or the contractor fail to provide for the appropriate placement outside the hospital in a timely manner, or the member cannot be safely discharged or transferred.~~

A. 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.

1. 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.
2. 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.
3. 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.

B. Administrative days do not include days when the member is awaiting appropriate placement or services that are currently available but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays.

C. 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.

E. Administrative days 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 (e.g., as nursing facility days).

Relkin, Gina

From: Ugarte, Mariaelena
Sent: Monday, May 09, 2016 4:31 PM
To: Relkin, Gina; Devlin, Matt; Silver, Shelli; Burns, Victoria; Upston, Amy; Johnson, Maureen
Subject: FW: Value-Based Purchasing
Attachments: Proposed Rule Comments 5-5-16 (Signed).docx

From: Jennifer Carusetta [mailto:jcarusetta@hsaaz.com]
Sent: Monday, May 09, 2016 4:19 PM
To: AHCCCS Rules
Subject: [Marketing Mail] Value-Based Purchasing

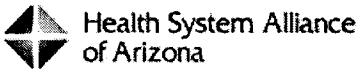
Greetings:

On behalf of the Health System Alliance of Arizona, thank you for providing us the opportunity to provide feedback on the proposed Value-Based Purchasing Differential Payment Rules. Our comments are attached.

Please do not hesitate to contact me if I can answer any questions.

Best Regards,

Jennifer A. Carusetta
Executive Director
Health System Alliance of Arizona
3200 N. Central Ave., Suite 1125
Phoenix, Arizona 85012
O: 602-296-5187
M: 602-430-6078



Health System Alliance of Arizona

June 17, 2016

Director Tom Betlach
Arizona Health Care Cost Containment System
801 E. Jefferson
Phoenix, Arizona 85034

Dear Director Betlach:

On behalf of the Health System Alliance of Arizona, I would like to commend the AHCCCS Administration for taking steps to incentivize quality, efficiency and innovation in the healthcare delivery system. As large integrated health systems, we share this vision and look forward to the opportunity to partner and identify ways to improve and lower the costs in delivering healthcare services.

The proposed rule package relating to Value-Based Purchasing Differential Payments is a positive step toward incentivizing hospitals to improve the delivery of care. As we've previously suggested, the Alliance would recommend that the Administration utilize existing nationally recognized healthcare performance measures when determining performance benchmarks and measuring hospital progress. As noted previously, hospitals already have systems in place to provide data in response to these measures.

Additionally, it continues to be our understanding that the Value-Based Purchasing project is intended to incentivize innovation and efficiency and shall not be used to penalize providers who are unable to meet established benchmarks. While all of our systems are intent in their mission to meet the goals established in this initiative, each of our systems are at different stages of the development process, specifically with regards to the implementation of electronic medical records. The proposed framework establishes a good construct to continue to incentivize hospitals to transition from a payment system based on inputs, to a system based on outputs, without penalizing them for any of the infrastructure or implementation challenges they currently face.

The proposed rules also clarify the circumstances under which hospitals may bill for Administrative Stays. Hospital holds are a continual challenge for our systems, particularly as related to pediatric and adult patients who are suffering from a behavioral health disorder. Often these patients are brought to the emergency department, and are either medically stabilized quickly, or do not require acute medical treatment. Our systems recognize the importance of moving these patients as quickly as possible into a behavioral health treatment setting. However, due to capacity challenges and system barriers between the behavioral health and medical delivery systems, these patients often cannot be discharged in a timely manner. Since these patients cannot be safely discharged, they will often be held in the emergency department for days, or even weeks, at a time. We are actively engaged with Mercy Maricopa Integrated Care

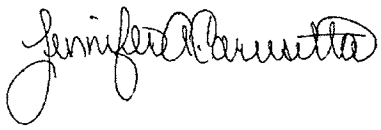
Health System Alliance of Arizona

to identify collaborative solutions to address this issue, but very much appreciate the additional clarification on how systems may be reimbursed for these hospital stays.

In addition to the comments outlined above, we would respectfully request one clarification. The proposed language defines "sub-acute" services as "comprehensive 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". The proposed definition states that sub-acute services occur when the patient does not require acute inpatient hospitalization, but then goes on to state that sub-acute care shall take place immediately after an inpatient hospitalization. While we believe we understand the intent of this language, it does appear to conflict and could lead to some confusion in its interpretation and application. For this reason, we would suggest additional clarification.

Once again, we appreciate the opportunity to provide comment and look forward to partnering with the Administration going forward.

Respectfully,



Jennifer A. Carusetta
Executive Director
Health System Alliance of Arizona

Hacienda
HEALTHCARE
In special lives, we make a difference

May 4, 2016

Ms. Mariaelena Ugarte
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Dear Ms. Ugarte:

The contents of this letter represents Hacienda HealthCare's and its affiliates, Los Niños Hospital's and Hacienda Children's Hospital's comments on the proposed rulemaking. The comments are specifically related to the:

1. "Sub-acute services" definition found at the bottom of page 13 of the Notice of Proposed Rulemaking.
2. R9-22-712.67. DRG Reimbursement Transfers – Item A found on page 20 of the Notice.
3. R9-22-712.75. DRG Reimbursement for Administrative Days – Item A.3 found on page 22 of the Notice.

Before proceeding I want to thank the AHCCCS representatives who were involved in writing these three sections. The clarity they add to the sub-acute services matter is significant.

As you are likely aware Shelli Silver, Assistant Director, DHCM, coordinated the last amendment to the DRG system. She and her colleagues addressed the negative impact the DRG system was having on our hospitals by amending both the Transfer and Administrative Day policies.

Los Niños Hospital's provision of sub-acute services to AHCCCS infants, children and teens for more than 20 years and Hacienda Children's Hospital duplicating this service in the East Valley was recognized by:

- A hospital transferring a patient to one of our hospitals would utilize the 70 Discharge Status Code rather than Discharge Status Code 03 which is described as "discharge/transfer to SNF with Medicare certification in anticipation of skilled care".
- "Administrative Days for the provision of sub-acute services shall be billed with Revenue Code 016X – Room and Board".

Ms. Silver and her colleagues distributed the Transfer and Administrative Day policy amendment information to all of the AHCCCS MCO's as well as all hospitals. However, to this day some MCO and hospital representatives remain confused. This confusion is having a significant negative impact on transfers to our hospitals. The result is that both hospitals struggle to make ends meet. The sections on which we will now comment, I believe, add the

clarity necessary to allow them, with the MCO's and hospital's support, to have a positive impact on our two hospitals and the AHCCCS infants, children and teens entrusted to our care.

1. "Sub-acute services" means comprehensive 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."

   I am pleased that "sub-acute services" is being defined. This is the type/level of care we have provided at LNH for 20+ years and are now providing at HCH. Although the care we provided was never defined, the lack of a definition was never an issue until the DRG system came along. It was then that a large AHCCCS health care plan began to question the type/level of care provided and decided that the care we provide is skilled nursing care that needs to be reimbursed at SNF rates. We pointed out that:

   - LNH and HCH are not licensed by DHS as SNF's and hold DHS issued Special Hospital – Pediatric licenses.
   - Our provider type, according to AHCCCS, is hospital not SNF.
   - The level and type of care an AHCCCS member needs and receives in a SNF is vastly different than the care provided to an AHCCCS member who needs and receives sub-acute care.

   So the question is whether the verbiage is sufficiently explicit to prevent implementation confusion. Following is my input:

   - The word "comprehensive" could mean different things to different individuals with their interpretation related to whether they work for a hospital or a health care plan. Thus, any attempt to define "comprehensive" would be difficult. For these reasons the word "comprehensive" adds no value to the definition and should be removed.
   - The phrase "instead of" is key since it supports our pursuit of direct admissions to both hospitals so we don't have to rely just on transfers from tertiary care hospitals.
   - The definition needs to include what it is not, i.e. it is not the type/level of care provided in a skilled nursing facility.

Based on the preceding information the preferred definition is, "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 but requires care at a level beyond that provided by a skilled nursing facility. Sub-acute care is rendered immediately after or instead of acute inpatient hospitalization.

2. 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."

It appears that this definition is specifically related to exempting the move of patients from tertiary care hospitals to LNH and HCH which I support. However, I believe that adding the following information from the Payment Policies manual that AHCCCS published on October 30, 2015 would add clarity which is important since we want to make sure that tertiary care hospitals are incentivized to transfer patients to LNH and HCH.

> "Clarification regarding transfers for sub-acute services: A recipient who no longer meets medical inpatient criteria may be discharged/transferred to another acute care facility without triggering a reduction to the transferring hospital via the 70 Discharge Status Code (Discharge/transfer to another type of health care institution not defined elsewhere in the code list) for the provision of sub-acute services."

3. R9-22-712.75. DRG Reimbursement: Payment for Administrative Days.

A2 "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".

The use of the term "other" in this context would seem to imply that nursing facility provides sub-acute services as defined in R9-22-701. There is a difference between the levels of care provided by skilled nursing facilities and hospitals providing sub-acute services. To avoid possible confusion I suggest restating section A2 as follows:

> "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 post-acute care setting, such as a nursing facility or a hospital providing sub-acute services."

A3 "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."

For clarity purposes I suggest that R9-22-712.75 Section E's example of "as nursing facility days" be amended to include "as sub-acute facility days".

Also, I suggest that Section E include the phrase "Administrative days will be reimbursed using a negotiated per diem rate". The reason for adding this sentence is because a number of the AHCCCS health care plans have already established their own non-negotiated Administrative day rates for nursing facilities and want us to accept these much lower rates that are not commensurate with the sub-acute level of care we provide.

My final comment is a politically sensitive one. However, the Transfer and Administrative Day policy amendments that have taken place and the three proposed sub-acute services clarifications will be for naught unless this matter is addressed. The matter is that there is no financial incentive for hospitals to transfer patients to our hospitals either under the DRG system or the per diem system. Also there is no financial incentive for the health care plans to authorize payment under the DRG system or the per diem system for patients transferred to our hospitals. The result is that many infants, children and teens who no longer need care in a tertiary care hospital are not being transferred to our hospitals. We can provide numerous on point examples should you need them.

Sincerely,

William J. Timmons
President/CEO

Cc: Board of Directors, Hacienda HealthCare
Jennefer Frost, Administrator/Director of Nursing, Hacienda Children's Hospital
Nayree Ross, Administrator/Director of Nursing, Los Niños Hospital
Tina Meredith, Director of Health Care Support Services/Contract Manager, Hacienda HealthCare
Debi Kulkay, Director of Revenue Cycle, AR, Hacienda HealthCare
Joe O'Malley, Chief Financial Officer
Nancy Salmon, Vice President Corporate Communications, Hacienda HealthCare

PHOENIX CHILDREN'S Hospital

100% FOR CHILDREN

Director Thomas J. Betlach
Office of Intergovernmental Relations
AHCCCS
801 E. Jefferson St., MD 4200
Phoenix, AZ 85034
AHCCCSRules@azahcccs.gov

Dear Director Betlach:

I write today regarding the DRG and Value Based Purchasing proposed rule that was released on March 21, 2016. Phoenix Children's Hospital appreciates the opportunity that Arizona Health Care Cost Containment System ("AHCCCS") has provided for public comment on this proposed rule. AHCCCS continuously delivers high quality medical care to the citizens of Arizona through excellent service and efficient use of taxpayer dollars. Phoenix Children's Hospital believes this proposed rule will continue in that strong tradition. Within the rule we would offer the following specific comments and proposed solutions:

R9-22-712.35 Outpatient Hospital Reimbursement: Adjustment to Fees

Section E:

1. By June 1, 2016, the hospital must have executed an agreement with and electronically submitted admission, discharge, and transfer information, as well as data from the hospital emergency department, to a qualifying health information exchange organization....

- Comment: Phoenix Children's Hospital has executed an agreement with a qualifying Health Information Exchange and currently is working through the process of exchanging data. Due to the complexity of the unique data flows in pediatrics, however, completing these processes may require more time than the proposed rule allows. Some of the challenges experienced in the pediatric context include obtaining appropriate parental consent when patients transfer in and out of foster care and the changing consent requirements as children get older. Furthermore, successful exchange of data requires all technology requirements be completed by both the Hospital and the HIE, and each Hospital is not in direct control of the timeline and priorities of a complex Health Information Exchange which must manage many clients.
- Solution: We would propose that in the first year hospitals must have an executed agreement with a qualifying Health Information Exchange and be actively engaged with the on-boarding process with the HIE. By the second year hospitals should be electronically submitting admission, discharge, and transfer information.

2. By June 1, 2016, the hospital must have CMS approval of an attestation by the hospital of Meaningful Use Stage 2 for Program Year 2015 (as described in 42 CFR 495.20) for the period of January 4, 2016 through February 29, 2016; or, for a children's hospital that does not participate in Medicare, AHCCCS approval of an attestation by the hospital of Meaningful Use Stage 2 for Program Year 2015 (as described in 42 CFR 495.20) for the period of January 4, 2016 through April 30, 2016.

- Comment: As an initial matter, there is currently no mechanism within AHCCCS to receive an attestation from an inpatient children's hospital, with the most recent direction from AHCCCS being that such a mechanism will be in place in May 2016 for submission of Program Year 2015 MU attestation. It also is unclear why attestation for program year 2015 would include data from January 2016 through April of 2016. The proposed rule also does not clarify whether a children's hospital must submit attestation of inpatient meaningful use or outpatient meaningful use.

- Solution: Phoenix Children's Hospital proposes that because of the lack of mechanism through which to submit an attestation for 2015, and since attestation for a program year cannot be filed until the following year, that this rules criteria be based on successfully submitting a meaningfull use attestation for Program Year 2015

R9-22-712.66. DRG Service Policy Adjustor

6. Claims for members under age 19 assigned DRG codes other than listed above:

a. 1.25 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. 1.25 for dates of discharge on or after January 1, 2016 for severity of illness levels 1 and 2

c. 1.60 for dates of discharge on or after January 1, 2016 for severity of illness levels 3 and 4

- Comment: Phoenix Children's Hospital appreciates the support from AHCCCS in recognizing that higher acuity patients require more resources and care. This new ruling will allow Phoenix Children's Hospital to continue to provide the highest quality of care for patients with the most demanding needs.

R9-22-712.75. DRG Reimbursement: Payment for Administrative Days

Section A:

A. 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.

1. 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.

2. 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.

3. 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.

- Comment: Phoenix Children's Hospital supports the changes to R9-22-712.75 regarding DRG Reimbursement and Payment for Administrative Days.

Phoenix Children's Hospital appreciates AHCCCS' work on behalf of Arizona families and taxpayers and thanks you for your consideration of the above comments and solutions. We look forward to a continued partnership with AHCCCS in facilitating the highest quality of care for Arizona's children.

Sincerely,

Bob Meyer
CEO, Phoenix Children's Hospital

ECONOMIC, SMALL BUSINESS AND CONSUMER IMPACT STATEMENT

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

Introduction:

The Arizona Health Care Cost Containment System (A.R.S. § 36-2901 et seq.) provides payment for medical and behavioral health services for low-income Arizonans. The system consists of a series of contracts with managed care organizations and a fee-for-service program. Under the managed care contracts, the AHCCCS Administration pays capitation on a per member per month basis to the managed care entities in return for which the managed care entity is responsible for establishing a network of contracted health care providers sufficient to meet the needs of members assigned to the managed care entity. Under the fee-for-service program, the AHCCCS Administration makes payments to health care providers directly for health services provided to eligible individuals, such as American Indians and non-qualified aliens, who are not enrolled with managed care entities. As of June 1, 2016, 1,849,578 Arizona residents were enrolled for coverage through AHCCCS. Of that total population, 236,590 have coverage though the fee-for-service program. Thus, the majority of coverage is provided through managed care contractors.

A.R.S § 36-2903.01(G) requires the AHCCCS Administration to adopt rules regarding the method by which the AHCCCS Administration will reimburse inpatient and outpatient services provided on a fee-for-service basis by hospitals that participate in the AHCCCS system. Participation is not mandatory, and health care providers that wish to participate are required to enter into provider participation agreements with the AHCCCS Administration. A.R.S. § 36-2904(D). About 116 hospitals, the majority of hospitals licensed in Arizona, have entered into provider participation agreements. Those reimbursement rules are found in 9 A.A.C. 22, Article 7, Standards for Payment. In the absence of contrary terms in the contract between a managed care entity and a hospital, the managed care entity is required to reimburse the hospital on the same terms as provided in rule for fee-for-services payments made by the AHCCCS Administration. A.A.C. R9-22-705(D).

The following summarizes the amendments in this rulemaking:

R9-22-701. Standard for Payments Related Definitions. Definitions have been added for "qualifying health information exchange organization" and "sub-acute services." The former term is used in R9-22-712.35 (outpatient hospital services) and R9-22-712.71 (inpatient hospital services) as amended by the rulemaking in relation to qualification for enhanced payments for adoption and use of a health information exchange. The latter term is used in R9-22-712.67 regarding inpatient reimbursement when a patient is transferred from one hospital to another and in R9-22-712.75 regarding reimbursement for administrative days: days when a patient does not meet the criteria for an acute inpatient stay, but is admitted or not discharged from the hospital 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. In addition, this section has been amended to update cross references within various definitions to reflect current legal references.

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees. This provision has been amended to include an upward adjustment to payments made for outpatient hospital services rendered between October 1, 2016 and September 30, 2017, for hospitals that have entered into an agreement with a qualifying health information exchange and that have demonstrated "meaningful use" of that exchange as defined in the federal Electronic Health Information Exchange Incentive Payment program. Under that federal program, hospitals receive supplemental payments from the Medicaid or Medicare programs for the cost of adoption and using of a health information exchange. This rulemaking provides additional payments for services rendered using such an exchange.

R9-22-712.60 Diagnosis Related Group Payments. – This provision has been amended to clarify the method by with the Administration will pay for inpatient services. Part of the diagnosis related group (DRG) payment methodology involves classifying inpatient hospital claims using a proprietary classification system. That classification system is updated by a third party that owns the system from time to time. The current rule language specifies that the Administration will use the "most current version" of the classification system. However,

employing a newer version of the system requires corresponding changes to the payment systems employed by the Administration, managed care entities, and hospitals. It is possible that the third party will update the system more frequently or more rapidly than is prudent for the AHCCCS system to adopt given corresponding costs to modify payment systems. Amending the rule to permit the use of "an updated version" rather than "the most current version" gives the AHCCCS Administration the flexibility to update the classification system on a timetable that takes into consideration the cost to the AHCCCS Administration, managed care contractors, and hospitals associated with system modifications that arise from an update of the classification system.

R9-22-712.61. DRG Payments: Exceptions. Subsections (A)(4) and (E) have been amended to clarify that reimbursements to hospitals for services associated with transplants are not paid using the DRG payment methodology but are paid under specialty contracts between the transplant facilities and the AHCCCS Administration. Under the terms of those contracts, managed care entities are also permitted to purchase transplant services on those terms. Subsection (B) has been amended to clarify that the "principal" diagnosis is used to identify the payment responsibility for both physical and behavioral health claims. The term used in the current rule, "primary," is not the standard term used in the completion of inpatient hospital claims. In addition, this subsection has been amended to reflect that the fee schedule for the payment of behavioral health claims is established by the AHCCCS Administration since responsibility for that system has been legislatively transferred from the Arizona Department of Health Services. Subsection (D) was amended to use the appropriate term for facilities operated by tribal governments or organizations under an agreement with the Indian Health Service.

R9-22-712.66. DRG Service Policy Adjuster. Under the DRG payment methodology, multipliers are applied to certain types of claims to account for differing costs associated with the types of inpatient stays and certain types of patients. For instance, the current rule applies an adjustment for pediatric admissions. This rule refines that adjustment by applying different modifiers to pediatric claims depending on the severity level of the services.

R9-22-712.67. DRG Reimbursement: Transfers. This rule was amended to exclude the transfer of a patient from one hospital to another for the purpose of receiving sub-acute services from the reimbursement rule otherwise applicable to transfers.

R9-22-712.71. Final DRG Payment. This provision has been amended to include an upward adjustment to payments made for inpatient hospital discharges between October 1, 2016 and September 30, 2017, for hospitals that have entered into an agreement with a qualifying health information exchange and that have demonstrated "meaningful use" of that exchange as defined in the federal Electronic Health Information Exchange Incentive Payment program. Under that federal program, hospitals receive supplemental payments from the Medicaid or Medicare programs for the cost of adopting and using of a health information exchange. This rulemaking provides additional payments for services rendered using such an exchange.

R9-22-712.75. DRG Reimbursement: Payment for Administrative Days. This rule was amended to clarify what is reimbursed as an Administrative day. The amended rule clarifies that an administrative day can occur prior to or following an acute episode and delineates three specific instances that qualify for reimbursement as administrative days: (1) admission for a high-risk pregnancy while awaiting delivery, (2) days in a hospital while awaiting placement in a nursing facility or other sub-acute setting, (3) days in a receiving hospital providing sub-acute services.

As required by A.R.S. § 41-1055(B), the AHCCCS Administration provides the following:

1. Identification of rulemaking.

a. The conduct and its frequency of occurrence that the rule is designed to change:

The rulemaking amends the methodology for reimbursement by the AHCCCS Administration for health care services provided by hospitals that have entered into participation agreements with the AHCCCS Administration. As such, the rulemaking does not regulate the conduct of the public or any segment of the public and is not designed to change any particular conduct. In part, the rulemaking provides increased payments to hospitals that have implemented electronic medical records systems and that

participated in a health information exchange. Those activities are expected to improve patient care and safety and to reduce unnecessary health care spending such as on duplicate imaging and testing. These increased payments may have the effect of encouraging health care providers to engage in other health care delivery system changes that will foster improved patient care and reduced costs.

b. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:

The rulemaking amends the methodology for reimbursement by the AHCCCS Administration for health care services provided by hospitals that have entered into participation agreements with the AHCCCS Administration. As such, the rulemaking does not regulate the conduct of the public or any segment of the public and is not designed to change any particular conduct or to reduce any particular harm.

c. The estimated change in frequency of the targeted conduct expected from the rule change:

The rulemaking amends the methodology for reimbursement by the AHCCCS Administration for health care services provided by hospitals that have entered into participation agreements with the AHCCCS Administration. As such, the rulemaking does not regulate the conduct of the public or any segment of the public and is not designed to change any particular conduct.

2. Identification of the persons who will be directly affected by, bear the costs of, or directly benefit from the rule making.

- The AHCCCS Administration will fund the cost of the increased payments from existing legislative appropriations for the program.
- Managed care entities that contract with the AHCCCS Administration will likely incur increased expenditures for hospital services under the terms of the contracts between hospitals and those managed care entities because many of those payment terms refer to the AHCCCS fee-for-service payment methodology. The increased cost to managed care entities will be offset by appropriate adjustments to the capitation payments made to the managed care entities by the AHCCCS Administration.
- Hospitals that participate in a health information exchange and/or that provide services to high-acuity pediatric patients will benefit from the rulemaking.

- Members receiving services from hospitals that establish electronic health records and participate in health information exchanges with benefit from better patient care.

3. Cost benefit analysis.

a. Probable costs and benefits to 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 (JLBC) of the number of new full-time employees necessary to implement and enforce the rule before the rule is approved by the council:

i. Cost: The Administration expects to make approximately $3.6 million more in payments to 19 hospitals that participate in a health information exchange for services provided between October 1, 2016 and September 30, 2017. The Administration expects to make approximately $19.4 million more in payments annually to 53 hospitals that provide care to high-acuity pediatric patients. The Administration does not anticipate that this rulemaking will create costs or benefits for other state agencies.

ii. Benefit: The Medicaid Act (specifically, 42 U.S.C. § 1396a(a)(30)(A)) requires the AHCCCS Administration to establish methods for payment that are consistent with efficiency, economy, quality of care and access to care. This rulemaking is intended to demonstrate some of the methodology employed by the Administration to comply with that federal requirement. The Administration does not anticipate that this rulemaking will create costs or benefits for other state agencies.

iii. Do any Full-time Employees need to be hired? The Administration does not anticipate the need to hire full-time employees as a result of the proposed rule changes.

b. Probable costs and benefits to political subdivision of the state directly affected by the implementation and enforcement of the proposed rulemaking.

The Administration does not anticipate that this rulemaking will create costs or benefits for political subdivisions of the state.

c. 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 businesses directly affected are hospitals that will receive the additional payments as described in paragraph 3.a. above. The AHCCCS Administration does not expect this rulemaking to impose any costs on hospitals.

4. General description of the probable impact on private and public employment in businesses, agencies, and political subdivisions of this state directly affected by the rulemaking.

The Administration does not anticipate any impact on private or public employment as the result of this rulemaking.

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.

According to the 2014 Uniform Accounting Reports filed by hospitals, seventeen AHCCCS-contracted hospitals have less than 100 employees, and three AHCCCS-contracted hospitals had 2014 revenues less than $4 million. None of the managed care entities under contract with the AHCCCS Administration are small businesses as defined in A.R.S. § 41-1001.

b. Administrative and other costs required for compliance with the proposed rulemaking.

Hospitals often have systems that emulate the claims payment systems of payers so that the hospital can estimate revenues. The rulemaking may require those hospitals to modify those systems; however, the AHCCCS Administration does not anticipate that those efforts will require hospitals to incur costs outside of normal operating expenses.

c. Description of methods prescribed in section A.R.S. § 41-1035 that the agency may use to reduce the impact on small businesses, with reasons for the agency's decision to use or not use each method:

i. Establishing less stringent compliance or reporting requirements in the rule for small businesses;

This rulemaking does not impose compliance or reporting requirements on any small businesses.

ii. Establishing less stringent schedule deadlines in the rule for compliance or reporting requirements for small businesses;

This rulemaking does not impose compliance or reporting requirements on any small businesses. As such, it does not establish any deadlines for compliance or reporting.

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

This rulemaking does not impose compliance or reporting requirements on any small businesses. As such, there are no requirements to simplify or consolidate.

iv. Establish performance standards for small businesses to replace design or operational standards in the rule; and

This rulemaking does not establish performance standards for any small businesses.

v. Exempting small businesses from any or all requirements of the rule.

This rulemaking does not impose any requirements on any small businesses.

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

This rulemaking does not directly affect private persons or consumers.

6. Statement of the probable effect on state revenues.

The rulemaking is not expected to affect state revenues.

7. Description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking, including the monetizing of the costs and benefits for each option and providing the rationale for not using nonselected alternatives.

The Administration did not consider other alternatives because the changes are the most cost effective and efficient method of complying with federal and state requirements.

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 Administration did not consider any data to base the rule upon.

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:
The rules are not more stringent than federal law, The rules comply with federal law. 42 U.S.C. 1396a(a)(30)(A)

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:
R9-22-703(A) – 42 CFR 431.107(b).

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 2. SCOPE OF SERVICES

Section
R9-22-204. Inpatient General Hospital Services

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-701. Standard for Payments Related Definitions
R9-22-703. Payments by the Administration
R9-22-705. Payments by Contractors
R9-22-708. Payments for Services Provided to Eligible ~~Native Americans~~ American Indians
R9-22-712. Reimbursement: General
R9-22-712.01. Inpatient Hospital Reimbursement for claims with admission dates and discharge dates from October 1, 1998 through September 30, 2014
R9-22-712.09. Hierarchy for Tier Assignment through September 30, 2014
R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update
R9-22-712.45. Outpatient Hospital Reimbursement: Outpatient Payment Restrictions
R9-22-712.60. Diagnosis Related Group Payments
R9-22-712.61. DRG Payments: Exceptions
R9-22-712.62. DRG Base Payment
R9-22-712.63. DRG Base Payments Not Based on the Statewide Standardized Amount
R9-22-712.64. DRG Base Payments and Outlier CCR for Out-of-State Hospitals
R9-22-712.65. DRG Provider Policy Adjustor
R9-22-712.66. DRG Service Policy Adjustor
R9-22-712.67. DRG Reimbursement: Transfers
R9-22-712.68. DRG Reimbursement: Unadjusted Outlier Add-on Payment
R9-22-712.69. DRG Reimbursement: Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment
R9-22-712.70. Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment for FES members
R9-22-712.71. Final DRG Payment
R9-22-712.72. DRG Reimbursement: Enrollment Changes During an Inpatient Stay
R9-22-712.73. DRG Reimbursement: Inpatient Stays for Members Eligible for Medicare
R9-22-712.74. DRG Reimbursement: Third Party Liability
R9-22-712.75. DRG Reimbursement: Payment for Administrative Days

R9-22-712.76. DRG Reimbursement: Interim Claims
R9-22-712.77. DRG Reimbursement: Admissions and Discharges on the Same Day
R9-22-712.78. DRG Reimbursement: Readmissions
R9-22-712.79. DRG Reimbursement: Change of Ownership
R9-22-712.80. DRG Reimbursement: New Hospitals
R9-22-712.81. DRG Reimbursement: Updates
R9-22-715. Hospital Rate Negotiations
R9-22-718. Urban Hospital Inpatient Reimbursement Program

ARTICLE 2. SCOPE OF SERVICES

R9-22-204. Inpatient General Hospital Services

~~A. A contractor, fee-for-service provider or noncontracting provider shall render inpatient general hospital services including:~~
~~1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:~~
~~a. Maternity care, including labor, delivery, and recovery room, birthing center, and newborn nursery;~~
~~b. Neonatal intensive care unit (NICU);~~
~~c. Intensive care unit (ICU);~~
~~d. Surgery, including surgery room and recovery room;~~
~~e. Nursery and related services;~~
~~f. Routine care; and~~
~~g. Emergency behavioral health services provided under Article 12 of this Chapter for a member eligible under A.R.S. § 36-2901(6)(a).~~
~~2. Ancillary services as specified by the Director and included in contract:~~
~~a. Laboratory services;~~
~~b. Radiological and medical imaging services;~~
~~c. Anesthesiology services;~~
~~d. Rehabilitation services;~~
~~e. Pharmaceutical services and prescription drugs;~~
~~f. Respiratory therapy;~~
~~g. Blood and blood derivatives; and~~
~~h. Central supply items, appliances, and equipment that are not ordinarily furnished to all patients and customarily reimbursed as ancillary services.~~

~~B.~~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.

~~C.~~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 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.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-701. Standard for Payments Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:

"Accommodation" means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is 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.

"CPT" means Current Procedural Terminology, published and updated by the American Medical Association. CPT is a nationally-accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians that provide a uniform language to accurately designate medical, surgical, and diagnostic services.

"Critical Access Hospital" is a hospital certified by Medicare under 42 CFR 485 Subpart F and 42 CFR 440.170(g).

"Direct graduate medical education costs" or "direct program costs" means the costs that are incurred by a hospital for the education activities of an approved graduate medical education program that are the proximate result of training medical residents in the hospital, including resident salaries and fringe benefits, the portion of teaching physician salaries and fringe benefits that are related to the time spent in teaching and supervision of residents, and other related GME overhead costs.

"DRI inflation factor" means Global Insights Prospective Hospital Market Basket.

"Eligibility posting" means the date a member's eligibility information is entered into the AHCCCS Pre-paid Medical Management Information System (PMMIS).

"Encounter" means a record of a medically-related service rendered by an AHCCCS-registered provider to a member enrolled with a contractor on the date of service.

"Existing outpatient service" means a service provided by a hospital before the hospital files an increase in its charge master as defined in R9-22-712(G), regardless of whether the service was explicitly described in the hospital charge master before filing the increase or how the service was described in the charge master before filing the increase.

"Expansion funds" means funds appropriated to support GME program expansions as described under A.R.S. § ~~36-2903.01(H)(9)(b) and (c)(i)~~ 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 provide the majority of the hospital's services to children.

"GME program approved by the Administration" or "approved GME program" means a graduate medical education program that has been approved by a national organization as described in 42 CFR 415.152.

"Graduate medical education (GME) program" means an approved residency program that prepares a physician for independent practice of medicine by providing didactic and clinical education in a medical environment to a medical student who has completed a recognized undergraduate medical education program.

"HCAC" means a condition described under 42 U.S.C. 1395ww(d)(4)(D)(iv) but does not include Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

"HCPCS" means the Health Care Procedure Coding System, published and updated by Center for Medicare and Medicaid Services (CMS). HCPCS is a listing of codes and descriptive terminology used for reporting the provision of physician services, other health care services, and substances, equipment, supplies or other items used in health care services.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as specified under 45 CFR 162, that establishes standards and requirements for the electronic transmission of certain health information by defining code sets used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

"ICU" means the intensive care unit of a hospital.

"Indirect program costs" means the marginal increase in operating costs that a hospital experiences as a result of having an approved graduate medical education program and that is not accounted for by the hospital's direct program costs.

"Intern and Resident Information System" means a software program used by teaching hospitals and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

"Medical education costs" means direct hospital costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, as described in the Medicare Provider Reimbursement Manual.

"Medical review" means a clinical evaluation of documentation conducted by AHCCCS or a contractor for purposes of prior authorization, concurrent review, post-payment review, or determining medical necessity. The criteria for

medical review are established by AHCCCS or a contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

"Medicare Urban or Rural Cost-to-Charge Ratio (CCR)" means statewide average capital cost-to-charge ratio published annually by CMS added to the urban or rural statewide average operating cost-to-charge ratio published annually by CMS.

"National Standard code sets" means codes that are accepted nationally in accordance with federal requirements under 45 CFR 160 and 45 CFR 164.

"New hospital" means a hospital for which Medicare Cost Report claim and encounter data are not available for the fiscal year used for initial rate setting or rebasing.

"NICU" means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

"Non-IHS Acute Hospital" means a hospital that is not run by Indian Health Services, is not a free-standing psychiatric hospital, such as an IMD, and is paid under ADHS rates.

"Observation day" means a physician-ordered evaluation period ~~of less than 24 hours~~ to determine whether a person needs treatment or needs to be admitted as an inpatient. Each observation day consists of a period of 24 hours or less.

"Operating costs" means AHCCCS-allowable accommodation costs and ancillary department hospital costs excluding capital and medical education costs.

"OPPC" means an Other Provider Preventable Condition that is: (1) a wrong surgical or other invasive procedure performed on a patient, (2) a surgical or other invasive procedure performed on the wrong body part, or (3) a surgical or other invasive procedure performed on the wrong patient.

"Organized health care delivery system" means a public or private organization that delivers health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

"Outlier" means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described under this Article and A.R.S. § ~~36-2903.01(H)~~ 36-2903.01(G).

"Outpatient hospital service" means a service provided in an outpatient hospital setting that does not result in an admission.

"Ownership change" means a change in a hospital's owner, lessor, or operator under 42 CFR 489.18(a).

"Participating institution" means an institution at which portions of a graduate medical education program are regularly conducted and to which residents rotate for an educational experience for at least one month.

"Peer group" means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services, including specialty hospitals that limit the provision of services to specific patient populations, such as rehabilitative patients or children.

"PPC" means prior period coverage. PPC is the period of time, prior to the member's enrollment, during which a member is eligible for covered services. The time-frame is the first day of the month of application or the first eligible month, whichever is later, until the day a member is enrolled with a contractor.

"PPS bed" means Medicare-approved Prospective Payment beds for inpatient services as reported in the Medicare cost reports for the most recent fiscal year for which the Administration has a complete set of Medicare cost reports for every rural hospital as determined as of the first of February of each year.

"Procedure code" means the numeric or alphanumeric code listed in the CPT or HCPCS manual by which a procedure or service is identified.

"Prospective rates" means inpatient or outpatient hospital rates set by AHCCCS in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-party payments regardless of billed charges or individual hospital costs.

"Public hospital" means a hospital that is owned and operated by county, state, or hospital health care district.

"Rebase" means the process by which the most currently available and complete Medicare Cost Report data for a year and AHCCCS claim and encounter data for the same year are collected and analyzed to reset the Inpatient Hospital Tiered per diem rates, or the Outpatient Hospital Capped Fee-For-Service Schedule.

"Reinsurance" means a risk-sharing program provided by AHCCCS to contractors for the reimbursement of specified contract service costs incurred by a member beyond a certain monetary threshold.

"Remittance advice" means an electronic or paper document submitted to an AHCCCS-registered provider by AHCCCS to explain the disposition of a claim.

"Resident" means a physician engaged in postdoctoral training in an accredited graduate medical education program,

including an intern and a physician who has completed the requirements for the physician's eligibility for board certification.

"Revenue code" means a numeric code, that identifies a specific accommodation, ancillary service, or billing calculation, as defined by the National Uniform Billing committee for ~~UB-92~~ UB-04 forms.

"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.

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 ~~March 6, 1992~~ 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 or electronic claim to be submitted on the date that it is received by the Administration. 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 IHS 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, ~~and~~ 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, ~~a different~~ the service, or level of care was not medically appropriate, the Administration shall adjust the claim payment, ~~to pay for the cost of the appropriate level of care~~.

E. Review of claims and coverage for hospital supplies.
1. The Administration may conduct prepayment and postpayment 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 ~~R9-22-102~~ 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.

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 ~~an admission date on or after March 1, 1993~~, 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).

E. 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.

~~E.~~G. Payment for in-state outpatient hospital services.

1. ~~A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after March 1, 1993 through June 30, 2005, at either a rate specified by a subcontract that complies with R9-22-715(A) or, in absence of a subcontract, as described in R9-22-712 or under A.R.S. § 36-2903.01. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.~~
2. 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.

~~F. Inpatient and 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 inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b). 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 state-wide outpatient cost-to-charge ratio.~~

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.

~~G.~~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. ~~An "observation day" means a physician-ordered evaluation period of less than 24 hours to determine the need of treatment or the need for admission as an inpatient.~~

~~H.~~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 post-payment 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 a specific level of care, but medical review of a claim indicates that a different level of care was medically appropriate, a contractor shall adjust the claim to pay for the cost for the appropriate level of care. An adjustment in payment for a different level of care is effective on the date when the different level of care is medically appropriate.~~
   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 ~~R9-22-102~~ 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.

~~I.~~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.

~~J.~~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.

~~K.~~M. Interest payment. In addition to the requirements in subsection ~~(J)~~ (L), a contractor shall pay interest for late claims as defined by contract.

~~L.~~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.

R9-22-708. Payments for Services Provided to Eligible ~~Native Americans~~ American Indians

A. For purposes of this Article "IHS enrolled" or "enrolled with IHS" means ~~a Native American~~ an American Indian who has elected to receive covered services through IHS instead of a contractor.

B. For ~~a Native American~~ 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 Chapter 29, Article 3 of this Title.

C. When IHS refers ~~a Native American~~ 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 ~~a Native American~~ an American Indian enrolled with a contractor, AHCCCS shall pay the contractor a monthly capitation payment.
E. Once ~~a Native American~~ an American Indian enrolls with a contractor, AHCCCS shall not reimburse any provider other than IHS or a Tribal facility.

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(H)(4)~~ 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(H)(5)~~ 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 ~~state-wide~~ statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(d). ~~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 state-wide outpatient cost-to-charge ratio.~~
   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. ~~If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more appropriate level of care, effective on the date when the different level of care was medically appropriate.~~
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 eli-

gible 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.

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 ~~with admissions on and after October 1, 1998~~ 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 appropriate to the services rendered. The rate for a tier is referred to as the tiered per diem rate of reimbursement. The number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier claims, transplant claims, or payment to out-of-state hospitals, freestanding psychiatric hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.

1. Tier rate data. The Administration shall base tiered per diem rates effective on and after October 1, 1998 on Medicare Cost Reports for Arizona hospitals for the fiscal year ending in 1996 and a database consisting of inpatient hospital claims and encounters for dates of service matching each hospital's 1996 fiscal year end.
   a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation, the Administration shall inflate all the costs to a common point in time as described in subsection (2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than one hospital, the Administration shall allocate the costs to each of the respective hospitals. A hospital shall submit information to assist the Administration in this allocation.
   b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed for rates effective on and after October 1, 1998. The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude from the database or adjust claims and encounters that fail these edits. The Administration shall also exclude from the database the following claims and encounters:
      i. Those missing information necessary for the rate calculation,
      ii. Medicare crossovers,
      iii. Those submitted by freestanding psychiatric hospitals, and
      iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.
2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on the sum of the operating and capital components. The rate for the operating component is a statewide rate for each tier except for the NICU and Routine tiers, which are based on peer groups. The rate for the capital component is a blend of statewide and hospital-specific values, as described in A.R.S. § 36-2903.01. The Administration shall use the following methodologies to establish the rates for each of these components.
   a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the Administration shall compute the rate for the operating component as follows:
      i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.
      ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports are grouped. The ancillary department cost-to-charge ratios for a particular hospital are multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters are multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day do not include medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1996, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs. The Administration shall further inflate operating costs to the midpoint of the rate year (March 31, 1999).
      iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these. For the NICU tier, the Administration shall further assign claims and encounters to NICU Level II or NICU Level III peer groups, based on the hospital's certification by the Arizona Perinatal Trust. For the Routine tier, the Administration shall further assign claims and encounters to the general acute care hospital or rehabilitation hospital peer groups, based on state licensure by the Department of Health Services. For claims and encounters assigned to more than one tier, the Administration shall allocate ancillary department costs to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (6).
      iv. Operating rate calculation. The Administration shall set the rate for the operating component for each tier by dividing total statewide or peer group hospital costs identified in this subsection within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that

tier.

b. Capital component. For rates effective October 1, 1999 the capital component is calculated as described in A.R.S. § 36-2903.01.

c. Statewide inpatient hospital cost-to-charge ratio. For dates of service prior to October 1, 2007, the statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, as described in subsections (4), (5), and (6), and out-of-state hospitals, as described in R9-22-712(B). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (1) and used to determine the tiered per diem rates. For each hospital, the covered inpatient days of care on the claims and encounters are multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters are multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital are determined in the same way described in subsection (2)(a) but include costs for operating and capital. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.

d. Unassigned tiered per diem rates. If a hospital has an insufficient number of claims to set a tiered per diem rate, the Administration shall pay that hospital the statewide average rate for that tier.

3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure, or revenue codes, peer group, NICU classification level, or a combination of these.

a. Tier hierarchy. In assigning claims for AHCCCS inpatient hospital days of care to a tier, the Administration shall follow the Hierarchy for Tier Assignment through September 30, 2014 in R9-22-712.09. The Administration shall not pay a claim for inpatient hospital services unless the claim meets medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that are submitted by the hospital.

b. Tier exclusions. The Administration shall not assign to a tier or pay AHCCCS inpatient hospital days of care that do not occur during a period when the person is eligible. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. The Administration shall pay same day admit and discharge claims that qualify for either the maternity or nursery tiers based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.

c. Seven tiers. The seven tiers are:

i. Maternity. The Administration shall identify the Maternity Tier by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the Administration shall pay the AHCCCS inpatient hospital days of care on the claim at the maternity tiered per diem rate.

ii. NICU. The Administration shall identify the NICU Tier by a revenue code. A hospital does not qualify for the NICU tiered per diem rate unless the hospital is classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier and have a NICU revenue code at the NICU tiered per diem rate. The Administration shall pay any remaining AHCCCS inpatient hospital day on the claim that does not meet NICU Level II or NICU Level III medical review criteria at the nursery tiered per diem rate.

iii. ICU. The Administration shall identify the ICU Tier by a revenue code. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that 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. ~~As described in R9-22-716, if~~ 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.

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

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.

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.

R9-22-712.60 Diagnosis Related Group Payments

A. Inpatient hospital services with discharge dates on or after October 1, 2014, shall be reimbursed using the diagnosis related group (DRG) payment methodology described in this section and sections R9-22-712.61 through R9-22-712.81.

B. Payments made using the DRG methodology shall be the sole reimbursement to the hospital for all inpatient hospital services and related supplies provided by the hospital. Services provided in the emergency room, observation area, or other outpatient departments that are directly followed by an inpatient admission to the same hospital are not reimbursed separately. Are reimbursed through the DRG methodology and not reimbursed separately.

C. Each claim for an inpatient hospital stay shall be assigned a DRG code and a DRG relative weight based on version 31 of the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. If version 31 of the APR-DRG classification system will no longer support assigning DRG codes and relative weights to claims, and 3M Health Information Systems issues a newer version of the APR-DRG classification system using updated DRG codes and/or updated relative weights, then the more current version established by 3M Health Information Systems will be used; however, if the newer version employs updated relative weights, those weights will be adjusted using a single adjustment factor applied to all relative weights to ensure that the statewide weighted average of the updated relative weights does not increase or decrease from the statewide weighted average of the relative weights used under version 31.

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 version 31 of 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.

R9-22-712.61. DRG Payments: Exceptions

A. Notwithstanding section R9-22-712.60, claims for inpatient services from the following hospitals shall be paid on a per diem basis, including provisions for outlier payments, where rates and outlier thresholds are included in the capped fee schedule published by the Administration on its website and available for inspection during normal business hours at 701 E. Jefferson St., Phoenix, AZ. 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;
4. Transplant facilities to the extent the inpatient days associated with the transplant exceed the terms of the contract.

B. Notwithstanding section R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the primary diagnosis is a behavioral health diagnosis, shall be reimbursed as prescribed by ADHS; however, if the primary diagnosis is a medical 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 from a hospital operated as a 638 facility 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. A 638 facility is a hospital operated by an Indian tribe or tribal organization, as defined in 25 USC 1603, funded, in whole or part, by the IHS as provided for in a contract or compact with IHS under 25 U.S.C. §§ 450 through 458aaa-18.

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, where the standardized amount is $5,295.40, and the hospital's labor share and the hospital's wage index are those used in the Medicare inpatient prospective payment system for the fiscal year beginning October 1, 2013.

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.

R9-22-712.63. DRG Base Payments Not Based on the Statewide Standardized Amount

Notwithstanding section R9-22-712.62, the amount of $3,436.08 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.

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 $5,184.75.

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, 2010.

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.

R9-22-712.65. DRG Provider Policy Adjustor

A. After calculating the DRG base payment as required in sections R9-22-712.62, R9-22-712.63, or R9-22-712.64, for claims from a high-utilization hospital, the product of the DRG base rate and the DRG relative weight for the post-HCAC DRG code shall be multiplied by a provider policy adjustor of 1.055.

B. A hospital is a high-utilization hospital if the hospital had:
1. At least 46,112 AHCCCS-covered inpatient days using adjudicated claim and encounter data during the fiscal year beginning October 1, 2010, which is equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals of 11,528 days; and,
2. A Medicaid inpatient utilization rate greater than 30% calculated as the ratio of AHCCCS-covered inpatient days to total inpatient days as reported in the hospital's Medicare Cost Report for the fiscal year ending 2011.

R9-22-712.66. DRG Service Policy Adjustor

In addition to subsection 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 following service policy adjustors:
1. Normal newborn DRG codes: 1.55
2. Neonates DRG codes: 1.10
3. Obstetrics DRG codes: 1.55
4. Psychiatric DRG codes: 1.65
5. Rehabilitation DRG codes: 1.65
6. Claims for members under age 19 assigned DRG codes other than listed above: 1.25

R9-22-712.67. DRG Reimbursement: Transfers

A. For purposes of this subsection a "transfer" means the transfer of a member from a hospital to a short-term general hospital for inpatient care, to a designated cancer center or children's hospital, or a critical access hospital.

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.

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 1st 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 is $5,000 for critical access hospitals and $65,000 for all other hospitals.

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 is 90% for claims assigned DRG codes associated with the treatment of burns and 80% for all other claims.

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 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.

R9-22-712.70. Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment for FES members

In addition to the covered day reduction factor in R9-22-712.69, a covered day reduction factor unadjusted is determined for an inpatient stay during which an FES member receives services for the treatment of an emergency medical condition and also receives services once the condition no longer meets the criteria as an emergency medical condition described in R9-22-217.

1. A covered day reduction factor unadjusted is calculated by adding one to the AHCCCS covered days and dividing the result by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of inpatient days during which an FES member receives services for an emergency medical condition as described in R9-22-217. For purposes of this adjustment, any portion of a day during which the FES member receives treatment for an emergency medical condition is counted as an AHCCCS covered day.
2. If the covered day reduction factor unadjusted is greater than one, then the covered day reduction factor final is one; otherwise, the covered day reduction factor final is equal to the covered day reduction factor unadjusted.
3. The covered day adjusted DRG base payment is an amount equal to the product of the unadjusted DRG base payment and the covered day reduction factor final.
4. The covered day adjusted DRG outlier add-on payment is an amount equal to the product of the unadjusted DRG outlier add-on payment and the covered day reduction factor final.

R9-22-712.71. Final DRG Payment

A. The final DRG payment is the sum of the final DRG base payment and the final DRG outlier add-on payment. The final DRG base payment is an amount equal to the product of the covered day adjusted DRG base payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

B. The final DRG outlier add-on payment is an amount equal to the product of the covered day adjusted DRG outlier add-on payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition

from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

C. The factor for each hospital and for each federal fiscal year is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS administration's website and is on file for public inspection at the AHCCCS administration located at 701 E. Jefferson St., Phoenix, AZ.

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. The claim may include all surgical procedures performed during the entire inpatient stay, but the hospital shall only include revenue codes, service units, and charges for services performed on or after the date of enrollment.

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.

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.

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.

R9-22-712.75. DRG Reimbursement: Payment for Administrative Days

A. Administrative days are days of a hospital stay in which a member does not meet criteria for an acute inpatient stay, but is not discharged because an appropriate placement outside the hospital is not available, the Administration or the contractor fail to provide for the appropriate placement outside the hospital in a timely manner, or the member cannot be safely discharged or transferred.

B. Administrative days do not include days when the member is awaiting appropriate placement or services that are currently available but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays.

C. 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.

E. Administrative days 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 (e.g., as nursing facility days).

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.

R9-22-712.77. DRG Reimbursement: Admissions and Discharges on the Same Day

A. Except as provided for in subsection (B), for any claim for inpatient services with an admission date and discharge date that are the same calendar date, the contractor or the Administration shall process the claim as an outpatient claim and the hospital shall be reimbursed under R9-22-712.10 through R9-22-712.50.

B. Claims with an admission date and discharge date that are the same calendar date that also indicate that the member expired on the date of discharge shall be reimbursed under the DRG methodology.

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, which 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. Fee adjustments made under subsection (A), (B), (C) and (D) are on file with AHCCCS and current adjustments are 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 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).

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

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.

G-1

ARIZONA STATE BOARD OF COSMETOLOGY (F-16-0410)

Title 4, Chapter 10, Article 1, General Provisions; Article 2, Schools; Article 3, Students; Article 4, Salons

GOVERNOR'S REGULATORY REVIEW COUNCIL
ANALYSIS OF FIVE-YEAR REVIEW REPORT

MEETING DATE: August 2, 2016 **AGENDA ITEM: G-1**

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

FROM: Chris Kleminich, Staff Attorney

DATE: July 15, 2016

SUBJECT: **ARIZONA STATE BOARD OF COSMETOLOGY (F-16-0410)**
Title 4, Chapter 10, Article 1, General Provisions; Article 2, Schools; Article 3, Students; Article 4, Salons

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COMMENTS ON THE FIVE-YEAR-REVIEW REPORT

Purpose of the Agency and Number of Rules in the Report

The purpose of the Board of Cosmetology (Board) is "to ensure that the public is protected from the incompetent practice of cosmetology by establishing minimum qualifications for entry into the profession and swift and effective discipline for those practitioners who violate cosmetology statutes or rules adopted pursuant to those statutes." Laws 2014, Ch. 247, § 12.

The Board issues licenses to cosmetologists, nail technologists, aestheticians, cosmetology instructors, nail technology instructors, aesthetician instructors, cosmetology salons, nail technology salons, aesthetic salons, cosmetology schools, nail technology schools, and aesthetic schools. This five-year-review report covers 35 rules in A.A.C. Title 4, Chapter 10. The rules, as written, have become effective at various times between 1996 and 2015.

Article Contents

Article 1 contains fifteen rules addressing general provisions, including fees and licensing time-frames.

Article 2 contains nine rules addressing schools, including license applications and requirements for various types of schools.

Article 3 contains six rules addressing students, including instruction and curriculum requirements.

Article 4 contains five rules addressing salons, including license applications and minimum equipment requirements.

Proposed Action

The Board intends to amend all of its rules by December 31, 2017 to address issues identified in the report and to generally make the rules more clear, concise, and understandable.

Substantive or Procedural Concerns

None.

Analysis of the agency's report pursuant to criteria in A.R.S. § 41-1056 and R1-6-301:

1. **Has the agency certified that it is in compliance with A.R.S. § 41-1091?**

Yes. The Board has certified its compliance with A.R.S. § 41-1091.

2. **Has the agency analyzed the rules' effectiveness in achieving their objectives?**

Yes. The Board indicates that the rule are effective in achieving their objectives.

3. **Has the agency received any written criticisms of the rules during the last five years, including any written analysis questioning whether the rules are based on valid scientific or reliable principles or methods?**

Yes. The Board indicates that it has not received any written criticisms of the rules during the last five years.

4. **Has the agency analyzed whether the rules are authorized by statute?**

Yes. The Board cites to both general and specific statutory authority for the rules. Of particular note is A.R.S. § 32-504(A)(1), under which the Board must "[a]dopt rules that are necessary and proper for the administration of this chapter [Title 32, Chapter 5, Cosmetology], including sanitary and safety requirements for salons and schools and sanitary and safety standards for the practice of cosmetology, aesthetics and nail technology."

5. **Has the agency analyzed the rules' consistency with other rules and statutes?**

Yes. The Board indicates that there are a number of inconsistencies with state statutes.

- A.R.S. § 41-1080 requires that the Board not issue a license to an individual unless the individual's presence in the U.S. is authorized under federal law. The Board complies with this provision but the rules do not provide notice of the requirement.
- A.R.S. § 32-551(B) requires the Board to return an incomplete application for a school license to the applicant within 30 days. This is inconsistent with the Board's licensing time frames in Section 106. The Board's licensing time frames are consistent with A.R.S. § 41-1074 regarding an incomplete application. The problem arises from the fact that

A.R.S. § 32-551(B) was enacted in 1984, many years before A.R.S. § 41-1074 was enacted. The Board notes that legislative action is required to eliminate the inconsistency.

- Section 115(A) and (D) are inconsistent with the times specified in A.R.S. § 41-1092.09, and the rule incorrectly refers to a contested case rather than an appealable agency action.

In addition, some of the rules are inconsistent with current procedures:

- Section 101(26) references an examination given by the Board. The required examination is actually given by the contracted examination provider.
- Section 104(A)(1) requires an examination fee to be submitted to the Board. The fee is actually submitted directly to the contracted examination provider.
- Section 108(E) directs the Board to notify applicants of the time and place for examination. This notification is given by the contracted examination provider.

Finally, some of the rules are internally inconsistent:

- Section 106, Section 108(A), and Table 1 reference Board approval to take an examination. Under the definition in Section 101(26), taking and passing an examination is part of the substantive review of an application for licensure, not a separate approval.
- Section 204(E), which indicates that a student "registers" for the Board examination, is inconsistent with Sections 104 and 106. The rules require applicants to apply for Board approval to take the examination.
- Section 306(H) refers to an approved course of instruction, but the Board does not approve courses of instruction.

6. <u>Has the agency analyzed the current enforcement status of the rules?</u>

Yes. The Board indicates that it enforces the rules either as written or, when there is an inconsistency with statute, in a manner consistent with statute. Additionally, staff would note that, as described above, there are instances in which the rules are not enforced as written because of contracted examination provider procedures.

7. <u>Has the agency analyzed whether the rules are clear, concise, and understandable?</u>

Yes. The Board indicates that the rules lack clarity, conciseness, and understandability in the following ways:

- Some of the rules are written in the passive voice;
- An internal citation in Section 103(C)(2) is incorrect and use of the term "penalty" is inaccurate;
- The heading for Section 108 is incomplete because much of the rule deals with a pre-screening review of examination qualifications;
- The heading for Section 114 is inaccurate because the substance of the rule does not deal with disciplinary action;
- The word "unexpected" in Section 201(A)(5) should be "unexecuted"; and
- An internal citation in Section 302(B) is incorrect.

8. Stringency of the Rules:

a. Are the rules more stringent than corresponding federal law?

No. The Board indicates that no federal laws directly correspond to the rules.

b. If so, is there statutory authority to exceed the requirements of federal law?

Not applicable.

9. For rules adopted after July 29, 2010:

a. Do the rules require issuance of a regulatory permit, license or agency authorization?

Yes. The rules require issuance of a regulatory permit, license or agency authorization.

b. If so, are the general permit requirements of A.R.S. § 41-1037 met or does an exception apply?

The rules made after July 29, 2010 comply with A.R.S. § 41-1037 because they are issued to qualified individuals or entities to conduct activities that are substantially similar in nature.

10. Has the agency indicated whether it completed the course of action identified in the previous five-year-review report?

Yes. In its 2010 five-year-review report, the Board indicated it would amend R4-10-115**,** as the time periods in subsections (A) and (D) are not consistent with those in A.R.S. § 41-1092.09. The Board did not complete the proposed course of action.

Conclusion

The Board intends to amend all of its rules by December 31, 2017 to address issues identified in the report and to generally make the rules more clear, concise, and understandable. The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Staff recommends that the report be approved.

GOVERNOR'S REGULATORY REVIEW COUNCIL
M E M O R A N D U M

MEETING DATE: August 2, 2016 **AGENDA ITEM: G-1**

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

FROM: GRRC Economic Team

DATE: July 15, 2016

SUBJECT: **ARIZONA STATE BOARD OF COSMETOLOGY (F-16-0410)**
Title 4, Chapter 10, Article 1, General Provisions; Article 2, Schools; Article 3, Students; Article 4, Salons

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I reviewed the five-year-review report's economic, small business, and consumer impact comparison for compliance with A.R.S. § 41-1056 and make the following comments.

1. <u>Economic Impact Comparison</u>

Economic, small business, and consumer impact statements (EIS) from the most recent rulemakings were available for the Article 1 through 4 rules contained in the five-year-review report.

The rules detail the qualifications, cost and length of licensure for cosmetologists, aestheticians, nail technicians, instructors, and salons. The number of cosmetologists and nail technicians licensed by the Board has remained steady for the last several years. The number of licensed aestheticians has grown substantially.

The Board currently licenses 73,363 individuals (62% cosmetologists; 20% nail technicians; 16% aestheticians; and 2% instructors). During the last year it received applications for licensure by examination from 2,659 and for licensure by reciprocity from 1,941 individuals. During the last year, the Board reactivated 729 licenses. There are currently 3,704 inactive licensees. The licensing examination, which consists of both written and practical parts, was taken by 2,839 individuals last year. Almost 89 percent of those taking the examination passed on the first taking. There are 1,865 salons and 79 schools licensed by the Board. The Board, which currently has 16 FTEs, collected $3,297,000 in licensing fees last year and was appropriated $1,807,700 for the current FY.

2. Has the agency determined that the rules impose the least burden and costs to persons regulated by the rules?

The Board has determined that the rules impose the least burden and costs to the regulated community. The cost to comply with these rules is minimal and necessary to protect public health and safety. Many of the costs result from statute rather than rule.

3. Was an analysis submitted to the agency under A.R.S. § 41-1056(A)(7)?

No analysis was submitted to the agency by another person that compares the rules' impact on this state's business competitiveness to the impact on businesses in other states under A.R.S. § 41-1056(A)(7).

4. Conclusion

After review, staff concludes that the report complies with A.R.S. § 41-1056 and recommends approval.

Arizona State
Board of Cosmetology

Donna Aune, Executive Director

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GRRC

January 15, 2015

Nicole A. Ong, Chair
Governor's Regulatory Review Council
100 North 15th Avenue, Ste. 402
Phoenix, AZ 85007

RE: Five-year-review Report on 4 A.A.C. 10, Articles 1 through 4

Dear Ms. Ong:

As required by A.R.S. § 41-1056, the Board of Cosmetology submits for your approval a report on a review of its rules. The Board reviewed all the referenced rules.

As required under A.R.S. § 41-1056(A), the Board certifies that it is in compliance with A.R.S. § 41-1091 regarding a substantive policy directory.

If you have questions regarding this report, please contact me at (480) 784-6963. Thank you for your consideration.

Sincerely,

Donna Aune

Donna Aune
Executive Director

BOARD OF COSMETOLOGY

Five-year-review Report: A.A.C. Title 4, Chapter 10, Articles 1-4

February 2016

Five-year-review Report

A.A.C. Title 4. Professions and Occupations

Chapter 10. Board of Cosmetology

INTRODUCTION

The mission of the Board is to ensure the public health, welfare, and safety through education and enforcement of the cosmetology laws and rules by the regulation of salons, schools, and individuals who practice cosmetology. The Board issues licenses in 12 categories[1].

Statute that generally authorizes the agency to make rules: A.R.S. § 32-504(A)(1)

1. Specific statute authorizing the rule:

R4-10-101:	A.R.S. § 32-504(A)(1)
R4-10-102:	A.R.S. § 32-507
R4-10-103:	A.R.S. §§ 32-504(A)(2) and 32-507
R4-10-104:	A.R.S. §§ 32-504(A)(3), 32-510, 32-511, and 32-512
R4-10-105:	A.R.S. §§ 32-513 and 32-532
R4-10-106:	A.R.S. § 41-1072
R4-10-107:	A.R.S. § 32-517
R4-10-108:	A.R.S. §§ 32-510, 32-511, 32-512, 32-514, 32-515, and 32-531
R4-10-110:	A.R.S. § 32-518
R4-10-111:	A.R.S. §§ 32-543 and 32-554
R4-10-112:	A.R.S. § 32-541(B)
R4-10-113:	A.R.S. § 32-541
R4-10-114:	A.R.S. §§ 32-542, 32-562, 32-572, and 32-573
R4-10-115:	A.R.S. § 41-1092.09
Table 1:	A.R.S. § 41-1072
R4-10-201:	A.R.S. §§ 32-551 and 32-564
R4-10-202:	A.R.S. § 32-563

[1] The twelve categories are: cosmetologist, nail technologist, aesthetician, cosmetology instructor, nail technology instructor, aesthetician instructor, cosmetology salon, nail technology salon, aesthetic salon, cosmetology school, nail technology school, and aesthetic school.

R4-10-203: A.R.S. § 32-555

R4-10-204: A.R.S. §§ 32-558, 32-560, and 32-561

R4-10-205: A.R.S. § 32-555

R4-10-206: A.R.S. § 32-555

R4-10-207: A.R.S. § 32-555

R4-10-208: A.R.S. § 32-555

R4-10-209: A.R.S. § 32-553

R4-10-301: A.R.S. § 32-531

R4-10-302: A.R.S. § 32-531

R4-10-303: A.R.S. § 32-510

R4-10-304: A.R.S. § 32-511

R4-10-305: A.R.S. § 32-512

R4-10-306: A.R.S. §§ 32-510, 32-511, and 32-512

R4-10-401: A.R.S. § 32-541

R4-10-402: A.R.S. §§ 32-543, and 32-545

R4-10-403: A.R.S. § 32-541

R4-10-404: A.R.S. § 32-541

R4-10-405: A.R.S. § 32-504(A)(1)

2. Objective of the rule including the purpose for the existence of the rule:

R4-10-101. Definitions: The objective of the rule is to define terms used in the rules in a manner that is not explained adequately by a dictionary definition. The definitions are designed to facilitate understanding by those who use the rules.

R4-10-102. Fees: The objective of the rule is to specify the fees that the Board charges for its licensing activities. This increases efficiency in the licensing process by enabling an applicant to submit the correct amount.

R4-10-103. Payment of Fees: The objective of the rule is to specify a required method of payment for agency services and a penalty payment for insufficient funds checks. This increases efficiency in the licensing process by enabling an applicant to submit payment in an acceptable form and avoid a penalty.

R4-10-104. Application for License by Examination: The objective of this rule is to specify the content of an application for a license by examination. This increases efficiency in the licensing process by enabling applicants to submit an administratively complete application.

R4-10-105. Application for License by Reciprocity: The objective of the rule is to specify the content of an application for a license by reciprocity. This increases efficiency in the licensing process by enabling applicants to submit an administratively complete application.

R4-10-106. Licensing Time-frames: The objective of this rule is to specify the time-frames within which the Board will act on a license application. This enables an applicant to anticipate when the Board-approval process will be completed.

R4-10-107. License Renewal: The objective of this rule is to specify the requirements for renewal of a license and the manner in which renewal application is made. This increases efficiency in the licensing process by enabling licensees to submit a timely and administratively complete renewal application and avoid having a license expire.

R4-10-108. Licensing Examinations: The objective of the rule is to prescribe the examination applicants are required to pass before being licensed, establish when the examination may be taken, and indicate materials that may be taken to the examination. This provides an applicant with necessary information regarding the examination qualification criteria.

R4-10-110. Reactivating an Inactive License: The objective of the rule is to specify the conditions under which and requirements to reactive an inactive license. This increases efficiency in the licensing process by enabling an individual with an inactive license to resume providing services to the public.

R4-10-111. Display of Licenses and Signs: The objective of the rule is to specify the notices that must be made to the public. This protects the public health and safety by

enabling members of the public to know whether a salon and personnel are licensed and required infection control and safety standards.

R4-10-112. Infection Control and Safety Standards: The objective of the rule is to establish infection control and safety standards. The standards are designed to protect public health and safety.

R4-10-113. Establishment Management: The objective of the rule is to establish the Board's expectations regarding the owner or manager of a salon or school. By providing clear expectations, the owner or manager of a salon or school is able to avoid disciplinary action.

R4-10-114. Disciplinary Action: The objective of the rule is to provide notice that a licensee is required to allow a representative of the Board to conduct an inspection of a salon or school. Conducting inspections is an important means by which the Board protects public health and safety.

R4-10-115. Rehearing or Review of Decision: The objective of this rule is to specify the procedures and standards for requesting a rehearing or review of a Board decision. This enables a licensee to know how to exhaust the licensee's administrative remedies before making application for judicial review under A.R.S. § 12-901.

Table 1. Time-frames (in days): The objective of this rule is to specify in table form the time frames within which the Board will act on a license application. This enables an applicant to anticipate when the Board-approval process will be completed.

R4-10-201. Application for School License; Renewal: The objective of the rule is to specify the requirements for submitting an application for an initial or renewal school license. This increases efficiency in the licensing process by enabling an applicant to submit a complete application and avoid the delays associated with an incomplete application.

R4-10-202. School Closure: The objective of the rule is to establish procedures to be followed when a school closes. This is designed to protect students from losing the investment made in attending the school.

R4-10-203. General School Requirements: The objective of the rule is to specify the minimum facilities, equipment, supplies, and materials required to operate a school. Clearly specified minimum requirements provide efficiencies in the licensing process by enabling a school applicant to prepare for licensure.

R4-10-204. School Records: The objective of the rule is to specify the records that a school must maintain regarding each student's participation and the information that must be transmitted to the Board as a monthly report verifying earned student hours. This is designed to protect students by ensuring they receive credit for participation at the school.

R4-10-205. Aesthetic School Requirements: The objective of the rule is to specify equipment necessary in a school of aesthetics and equipment that must be provided to each student. Clearly specified minimum requirements provide efficiencies in the licensing process by enabling a school applicant to prepare for licensure.

R4-10-206. Cosmetology School Requirements: The objective of the rule is to specify equipment necessary in a school of cosmetology and equipment that must be provided to each student. Clearly specified minimum requirements provide efficiencies in the licensing process by enabling a school applicant to prepare for licensure.

R4-10-207. Nail Technology School Requirements: The objective of the rule is to specify equipment necessary in a school of nail technology and equipment that must be provided to each student. Clearly specified minimum requirements provide efficiencies in the licensing process by enabling a school applicant to prepare for licensure.

R4-10-208. Combined School Requirements: The objective of the rule is to specify equipment necessary in a school that teaches aesthetics, cosmetology, and nail technology to

both students and instructors and equipment that must be provided to each student. Clearly specified minimum requirements provide efficiencies in the licensing process by enabling a school applicant to prepare for licensure.

R4-10-209. Demonstrators, Exclusions: The objective of the rule is to specify the limits on an individual who gives demonstrations in a licensed school. This protects students by limiting the teaching done by individuals who are not licensed instructors.

R4-10-301. Instructors; Licensed Individuals: The objective of the rule is to specify requirements for schools that provide professional development instruction for licensees. This protects licensees by having a record of their professional development and clearly distinguishing between education necessary for licensure and professional development.

R4-10-302. Instructor Curriculum Required Hours: The objective of the rule is to specify the hours of education required in a course for an instructor of aesthetics, cosmetology, and nail technology and to place limits on teaching done by student instructors. This increases efficiency in the licensing process by enabling individuals who wish to be an instructor to know the requirements for licensure.

R4-10-303. Aesthetics Curriculum Required 600 Hours: The objective of the rule is to specify the hours of education required in an aesthetics curriculum and place limits on remuneration for student services. This increases efficiency in the licensing process by enabling individuals who wish to be an aesthetician to know the requirements for licensure.

R4-10-304. Cosmetology Curriculum Required 1600 Hours: The objective of the rule is to specify the hours of education required in a cosmetology curriculum and place limits on remuneration for student services. This increases efficiency in the licensing process by enabling individuals who wish to be a cosmetologist to know the requirements for licensure.

R4-10-305. Nail Technology Curriculum Required 600 Hours: The objective of the rule is to specify the hours of education required in a nail technology curriculum and place limits on

remuneration for student services. This increases efficiency in the licensing process by enabling individuals who wish to be a nail technologist to know the requirements for licensure.

R4-10-306. Curricula Hours: The objective of the rule is to specify the number of hours in one discipline of study that may transfer to another discipline and to specify the number of hours that may be obtained in an alternative format or at an alternative location. This increases efficiency in the licensing process by enabling individuals to know the requirements for licensure.

R4-10-401. Application for a Salon License: The objective of the rule is to specify the requirements for submitting an application for a salon license. This increases efficiency in the licensing process by enabling an applicant to submit a complete application and avoid the delays associated with an incomplete application.

R4-10-402. Changes Affecting a Salon License: The objective of the rule is to specify the changes in a salon ownership or location that require a new application for salon licensure. The rule also specifies that the Board-issued license be publically posted. This protects the public by providing notice that the salon is properly licensed to operate in Arizona.

R4-10-403. Salon Requirements and Minimum Equipment: The objective of the rule is to specify the minimum equipment, materials, supplies, tools, and instruments required for the kind of services provided at a salon and to protect the public and employees. This protects the public by ensuring a salon is equipped to safely provide the advertised services.

R4-10-404. Mobile Services: The objective of the rule is to specify the requirements for providing mobile services. This protects the public by ensuring that mobile services comply with the same standards as services provided in a stationary salon.

R4-10-405. Shampoo Assistants: The objective of the rule is to specify the work that may be performed by an unlicensed individual working in a salon. This protects the public by ensuring that skilled work is performed by licensees.

3. Effectiveness of the rule in achieving the objective including a summary of any available data supporting the conclusion:

   The Board concludes the rules are effective in achieving their objectives. The Board bases this conclusion of the fact that it is able to license and regulate individuals in the cosmetology industry while protecting public health and safety.

4. Consistency of the rule with state and federal statutes and other rules made by the agency, and a listing of the statutes or rules used in determining the consistency:

   The rules are consistent with applicable federal statutes. The applicable federal statutes are:

   - 42 U.S.C. 7412: This establishes a list of hazardous air pollutants and is consistent with R4-10-112(M).
   - 34 CFR Part 600: This establishes the rules and procedures used by the U.S. Department of Education to determine whether an educational institution qualifies as an eligible institution and may apply to participate in programs authorized by the Higher Education Act of 1965. A school licensed by the Board under R4-10-201 is qualified.

   There are some minor inconsistencies with state statutes.

   - A.R.S. § 41-1080 requires that the Board not issue a license to an individual unless the individual's presence in the U.S. is authorized under federal law. The Board complies with this provision but the rules do not provide notice of the requirement.
   - A.R.S. § 32-551(B) requires the Board to return an incomplete application for a school license to the applicant within 30 days. This is inconsistent with the Board's licensing time frames at R4-10-106. The Board's licensing time frames are consistent with A.R.S. § 41-1074 regarding an incomplete application. The problem arises from the fact that A.R.S. § 32-551(B) was enacted in 1984, many years before A.R.S. § 41-1074 was enacted. Legislative action is required to eliminate the inconsistency.
   - R4-19-115(A) and (D) are inconsistent with the times specified in A.R.S. § 41-1092.09 and the rule incorrectly refers to a contested case rather than an appealable agency action.

The following are inconsistencies with current Board procedure:

- R4-10-101(26) references an examination given by the Board but the required examination is actually given by the contracted examination provider.
- R4-10-104(A)(1) requires the examination fee be submitted to the Board but the fee is actually submitted directly to the contracted examination provider.
- R4-10-108(E) indicates the Board shall notify applicants of the time and place for examination but this is actually done by the contracted examination provider.

The following are internal inconsistencies in the Board's rules:

- R4-10-106(B)(1)(a) and (C)(3), R4-10-108(A), and Table 1 reference Board approval to take an examination. However, by the Board's definition at R4-10-101(26), taking and passing an examination is part of the substantive review of an application for licensure rather than a separate approval.
- R4-10-204(E), which indicates a student "registers" for the Board examination is inconsistent with R4-10-104 and R4-10-106, which require applicants to apply for Board approval to take the examination.
- R4-10-306(H) refers to an approved course of instruction. However, the Board does not approve courses of instruction.

5. Agency enforcement policy including whether the rule is currently being enforced and, if so, whether there are any problems with enforcement:

   The Board enforces the rules either as written or, when there is an inconsistency with statute, in a manner consistent with statute.

6. Clarity, conciseness, and understandability of the rule:

   The Board concluded the rules are generally clear, concise, and understandable. However, the following issues impair clarity:

   - Contrary to current rule-writing standards, some of the rules are written in the passive voice and items in a list do not follow the lead language;
   - The heading for R4-10-108 is incomplete because much of the Section deals with a pre-screening review of examination qualifications;
   - The heading for R4-10-114 is inaccurate because the substance of the Section does not deal with disciplinary action;
   - The word "unexpected" in R4-10-201(A)(5) should be "unexecuted;"

- The internal citation in R4-10-103(C)(2) is incorrect and use of the term "penalty" is inaccurate;
- The internal citation in R4-10-302(B) is incorrect.

7. Summary of written criticisms of the rule received by the agency with the past five years, including letters, memoranda, reports, written analyses submitted to the agency questioning whether the rule is based on valid scientific or reliable principles or methods, and, written allegations made in litigation or administrative proceedings in which the agency was a party that the rule is discriminatory, unfair, unclear, inconsistent with statute or beyond the authority of the agency to enact, and the result of the litigation of administrative proceedings:
The Board received no written criticisms of the rules during the last five years, including analyses regarding whether the rules are based on valid scientific or reliable principles or methods.

8. A comparison of the estimated economic, small business, and consumer impact of the rule with the economic, small business, and consumer impact statement prepared on the last making of the rule or, if no economic, small business, and consumer impact statement was prepared on the last making of the rule, an assessment of the actual economic, small business, and consumer impact of the rule:

The Board currently licenses 73,363 individuals (62% cosmetologists; 20% nail technicians; 16% aestheticians; and 2% instructors). During the last year it received applications for licensure by examination from 2,659 and for licensure by reciprocity from 1,941 individuals. During the last year, the Board reactivated 729 licenses. There are currently 3,704 inactive licensees. The licensing examination, which consists of both written and practical parts, was taken by 2,839 individuals last year. Almost 89 percent of those taking the examination passed on the first taking. There are 1,865 salons and 79 schools licensed by the Board. The Board, which currently has 16 FTEs, collected $3,297,000 in licensing fees last year and was appropriated $1,807,700 for the current FY.

1996 rulemaking

The only rules made in 1996 and not subsequently amended are R4-10-202 (School Closure) and R4-10-209 (Demonstrators, Exclusions). The EIS prepared in 1996 is not available. The Board believes these two Sections have minimal economic consequences. R4-10-202

imposes requirements necessary to protect students when a school closes. It requires the school to provide notice of closure and send student records to the Board for safe keeping. R4-10-209 also protects students by specifying the limited circumstances in which instruction may be provided by an unlicensed individual.

1999 rulemaking

The following rules have not been amended since being made in 1999: R4-10-106 (Licensing Time-frames), R4-10-113 (Establishment Management), R4-10-114 (Disciplinary Action), R4-10-115 (Rehearing or Review of Decision), Table 1 (Time-frames), and R4-10-405 (Shampoo Assistants). The EIS prepared in 1999 is not available. The Board believes these Sections have minimal economic consequences. R4-10-106, R4-10-114, R4-10-115, and Table 1 simply provide information useful to an applicant or licensee is dealing with the Board. R4-10-113 imposes requirements regarding the responsibilities of the individual who manages a salon, school, or mobile service. These requirements are designed to protect the public. R4-10-405 addresses the limited services that can be provided by an unlicensed individual. This is to protect the public.

2003 rulemaking

The only rule made in 2003 and not subsequently amended is R4-10-103 (Payment of Fees). The EIS prepared in 2003 is not available. The Board believes this Section has minimal economic consequences. This Section facilitates the licensing process by specifying the manner in which fees and charges are to be paid.

2005 rulemaking

The following rules have not been amended since being made in 2005: R4-10-104 (Application for License by Examination), R4-10-207 (Nail Technology School Requirements), R4-10-208 (Combined School Requirements), R4-10-302 (Instructor Curriculum Required Hours), and R4-10-305 (Nail Technology Curriculum Required 600 Hours). The EIS prepared in 2005 is available. The Board believes these Sections have minimal economic consequences. The changes to all Sections except R4-10-302 were made

to be consistent with statutory changes. The amendment to R4-10-302 provided needed flexibility in the education of instructors.

2006 rulemaking

The following rules have not been amended since being made in 2006: R4-10-101 (Definitions), R4-10-105 (Application for License by Reciprocity), R4-10-108 (Licensing Examination), R4-10-111 (Display of Licenses and Signs), R4-10-201 (Application for School License; Renewal), R4-10-203 (General School Requirements), R4-10-204 (School Records), R4-10-205 (Aesthetic School Requirements), R4-10-206 (Cosmetology School Requirements), R4-10-401 (Application for Salon License), R4-10-402 (Changes Affecting a Salon License), R4-10-403 (Salon Requirements and Minimum Equipment), and R4-10-404 (Mobile Services). The EIS prepared in 2006 is available. The Board believes these Sections have minimal economic consequences.

In addition to making the rules more clear, concise, and understandable and consistent with statutory changes, the Board created the option of a pre-screening for examination, eliminated the requirement that the practical examination use a live model, expanded the ability to reactivate a license after years of inactivity, and updated the requirements regarding school supplies.

2008 rulemaking

The following rules have not been amended since being made in 2008: R4-20-112 (Infection Control and Safety Standards), R4-10-301 (Instruction; Licensed Individuals), R4-10-303 (Aesthetics Curriculum Required 600 Hours), R4-10-304 (Cosmetology Curriculum Required 1600 Hours), and R4-10-306 (Curricula Hours). The EIS prepared in 2008 is available. The Board believes these Sections have minimal economic consequences. In this rulemaking, the Board took steps to protect the public by updating provisions regarding cleanliness of spas and allowing licensees to provide invasive procedures, as allowed under law, if they had proper training and supervision.

2015 rulemaking

The following rules were amended in 2015: R4-10-102 (Fees), R4-10-107(License Renewal), and R4-10-110 (Reactivating an Inactive License). The EIS prepared in 2015 is available. The Board believes these Sections have minimal economic consequences. The amendments made were in response to a statutory change requiring biennial rather than annual license renewal. The cost of licensure and renewal was not changed except that the cost for delinquent renewal was actually decreased minimally.

9. Any analysis submitted to the agency by another person regarding the rule's impact on this state's business competitiveness as compared to the competitiveness of businesses in other states:

   No analysis has been submitted.

10. How the agency completed the course of action indicated in the agency's previous 5YRR:

    In a five-year-review report approved by Council in October 2010, the Board indicated it would amend R4-10-115. It has yet to do so.

11. A determination after analysis that the probable benefits of the rule outweigh within this state the probable costs of the rule and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:

    Most of the costs associated with licensing and regulating cosmetologists result from statute rather than rule. For example, it is statute that establishes the requirements for obtaining a license from the Board and requires cosmetologists to be licensed and renew the license biennially and pass a licensing examination. Statute requires that the Board fund its activities by charging fees. Statute establishes nine grounds for disciplinary action.

    To protect public health and safety, the rules provide detail about necessary infection control and sanitation standards, as required by A.R.S. § 32-504(A)(1). To protect students, the rules impose curriculum and recordkeeping standards. The costs associated with these standards are a cost of doing business.

    The Board believes the rules are the least burdensome possible to achieve the statutory responsibility of protecting the public.

12. A determination after analysis that the rule is not more stringent than a corresponding federal law unless there is statutory authority to exceed the requirements of that federal law:
    The rules are not more stringent than applicable federal law: 42 U.S.C. 7412 and 34 CFR Part 600.
13. For a rule made after July 29, 2010, that require issuance of a regulatory permit, license, or agency authorization, whether the rule complies with A.R.S. § 41-1037:
    The only rules made after July 29, 2010, are R4-10-102 (Fees), R4-10-107(License Renewal), and R4-10-110 (Reactivating an Inactive License). All the licenses for which a fee is required under R4-10-102, including a license renewal or reactivation, comply with A.R.S. § 41-1037 because they are issued to qualified individuals or entities to conduct activities that are substantially similar in nature.
14. Course of action the agency proposes to take regarding each rule, including the month and year in which the agency anticipates submitting the rules to the Council if the agency determines it is necessary to amend or repeal an existing rule or to make a new rule. If no issues are identified for a rule in the report, the agency may indicate that no action is necessary for the rule:
    The Board intends to amend all of its rules by December 31, 2017.

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 10. BOARD OF COSMETOLOGY

(Authority: A.R.S. § 32-501 et seq.)

ARTICLE 1. GENERAL PROVISIONS

Article 1, consisting of Sections R4-10-01 thru R4-10-19, repealed; Section R4-10-27 renumbered to R4-10-105; and Sections R4-10-101 thru R2-10-112 adopted effective April 9, 1996 (Supp. 96-2).

Section
R4-10-101. Definitions
R4-10-102. Fees
R4-10-103. Payment of Fees
R4-10-104. Application for License by Examination
R4-10-105. Application for License by Reciprocity
R4-10-106. Licensing Time-frames
R4-10-107. License Renewal
R4-10-108. Licensing Examinations
R4-10-109. Repealed
R4-10-110. Reactivating an Inactive License
R4-10-111. Display of Licenses and Signs
R4-10-112. Infection Control and Safety Standards
R4-10-113. Establishment Management
R4-10-114. Disciplinary Action
R4-10-115. Rehearing or Review of Decision
Table 1. Time-frames (in days)

ARTICLE 2. SCHOOLS

Article 2, consisting of Sections R4-10-28 thru R4-10-32, repealed; Section R4-10-33 renumbered to R4-10-112; Section R4-10-34 repealed; and Sections R4-10-201 thru R4-10-R4-10-209 adopted effective April 9, 1996 (Supp. 96-2).

Section
R4-10-201. Application for a School License; Renewal
R4-10-202. School Closure
R4-10-203. General School Requirements
R4-10-204. School Records
R4-10-205. Aesthetic School Requirements
R4-10-206. Cosmetology School Requirements
R4-10-207. Nail Technology School Requirements
R4-10-208. Combined School Requirements
R4-10-209. Demonstrators, Exclusions

ARTICLE 3. STUDENTS

Article 3, consisting of Sections R4-10-301 thru R4-10-306, adopted effective April 9, 1996 (Supp. 96-2).

Section
R4-10-301. Instruction; Licensed Individuals
R4-10-302. Instructor Curriculum Required Hours
R4-10-303. Aesthetics Curriculum Required 600 Hours
R4-10-304. Cosmetology Curriculum Required 1600 Hours
R4-10-305. Nail Technology Curriculum Required 600 Hours
R4-10-306. Curricula Hours

ARTICLE 4. SALONS

Article 4, consisting of Sections R4-10-401 thru R4-10-404, adopted effective April 9, 1996 (Supp. 96-2).

Section
R4-10-401. Application for a Salon License
R4-10-402. Changes Affecting a Salon License
R4-10-403. Salon Requirements and Minimum Equipment
R4-10-404. Mobile Services
R4-10-405. Shampoo Assistants

ARTICLE 1. GENERAL PROVISIONS

Editor's Note: The Board of Cosmetology repealed or renumbered Sections with the old Administrative Code numbering scheme and adopted new Sections under the current numbering scheme (Supp. 96-2). The old and new Sections cannot be shown in numerical order because of the two Articles; therefore the old numbers are not shown here. Please refer to this Chapter as published in Revised Format 6-92 for historical note information on the old numbered Sections.

R4-10-101. Definitions

In this Chapter unless otherwise specified:

1. "Accredited" means approved by the:
   a. New England Association of Schools and Colleges,
   b. Middle States Association of Colleges and Secondary Schools,
   c. North Central Association of Colleges and Schools,
   d. Northwest Association of Schools and Colleges,
   e. Southern Association of Colleges and Schools, or
   f. Western Association of Schools and Colleges.
2. "Administrative completeness review" means the Board's process for determining that an applicant has provided all information and documents required by Board statute or rule for an application.
3. "Applicant" means an individual or any of the following seeking licensure by the Board:
   a. If a corporation, any two officers of the corporation;
   b. If a partnership, any two of the partners; or
   c. If a limited liability company, the designated corporate contact person, or if no contact person is designated, any two members of the limited liability company.
4. "Application packet" means the forms and documents the Board requires an applicant to submit.
5. "Certification of hours" means a document that states the total number of hours completed at a school, including:
   a. A written statement of the hours a student received in a licensed school, or credits a student received, signed by the administrator of the agency authorized to record hours in the jurisdiction in which the applicant received certified or accredited vocational or academic training, affixed with the agency's official seal; or
   b. If a student is transferring from one Arizona school to another under A.R.S. § 32-560, a transfer application that reflects the hours or credits a student received, signed by the administrator of the school where the applicant received certified or accredited training.
6. "Certification of licensure" means the status of the license, signed by the administrator of the agency authorized to issue cosmetology, nail technician, aesthetics, or instructor licenses in the jurisdiction in which the applicant received a license, affixed with the agency's official seal.
7. "Clinic means the area where a student practices cosmetology, nail technology, or aesthetics on the general public for a fee.
8. "Course" means an organized subject matter in which instruction is offered within a given period of time and for which credit toward graduation or certification is given.
9. "Credit" means one earned academic unit of study based on completing a high school's required number of class sessions per calendar week in a course or an earned academic unit of study based on attending a one-hour class session per calendar week at a community college, an accredited college or university, or a high school.
10. "Days" means calendar days.
11. "Double bracing" means using a stable base of support and two points of contact for the hand while performing a procedure.
12. "Establishment" means a business that functions as a school or a salon at least an average of 20 hours a week for the majority of the year.
13. "Graduation" or "graduated from a school" means the completion of the criteria established by a cosmetology, aesthetics, or nail technology school for the course in which the applicant was enrolled including the completion of the required curriculum hours.
14. "High school equivalency" means:
    a. A high school diploma from a school recognized by the basic education authority or the Department of Education in the jurisdiction in which the school is located,
    b. A total score of 45 points on a high school equivalency general educational development test or its equivalent as required by the Department of Education,
    c. An associate degree or 15 academic credits from a junior college recognized by the basic education authority in the jurisdiction in which the college is located, or
    d. Any degree from a college or university recognized by the basic education authority in the jurisdiction in which the college or university is located.
15. "Hour" means one clock hour.
16. "Instructor training" means the courses specified in R4-10-302.
17. "Lab" means the area in which instruction is provided regarding demonstration, theory, and practice on models.
18. "Licensed in another state of the United States or foreign country" means:
    a. A governmental regulatory agency in the state or country is authorized to examine, for competency, candidates who graduate from a licensed cosmetology, nail technology, aesthetics school, or instructors for these disciplines; and
    b. The agency issues licenses over which the state or country has jurisdiction and monitors.
19. "Manager" means an individual licensed by the Board who is responsible for ensuring an establishment's compliance with A.R.S. §§ 32-501 et seq. and this Chapter.

20. "Model" means a person or a mannequin on whom an applicant performs demonstrations for the practical section of a licensing examination or lab.
21. "Owner" means an individual or entity that has a controlling legal or equitable interest and authority and is responsible for ensuring an establishment's compliance with A.R.S. § 32-501 et seq. and this Chapter.
22. "Patron" means any client of an establishment or student of a school.
23. "Personal knowledge" means actual observation of an individual who practiced aesthetics, cosmetology, or nail technology in any state or country.
24. "Practice" means engaging in the profession of aesthetics, cosmetology, nail technology, or instructor.
25. "Reciprocity" means the procedure for granting an Arizona license to an applicant who received the required hours from a school licensed in another state of the United States or a foreign country or is currently licensed in another state of the United States or a foreign country.
26. "Substantive review" means the Board's process for determining whether an applicant for licensure meets the requirements for the license for which application is made including, if applicable, taking and passing an examination given by the Board.
27. "Tenth grade equivalency" means:
    a. Ten high school credits, including two in English, from any school recognized by the basic education authority or the Department of Education in the jurisdiction in which the credits were obtained;
    b. Proof that the prospective student is 23 years old. Satisfactory proof of the prospective student's age is shown by a government-issued driver's license or identification card, a birth certificate, or a passport; or
    c. High school equivalency.
28. "Transfer application", as used in A.R.S. § 32-560, means an application that documents the transfer of a student from one Arizona cosmetology, nail technology, or aesthetics school to another and contains the student's name, address, identification number, telephone number, and number of hours of instruction received.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Amended by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 12 A.A.R. 807, effective April 8, 2006 (Supp. 06-1).

R4-10-102. Fees and Charges

A. ~~Subject~~ Under the specific authority provided by A.R.S. § 32-507(A) and subject to R4-10-103(E), the Board establishes and shall collect the following fees:

~~1. Written examination: $50.00~~

~~2. Practical examination: $50.00~~

~~3.~~1. Initial personal license: ~~$40.00~~ $70.00

~~4.~~2. Personal licensing renewal fees: ~~$30.00~~ $60.00

~~5.~~3. Delinquent personal license renewal: $90.00 ($60 for personal license renewal as specified under subsection (A)(4) plus $30 for delinquent renewal) for ~~each year~~ every two years or portion of ~~a year~~ two years ~~for which~~ that the license is inactive to a maximum of four years ~~delinquent fees: $50.00~~

~~6. Duplicate license: $20.00~~

~~7.~~4. Personal reciprocity license: ~~$110.00~~ $140.00

~~8.~~5. Salon initial license: $110.00

~~9.~~6. Salon renewal: $50.00

~~10.~~7. Salon delinquent renewal: $80.00

~~11.~~8. School license: $600.00

~~12.~~9. School renewal: $500.00

~~13.~~10. Delinquent school renewal: $600.00

B. An applicant for licensure by examination shall pay directly to the national professional organization with which the Board contracts the amount charged to administer and grade the written and practical examinations.

C. Under the specific authority provided by A.R.S. § 32-507(B) and subject to R4-10-103(E), the Board establishes and shall collect the following charges for the services provided:

~~14.~~1. Board administered educational classes: $25.00

~~15.~~2. Review of examination: $50.00

~~16.~~3. ~~Regrading~~ Re-grading of examination: $25.00

~~17.~~4. Certification of licensure or hours: $30.00

~~18.~~5. ~~Service charge for~~ For use of an alternative ~~payment~~ method of payment: $3.00 per transaction~~: 2.5% of applicable fee~~

~~19.~~6. ~~The fee for~~ For copying public documents: ~~is~~ 50¢ per page~~. The fee for~~

7. For audiotapes, videotapes, computer discs, or other media used for recording sounds, images, or information~~, is~~ : $15 per tape, disc, ~~page,~~ or other medium~~.~~

~~20.~~8. ~~The fee for providing~~ For a list of licensees' names and addresses: ~~is~~ 25¢ per name~~.~~

9. Duplicate license: $20.00

~~21.~~**C.** ~~The~~ As authorized by A.R.S. § 44-6852, the Board shall charge a service fee of $20.00 for the return of a dishonored check or the failure of any other means of payment to be honored plus the actual charges assessed by the financial institution dishonoring the check or other means of payment.

R4-10-103. Payment of Fees

A. A fee is not considered paid until the Board receives the amount required. The Board shall not provide services, administer examinations, or issue certifications or licenses until it receives the required fee.

B. The Board shall accept personal checks only for license renewals. If a check for a license renewal is returned because it is dishonored for any reason including insufficient funds, the renewal application is incomplete, and any license renewal that has been issued is void effective the date the Board mails written notice to the licensee that the license is void.

C. An applicant or licensee whose fee payment to the Board is dishonored for any reason including an insufficient funds check is not entitled to a further service, examination, certification, or license until the Board receives the following:

1. The amount of the fee for which the payment was dishonored;
2. The penalty provided in R4-10-102(21);
3. If applicable, the delinquent fee for each year or part of a year the license was inactive for the type of license to be renewed.

D. Fees are nonrefundable except if A.R.S. § 41-1077 applies.

E. The Board shall not refund fees tendered for $5.00 or less over the amount specified in R4-10-102, except the Board shall refund fees paid over the amount specified as the maximum fee in A.R.S. § 32-507.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Amended by final rulemaking at 9 A.A.R. 1050, effective May 6, 2003 (Supp. 03-1).

R4-10-104. Application for License by Examination

A. An applicant for an aesthetics, cosmetology, nail technology, or instructor license by examination shall submit to the Board:

1. The applicable fees required for the practical and written examination and initial personal license in R4-10-102;
2. An application provided by the Board that contains:
   a. A passport quality photo of the applicant;
   b. The applicant's name, address, telephone number, Social Security number, gender, and birth date;
   c. The name and address of each licensed school attended by the applicant;
   d. The name of course completed, the name of the school where completed, and the starting date and date of graduation;
   e. If previously licensed by the Board, type of license, license number, license expiration date, and the name used on the license;
   f. A statement of whether the applicant has ever had an aesthetics, cosmetology, nail technology, or instructor license suspended or revoked in any state or foreign country;
   g. A statement by the applicant verifying the truthfulness of the information provided by the applicant; and
   h. The applicant's signature.

B. In addition to complying with the requirements in subsection (A), an applicant for an aesthetics, nail technology, or cosmetology license by examination shall:
1. Comply with A.R.S. § 32-510, 32-511, or 32-512 by submitting documentation of 10th grade equivalency.
2. Comply with A.R.S. § 32-510, 32-511, or 32-512 by submitting a copy of one of the following:
   a. If the applicant graduated from a course presented by a school licensed by the Board, a written statement signed by the administrator of the school that documents proof of graduation and completion of all required hours; or
   b. If the applicant attended more than one licensed school in Arizona, a copy of a transfer application or certification of hours from each school attended that includes the starting and ending dates, and a written statement signed by the administrator of each school that documents proof of the total number of hours completed at the school, and, if applicable, proof of graduation.

C. In addition to complying with the requirements in subsection (A), an applicant for an instructor license by examination shall:
1. Comply with A.R.S. § 32-531 by submitting the following:
   a. Documentation of required work experience;
   b. Proof of current licensure in the profession in which experience was gained;
   c. Proof of licensure during the period experience was gained; and
   d. Proof of attainment of 23 years of age; or
   e. Proof of high school equivalency.
2. If qualifying under A.R.S. § 32-531(3)(a), submit a copy of the following:
   a. Documentation of graduation from a Board-licensed school by a certification of graduation on a form supplied by the Board including the starting and ending dates, total number of hours completed, and signature of the administrator of the school; and
   b. If the applicant attended more than one licensed school in Arizona, a copy of a transfer application or certification of hours from each school attended, including the starting and ending dates, total number of hours completed, and signature of the administrator of the school.
3. Documentation of the work experience required by A.R.S. § 32-531 shall be signed by an owner or manager of a licensed salon, an individual, or a supplier of cosmetology products with personal knowledge of the applicant's licensed experience in the profession for which the applicant seeks an instructor license. The person providing the documentation verifying the applicant's experience shall also indicate the following:
   a. Profession in which applicant gained the experience;
   b. Starting and ending dates of applicant's experience in the profession;
   c. Name of licensed salon and address where applicant gained experience in the profession; and
   d. License number and name of the licensed individual completing the form; or
   e. Name, address, and telephone number of the individual completing the information.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Former Section R4-10-104 renumbered to R4-10-108; new Section adopted by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking 11 A.A.R. 4239, effective December 5, 2005 (Supp. 05-4).

R4-10-105. Application for License by Reciprocity

An applicant for an aesthetics, cosmetology, nail technology, or instructor license by reciprocity shall submit the applicable fee required in R4-10-102 and all of the following to the Board:
1. An application provided by the Board and signed by the applicant that contains:
   a. The applicant's name, address, telephone number, gender, passport quality photo, Social Security number, and birth date;
   b. If previously licensed by the Board, the type of license, license number, license expiration date, and the name used on the license; and
   c. A statement of whether the applicant has ever had an aesthetics, cosmetology, nail technology, or instructor license suspended or revoked in any state or foreign country.
2. A certification of hours and proof of graduation or licensure in another state of the United States or a foreign country that shows the number of hours received in a school or the initial and final dates of licensure.

Historical Note

Section R4-10-105 renumbered from former Section R4-10-27 and amended effective April 9, 1996 (Supp. 96-2). Former Section R4-10-105 renumbered to R4-10-109; new Section adopted by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 12 A.A.R. 807, effective April 8, 2006 (Supp. 06-1).

R4-10-106. Licensing Time-frames

A. The overall time-frame described in A.R.S. § 41-1072 for each type of approval granted by the Board is set forth in Table 1. The applicant and the Executive Director of the Board may agree in writing to extend the overall time-frame. The substantive review time-frame may not be extended by more than 25% of the overall time-frame.

B. The administrative completeness time-frame described in A.R.S. § 41-1072(1) for each type of approval granted by the Board is set forth in Table 1.
1. The administrative completeness review time-frame begins:

a. For approval to take an examination, approval or denial of school or salon license, or approval or denial of a license by reciprocity, when the Board receives an application packet; or
b. For approval or denial of a license by examination, when the applicant takes an examination.

2. If an application packet is incomplete, the Board shall send to the applicant a written notice specifying the missing document or incomplete information. The administrative completeness review time-frame and the overall time-frame are suspended from the postmark date of the notice until the date the Board receives a complete application packet from the applicant.
3. If an application packet is complete, the Board shall send a written notice of administrative completeness to the applicant.
4. If the Board grants a license or approval during the time provided to assess administrative completeness, the Board shall not issue a separate written notice of administrative completeness.

C. The substantive review time-frame described in A.R.S. § 41-1072(3) is set forth in Table 1 and begins on the postmark date of notice of administrative completeness.

1. As part of the substantive review for a school license, the Board shall conduct an inspection that may require more than one visit to the school.
2. During the substantive review time-frame, the Board may make one comprehensive written request for additional information or documentation. The time-frame for the Board to complete the substantive review is suspended from the postmark date of the comprehensive written request for additional information or documentation until the Board receives the additional information or documentation.
3. If an applicant meets the requirements of A.R.S. § 32-501 through § 32-575 and this Chapter, the Board shall send written notice of approval to the applicant. If an applicant is applying for approval to take an examination, the notice shall include the date, time, and place the applicant is scheduled to take an examination.
4. If an applicant does not meet the requirements of A.R.S. § 32-501 through § 32-575 and this Chapter, the Board shall send a written notice of denial to the applicant including a basis for the denial and an explanation of the applicant's right to appeal as prescribed in A.R.S. § 41-1076.

D. The Board shall consider an application withdrawn if within 180 days from the application submission date the applicant fails to:

1. Supply the missing information under subsection (B)(2) or (C)(2); or
2. Take an examination.

E. An applicant who does not wish an application withdrawn may request a denial in writing within 180 days from the application submission date.

F. An individual shall not practice as an aesthetician, cosmetologist, instructor, or nail technician until the individual receives and posts the license at the individual's place of employment.

G. If a time-frame's last day falls on a Saturday, Sunday, or a legal holiday, the Board shall consider the next business day the time-frame's last day.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Section repealed; new Section adopted by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2).

R4-10-107. License Renewal

A. An aesthetician, cosmetologist, nail technician, or instructor licensee shall postmark or electronically submit an application for renewal to the Board on or before the licensee's birthday every two years.

1. If ~~an applicant's~~ a licensee's birthday falls on a Saturday, Sunday, or legal holiday, the ~~applicant~~ licensee may file the renewal application on the next business day following the ~~applicant's~~ licensee's birthday.
2. ~~An~~ A renewal application consists of:
   a. A form provided by the Board that contains: the ~~applicant's~~ licensee's name, address, Social Security number, and signature or Personal Identification Number (PIN) supplied by the Board if filed electronically;
   b. A statement of whether the ~~applicant~~ licensee has changed the ~~applicant's~~ licensee's name since the previous application and, if name has changed, a copy of a legal document, such as a marriage license or divorce decree, showing the name change; and
   c. The fee required in R4-10-102.

B. An establishment licensee shall annually postmark or electronically submit to the Board an application for renewal and the fee required in R4-10-102 on or before the license renewal date.

1. If the license renewal date falls on a Saturday, Sunday, or legal holiday, the ~~applicant~~ licensee may file the application on the next business day following the license renewal date.
2. ~~An~~ A renewal application consists of a form provided by the Board that contains:
   a. The establishment's name and license number; and
   b. If the owner is an individual or partnership, the signature and tax identification number of the owner; if the owner is a corporation, the signature of the authorized signer and the tax identification number of the corporation; if filed electronically, the Personal Identification Number (PIN) supplied by the Board may be used in place of the signature~~; and~~
   ~~c. The fee required in R4-10-102~~.

R4-10-108. Licensing Examinations

A. The Board may complete a pre-screening review of examination qualifications, if requested, before the student graduates from a school, but the Board shall not approve the examination application until the student has completed a minimum of:
1. 1450 hours of cosmetology training,
2. 500 hours of aesthetics or nail technician training,
3. 550 hours of cosmetology instructor training,
4. 400 hours for aesthetics instructor training, or
5. 250 hours of nail technician instructor training.

B. After the Board completes the pre-screening, an applicant may receive an examination date, but the applicant is not allowed in the examination site until the applicant provides a certification of graduation. If the applicant fails to provide a certification of graduation by the date set for the examination or the applicant does not appear at the examination site at the scheduled examination time, the applicant forfeits the examination fee. A pre-screening review is not a substitute for an official agency acceptance or issuance of a license.

C. If the applicant does not request an examination pre-screening review, the Board shall not consider an examination application until the applicant has received the hours required for graduation and has graduated from a school licensed by the Board.

D. All examinations shall be held in the Board's examination center at the Board's office unless another location is designated by the Board in its written notice to the applicant.

E. The Board shall notify applicants in writing of the time and place assigned for the examination.

F. An applicant shall provide identification upon entering the examination center. Acceptable forms of identification include United States issued: passport, driver license, bank identification card, military identification, or government-issued identification card. Identification shall contain a photograph of the applicant.

G. An examination shall consist of both written and practical sections and the practical sections shall include live demonstrations on a model as follows:
1. An applicant shall perform a cosmetology or nail technology demonstration on a mannequin,
2. An applicant shall perform a demonstration for an aesthetics examination on a person, and
3. An applicant shall perform demonstrations for an instructor examination on a person for an aesthetics class or a mannequin for a cosmetology or nail technology class.

H. An applicant shall comply with all infection control and safety standards required by R4-10-112 during the examination.

I. An applicant who cannot appear for an examination as scheduled shall forfeit the examination fee. An applicant who arrives at an examination site after a scheduled examination begins shall not be allowed to test at the scheduled time. If an applicant arrives after the examination begins or fails to appear for a scheduled examination, the Board shall reschedule the examination upon payment of another examination fee. The applicant is allowed a one time cancellation of the examination test date if the applicant cancels at least 48 hours before the examination start time. The Board does not require another examination fee for rescheduling a canceled examination.

J. An applicant shall supply equipment, supplies, tools or instruments, and a model as required.

K. An applicant shall not use a current or former student in an aesthetics, cosmetology, or nail technology school as a model in the live demonstration of aesthetics or instructor examinations.

L. Examination materials are not available for inspection or copying by any person nor shall any person attempt to obtain or provide examination materials.

M. The applicant shall not bring and the examination administrator shall not allow written material or recording media in either the written or practical sections of the examination for aestheticians, cosmetologists, or nail technicians. The examination administrator may exclude other items from the written or practical sections of the examination that may impede the fair administration or security

of the examination. An applicant who seeks to impede the fair administration of an exam, or copies or asks for information from another applicant shall be dismissed from the examination and shall forfeit the examination fee. An applicant who has a blood spill that is not treated following proper blood spill procedures in R4-10-112 shall be dismissed from the examination and shall forfeit the examination fee.

N. If an applicant passes the examination but does not apply for an original license within one year after the date of the examination, the Board shall void the examination scores.

O. If application is made by reciprocity, the Board may accept a score on a written or practical examination from another jurisdiction if the examination:

1. Is the same national examination as that administered in Arizona,
2. The score is at least the same as the passing score that was required by the Board at the time the applicant took the examination in the other jurisdiction, and
3. The applicant provides the Board with documentation from the other jurisdiction verifying the passing score and that the score was received within one year of the application for reciprocity.

P. The Board shall conduct all examinations in English and applicants shall submit answers in English.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Former Section R4-10-108 renumbered to R4-10-111; new Section R4-10-108 renumbered from Section R4-10-104 by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 12 A.A.R. 807, effective April 8, 2006 (Supp. 06-1).

R4-10-110. Reactivating an Inactive License

A. A cosmetology, nail technology, aesthetics, or instructor license that has been inactive for less than ~~one year will~~ two years may be reactivated by paying the delinquent renewal fee.

B. A cosmetology, nail technology, aesthetics, or instructor license that has been inactive for more than ~~one year~~ two years, but less than five years, may be reactivated by the licensee paying the delinquent renewal fee and paying for and completing the infection protection class and law review class, offered by the Board~~, but paid for by the licensee~~.

C. A cosmetology, nail technology, aesthetics, or instructor license that has been inactive for more than five years, but less than 10 years, may be reactivated by the licensee if the licensee does all of the following:

1. Provides a certification of licensure;
2. Completes the infection protection class and law review class given by the Board;
3. Takes and passes the Board examination pertaining to the type of license formerly held; and
4. Pays for the classes required under subsection (C)(2) and the delinquent renewal fee.

D. If a cosmetology, nail technology, aesthetics, or instructor license has been inactive for more than 10 years, the licensee shall comply with all application requirements in R4-10-104 before practicing or teaching cosmetology in Arizona.

R4-10-111. Display of Licenses and Signs

A. The name on an establishment's exterior sign, advertising, and publications shall be the same as the name on the establishment license issued by the Board. The establishment's exterior sign shall contain lettering at least 2 1/2 inches in height.

B. A school shall prominently post a class schedule that lists the names of instructors and classes. The school shall display the school and instructor licenses near the school entrance, visible to the public.

C. A salon shall prominently post the salon license and ensure that the personal license of each licensee performing services in the salon is posted at the licensee's station.

D. A licensee performing mobile services shall prominently display a duplicate personal and establishment license in the area where mobile services are provided. The licensee's original license shall be prominently displayed in the salon from which the licensee was dispatched in accordance with subsection (C).

E. A copy of R4-10-112 shall be prominently posted in each establishment.

F. A salon shall prominently post a notice of salon services that are not regulated by the Board and that are provided at the salon.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Former Section R4-10-111 renumbered to Section R4-10-114; new Section R4-10-111 renumbered from R4-10-108 by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 12 A.A.R. 807, effective April 8, 2006 (Supp. 06-1).

R4-10-112. Infection Control and Safety Standards

A. An establishment shall have and maintain the following minimum equipment and supplies:
1. Non-leaking, waste receptacles, which shall be emptied, cleaned, and disinfected daily;
2. Ventilated containers for soiled linens including towels and capes;
3. Closed, clean containers to hold clean linens including towels and capes;
4. A covered, wet disinfectant container made of stainless steel or a material recommended by the manufacturer of the wet disinfectant that:
   a. Is large enough to contain sufficient disinfectant solution to allow for the total immersion of tools and instruments,
   b. Is set up with disinfectant at all times the establishment is open, and
   c. Is changed as determined by manufacturer's instructions or when visibly cloudy or contaminated;
5. An Environmental Protection Agency (EPA)-registered bactericidal, virucidal, fungicidal, and pseudomonacidal (formulated for hospitals) disinfectant which shall be mixed and used according to manufacturer's directions on all tools, instruments, and equipment, except those that have come in contact with blood or other body fluids; and
6. An EPA-registered disinfectant that is effective against HIV-1 and Human Hepatitis B Virus or Tuberculocidal which shall be mixed and used according to the manufacturer's directions on tools, instruments, and equipment that come in contact with blood or other body fluids.

B. Procedure for disinfecting non-electrical equipment.
1. Non-electrical equipment shall be disinfected by cleaning with soap or detergent and warm water, rinsing with clean water, and patting dry; and
2. Totally immersing in the wet disinfectant required under subsection (A)(5) or (A)(6) following manufacturer's recommended directions.

C. Procedure for storage of tools and instruments.
1. A tool or implement that has been used on a client or soiled in any manner shall be placed in a properly labeled receptacle; and
2. A disinfected implement shall be stored in a disinfected, dry, covered container and isolated from contaminants.

D. Procedure for disinfecting electrical equipment, which shall be in good repair, before each use.
1. Remove all foreign matter;
2. Clean and spray or wipe with a disinfectant, compatible with electrical equipment, as required in subsection (A)(5) or (A)(6); and
3. Disinfect removable parts as described in subsection (B).

E. Tools, instruments and supplies.
1. All tools, instruments, or supplies that come into direct contact with a client and cannot be disinfected (for example, cotton pads, sponges, porous emery boards, and neck strips) shall be disposed of in a waste receptacle immediately after use;
2. Disinfected tools and instruments shall not be stored in a leather storage pouch;
3. A sharp cosmetology tool or implement that is to be disposed of shall be sealed in a rigid, puncture-proof container and disposed of in a manner that keeps licensees and clients safe;
4. An instrument or supply shall not be carried in or on a garment while practicing in the establishment;
5. Clips or other tools and instruments shall not be placed in mouths, pockets, or other unsanitized holders;
6. Pencil cosmetics shall be sharpened before each use;
7. All supplies, equipment, tools, and instruments shall be kept clean, disinfected, free from defects, and in good repair;
8. Cutting equipment shall be kept sharp; and
9. A client's personal cosmetology tools and instruments that are brought into and used in the establishment shall comply with these rules.

F. If there is a blood spill or exposure to other body fluids during a service, licensees and students shall stop the service and:
1. Before returning to service, clean the wound with an antiseptic solution;
2. Cover the wound with a sterile bandage;
3. If the wound is on a licensee's or student's hand in an area that can be covered by a glove or finger cover, the licensee or student shall wear a clean, fluid-proof protective glove or finger cover. If the wound is on the client, the licensee or student providing service to the client shall wear gloves on both hands;
4. Blood-stained tissue or cotton or other blood-contaminated material shall be placed in a sealed plastic bag and that plastic bag shall be placed into another plastic bag (double bagged), labeled with a red or orange biohazard warning, and discarded;
5. All equipment, tools, and instruments that have come in contact with blood or other body fluids shall be disinfected as discussed in subsections (A)(6) and (B); and
6. Electrical equipment shall be disinfected as discussed in subsection (D).

G. All circulating and non-circulating tubs or spas shall be cleaned as follows using the disinfectant in subsection (A)(5) or (6):
1. After each client or service, complete all of the following:
   a. Drain the tub;
   b. Clean the tub according to manufacturer's instructions, taking special care to remove all film, especially at the water line;
   c. Rinse the tub;

d. Fill the tub with water and disinfectant as in subsection (A)(5) or (6); and
e. Allow the disinfectant to stand for non-circulating tubs or to circulate for circulating tubs for the time specified in manufacturer's instructions.

2. At the end of the day, complete all of the following:
a. Remove all filters, screens, drains, jets, and other removable parts;
b. Scrub with a brush and soap or detergent until free from debris;
c. Rinse;
d. Completely immerse in the solution described in subsection (A)(5);
e. Rinse;
f. Air dry; and
g. Replace the disinfected parts in the tubs or store in a disinfected, dry, covered container.

H. Personal cleanliness.
1. A licensee or student shall thoroughly wash his or her hands with soap and warm water or any equally effective cleansing agent immediately before providing services to each client, before checking a student's work on a client, or after smoking, eating, or using the restroom;
2. A licensee or student shall wear clothing and shoes;
3. A client's skin upon which services will be performed shall be washed with soap and warm water or wiped with disinfectant or waterless hand cleanser approved for use on skin before a nail technology service, including a pedicure service, is provided; and
4. A licensee or student shall wear clean, fluid-proof protective gloves while performing any service if any bodily discharge is present from the licensee, student, or client or if any discharge is likely to occur from the client because of services being performed.

I. Disease and infestation.
1. A licensee or student who has a contagious disease shall not perform services on a client until the licensee or student takes medically approved measures to prevent transmission of the disease; and
2. Services shall not be performed on an individual who has a contagious disease that may be transmitted by the performing of the services on the individual.

J. Client protection.
1. A client's clothing shall be protected from direct contact with shampoo bowls or headrests by the use of clean linens, capes, robes, or protective neck strips;
2. Infection control shall be maintained and services shall be performed safely to protect the licensee or student and client;
3. Double bracing shall be used around a client's eyes, ears, lips, fingers, and toes; and
4. A client shall receive a pre- and post-analysis that includes appropriate instructions for follow-up.

K. Care and storage of linens including towels, robes, and capes.
1. Clean linens shall be provided for each client and laundered after each use;
2. Soiled linens shall be stored in a ventilated receptacle;
3. Laundering shall include disinfecting linens by using detergent and bleach; and
4. Clean linens shall be stored in closed containers or closets.

L. Care and storage of products including liquids, creams, powders, cosmetics, chemicals, and disinfectants.
1. All products shall be stored in a container that is clean and free of corrosion and labeled to identify contents, in compliance with state and local laws and manufacturer's instruction;
2. All products containing poisonous substances shall be distinctly marked;
3. When only a portion of a cosmetic product is to be used, the portion shall be removed from the container in a way that does not contaminate the remaining product; and
4. Once dispensed, a product shall not be returned to the original container.

M. Prohibited hazardous substances and use of products.
1. An establishment shall not have on the premises cosmetic products containing hazardous substances banned by the U.S. Food and Drug Administration (FDA) for use in cosmetic products, including liquid methyl methacrylate monomer and methylene chloride; and
2. Product shall be used only in a manner approved by the FDA.

N. Care of headrests, shampoo bowls, and treatment tables.
1. Headrests of chairs and treatment tables shall be disinfected at least daily and treatment tables covered with a clean linen or paper sheet for each client;
2. Shampoo bowls and neck rests shall be cleansed with soap and warm water or other detergent after each use and kept in good repair; and
3. Shampoo neck rests shall be disinfected with a solution described in subsection (A)(5) or (A)(6) before each use.

O. Prohibited devices, tools, or chemicals; invasive procedures.
1. Except as provided in this subsection and subsection (O)(2), all of the following devices, tools, or chemicals are prohibited from being present in or used in a salon:
a. A devise, tool, or chemical that is designed or used to pierce the dermis; and
b. A low-frequency, or low-power ultrasonic, or sonic device except one intended for skin cleansing, exfoliating, or product application.

2. A salon or licensee that provides an invasive procedure, using a device, tool, or chemical described in subsection (O)(1), that is otherwise allowed under Arizona law shall ensure that the performance of the procedure complies with statutes and rules governing the procedure, training, or supervision as required by the relevant, regulatory authorities.

P. Skin peeling.

1. Except as provided in subsections (O)(1) and (O)(2), only the non-living, uppermost layer of skin, known as the epidermis, may be removed by any method or means and only for the purpose of beautification;
2. A skin removal technique or practice that affects the dermal layer of the skin is prohibited;
3. Skin removal products shall not be mixed or combined except as required by manufacturer instructions and approved by the FDA; and
4. Only commercially available products for the removal of epidermis for the purpose of beautification shall be used.

Q. Restricted use tools and instruments.

1. Nippers shall be used only to remove loose cuticles; and
2. Pre-sterilized, disposal lancets shall be used only to dilate follicles and release sebaceous debris from the follicle.

R. Cleanliness and repair of the establishment shall be maintained according to the following guidelines.

1. After each client, hair and nail clippings shall immediately be discarded;
2. All areas of the establishment, including storerooms and passageways, shall be well lighted, ventilated, and free from infectious agents;
3. Floors, walls, woodwork, ceilings, furniture, furnishings, and fixtures shall be clean and in good repair;
4. Shampoo bowls shall be clean and disinfected by using a disinfectant discussed in subsection (A)(5) or (A)(6) and drains shall be free running;
5. Counters and all work areas shall be disinfected after each client by using a disinfectant discussed in subsection (A)(5) or (A)(6); and
6. Waste or refuse shall be removed timely so there is no accumulation.

S. Building standards.

1. There shall be a direct entrance from the outside, not through living quarters, into the establishment;
2. If connected to a residence, all passageways between the living quarters and the establishment shall have a door that remains closed during business hours;
3. The establishment shall not be used for residential or other living purposes;
4. The establishment shall have a restroom for employees' and clients' use during business hours that has a wash basin, running water, liquid soap, and disposable towels; is kept clean and sanitary at all times; is in close enough proximity to the salon to ensure safety for cosmetology procedures during use; and is open and available for use by employees and clients of the salon;
5. Any excess material stored in a restroom shall be in a locked cabinet;
6. The establishment shall have hot and cold running water;
7. A mobile unit shall have sufficient water at all times; and
8. The establishment shall have a natural or mechanical ventilation and air filtration system that provides free flow of air to each room, prevents the build-up of emissions and particulates, keeps odors and diffusions from chemicals and solutions at a safe level, and provides sufficient air circulation and oxygen.

T. General requirements.

1. The establishment shall have a first-aid kit that contains, at a minimum, small bandages, gauze, antiseptic, and a blood-spill kit that contains disposable bags, gloves, and hazardous waste stickers;
2. No bird or animal, except fish aquariums and service animals, are allowed in the establishment; and
3. The establishment shall comply with federal and state requirements.

Historical Note

Section R4-10-112 renumbered from former Section R4-10-33 and amended effective April 9, 1996 (Supp. 96-2). Former Section R4-10-112 renumbered to Section R4-10-115; new Section R4-10-112 renumbered from Section R4-10-109 by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 11 A.A.R. 4239, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 2083, effective July 5, 2008 (Supp. 08-2).

R4-10-113. Establishment Management

A. The manager of each establishment shall ensure that:

1. Licenses, notices, and the Board's most recent inspection sheet are prominently displayed;
2. The establishment and all licensees in a salon, school, or a mobile service area have current licenses;
3. Infection control and safety standards are maintained.

B. The salon and school owner and salon and school manager or director shall be responsible for all violations enumerated in subsection (A), occurring within the salon, school, or mobile service areas.

C. If a salon owner rents or leases space within the salon to a person who obtains a separate salon license, that second licensee and their salon manager and the owner shall each be responsible for all violations of requirements enumerated in subsection (A) occurring within the second licensee's licensed portion of the salon, and are each responsible for the common areas.

Historical Note

New Section R4-10-113 renumbered from Section R4-10-110 by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2).

R4-10-114. Disciplinary Action

A. Licensees shall permit an inspector or Board representative to inspect the premises of any salon or school, or other location identified by a complaint or the Board, alleging the location is operating a salon or school.

B. Board action is required to dismiss a complaint.

Historical Note

New Section R4-10-114 renumbered from Section R4-10-111 by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2).

R4-10-115. Rehearing or Review of Decisions

A. Except as provided in subsection (G), any party in a contested case before the Board who is aggrieved by a decision rendered in such case may file with the Board, not later than 15 calendar days after service of the decision, a written motion for rehearing or review of the decision specifying particular grounds therefor. For purposes of this subsection, a decision shall be deemed to have been served when personally delivered or mailed by certified mail to the party's last known residence or place of business.

B. A motion for rehearing or review may be amended at any time before it is ruled upon by the Board. A response may be filed within 10 calendar days after service of such motion or amended motion by any party. The Board may require the filing of written briefs upon the issues raised in the motion and may provide for oral argument.

C. A rehearing or review of the decision may be granted for any of the following causes materially affecting the moving party's rights:

1. Irregularity in the administrative proceedings of the agency or its hearing officer or the prevailing party, or any order or abuse of discretion, whereby the moving party was deprived of a fair hearing;
2. Misconduct of the Board or its hearing officer or prevailing party;
3 Accident or surprise which could not have been prevented by ordinary prudence;
4. Newly discovered material evidence which could not with reasonable diligence have been discovered and produced at the original hearing;
5. Excessive or insufficient penalties;
6. Error in the admission or rejection of evidence or other errors of law occurring at the administrative hearing; or
7. A decision which is not justified by the evidence or is contrary to law.

D. Not later than 10 calendar days after the Board's receipt of a motion for rehearing or review, the Board may affirm or modify the decision or grant a rehearing or review to any of the parties and on all or part of the issues for any of the reasons set forth in subsection (C). An order granting a rehearing or review shall specify with particularity the ground or grounds on which the rehearing or review is granted, and the rehearing or review shall cover only those matters so specified.

E. Not later than 15 calendar days after a decision is rendered, the Board may on its own initiative, order a rehearing or review of its decision for any reason for which it might have granted a rehearing or review on motion of a party. After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Board may grant a motion for rehearing or review for a reason not stated in the motion. In either case the order granting such a rehearing or review shall specify the grounds therefor.

F. When a motion for rehearing or review is based upon affidavits, they shall be served with the motion. An opposing party may, within 10 calendar days after such service, serve opposing affidavits, which period may be extended for an additional period not exceeding 20 calendar days by the Board for good cause shown or by written stipulation of the parties. Reply affidavits may be permitted.

G. If in a particular decision the Board makes specific findings that the immediate effectiveness of the decision is necessary for the immediate preservation of the public peace, health, or safety and that a rehearing or review of the decision is impractical, unnecessary, or contrary to the public interest, the decision may be issued as a final decision without an opportunity for rehearing or review. An application for judicial review of the decision shall be made within the time limits permitted for applications for judicial review of the Board's final decisions.

H. For purposes of this Section, the terms "contested case" and "party" shall be defined as provided in A.R.S. § 41-1001.

Historical Note

New Section R4-10-115 renumbered from Section R4-10-112 by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2).

Table 1. Time-frames (in days)

Type of Approval	Statutory Authority	Overall Time-frame	Administrative Completeness Time-frame	Substantive Review Time-frame
Approval to Take an Examination	A.R.S. §§ 32-514, 32-515, 32-533	90	60	30

License by Examination	A.R.S. §§ 32-510, 32-511, 32-512, 32-531	60	30	30
License by Reciprocity	A.R.S. §§ 32-513, 32-532	60	30	30
School License	A.R.S. § 32-551	90	30	60
License Renewal	A.R.S. §§ 32-517, 32-535, 544, 32-564	75	45	30
Salon License	A.R.S. §§ 32-541, 32-542	90	30	60
License Reactivation	A.R.S. § 32-518	30	15	15

Historical Note
New Table adopted by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2).

ARTICLE 2. SCHOOLS

Editor's Note: The Board of Cosmetology repealed or renumbered Sections with the old Administrative Code numbering scheme and adopted new Sections under the current numbering scheme (Supp. 96-2). The old and new Sections cannot be shown in numerical order because of the two Articles; therefore the old numbers are not shown here. Please refer to this Chapter as published in Revised Format 6-92 for historical note information on the old numbered Sections.

R4-10-201. Application for a School License; Renewal

A. An applicant for a school license shall submit the documents required in A.R.S. § 32-551 and:
1. An application on a form provided by the Board, signed by the applicant, and notarized that contains:
   a. The applicant's name, address, federal tax identification number, and telephone number;
   b. If a partnership, each partner's name and address and an identification of whether a limited or general partner;
   c. If a corporation, the state of incorporation and the name, title, and address of at least two officers of the corporation;
   d. The name under which the school will be operated as registered with the Secretary of State;
   e. The name and Board-issued license number of the instructor in charge of the school;
   f. If an existing school, the date the applicant will be assuming ownership; and
   g. If a new school, the scheduled date for opening the school;
2. If a partnership, a copy of the partnership agreement;
3. If a corporation, the articles of incorporation and a Certificate of Good Standing from the Corporation Commission;
4. A signed statement that the establishment has the equipment required by statute and rule for the school;
5. An unexpected contract form required by A.R.S. § 32-558;
6. A schedule that includes the hours of each day and each day of a calendar week during which the school will be open for instruction;
7. A proposed schedule of classes to be taught at the school;
8. The name, address, and telephone number of the bonding company and a copy of the bond;
9. A copy of all school policies and procedures;
10. A school catalog that contains the information required by A.R.S. § 32-559 and:
    a. The number of days during course enrollment that are necessary to complete the hours for the course;
    b. The days and hours of operation, vacation periods, and holidays;
    c. A listing of policies regarding leaves of absence and vacation approval for students;
11. Demonstrate evidence of compliance with A.R.S. §§ 32-551 through 32-575 and these rules through a school inspection conducted by the Board; and
12. The fee required in R4-10-102.

B. In addition to the requirements in R4-10-107, a licensee shall submit the following when renewing a license:
1. The most recent school catalog that:
   a. Indicates where any modifications, additions, or deletions from the previously submitted catalog may be found;
   b. Contains an index that shows where the information required by A.R.S. § 32-559 is located in the catalog;
   c. Contains the name of each accrediting or approving organization; and

d. Provides a signed statement that the establishment has the equipment required by statute and rule for the school.

2. A subject description for each new course and its schedule, if applicable;
3. A new operating schedule if changes will occur beginning with the new license year;
4. The name and address of any new statutory agent if the change will take effect with the new license year;
5. The name and license number of the current licensed instructor in charge of the school; and
6. The name, address, and telephone number of the bonding company, the bond number, the expiration date of the bond, and a copy of the bond.

C. The owner of a school shall submit to the Board the terms and conditions of any management contract entered into for the school after the contract is executed;

D. Within five days after a change occurs during the year, the owner of a school shall submit to the Board the subject description of any new course; the name of any new statutory agent; or any change to the catalogue, generic student contract, policies, procedures, hours of operation, or bond.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Section repealed; new Section adopted by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 12 A.A.R. 807, effective April 8, 2006 (Supp. 06-1).

R4-10-202. School Closure

A. For purposes of A.R.S. § 32-563, the Board may consider a school to be closed if it fails for five consecutive school days to provide instruction in accordance with its schedule of operations on file with the Board.

1. All enrolled students and employees shall be notified by the school in writing of a pending closure at least five calendar days before closure of the school, unless the time of such closure could not have been anticipated. A copy of the notice shall be sent to the Board at the time it is delivered to the students and employees. The students' and employees' personal belongings, including equipment, tools, and implements shall be released to each student or employee immediately upon request.
2. Student records as specified by A.R.S. § 32-563 shall be sent to the Board within 10 calendar days after the school closure, including:
   a. Copies of hour sheets documenting all student hours and the current time cards or time records received by the student after the last monthly report before the school closure as specified by R4-10-204;
   b. A copy of the file of each student who was enrolled the last school day prior to closure as specified by R4-10-204. If a teachout was arranged with another school which agreed to complete the training, the student's file shall be transferred to that school; and
   c. A written statement signed by each enrolled student verifying the school's compliance with subsection (A)(1) as it applies to students.

B. Failure to comply with subsection (A) may be grounds for refusal to issue a school license to an owner, manager, director, or instructor of the school at the time of the school closure.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2).

R4-10-203. General School Requirements

A. Aesthetics, cosmetology, and nail technology schools shall comply with R4-10-112 and have the following minimum facilities, equipment, supplies, and materials:

1. One area of instruction for every 20 students;
2. A licensed instructor as manager or director;
3. A desk, table and chair, or other instructional fixtures and facilities for each student during theory instruction;
4. Filing cabinets to hold all school and student records;
5. An instruction board in each room used for instruction;
6. At least two cubic feet of an individual locked area with a different locking device for each enrolled student and each instructor to store personal objects and training kits;
7. A sink area for each 50 students in attendance for the preparation, mixing, and dispensing of supplies and chemicals, and for the disinfection of small tools or instruments;
8. At least one restroom that meets the requirements of R4-10-112;
9. Separate receptacles for garbage and soiled linens; and
10. One container for wet disinfectant for each student performing aesthetics and nail technology.

B. The school shall furnish equipment, tools, instruments, materials, and supplies needed to perform assignments and for instructional purposes, except that the school may require each student to furnish small tools or instruments. All equipment, tools, and materials shall be salon quality and maintained in good repair at all times.

C. The school shall have a library for student use which contains at least the following materials relating to the courses offered by the school:

1. Standard dictionary;
2. Medical dictionary;
3. Anatomy chart on bones, muscles, nerves, hands, arms, nails, veins, arteries, circulatory system, hair, and skin;
4. Three current periodicals on the art and science of cosmetology;
5. Current cosmetology instruction manuals or textbooks;
6. Current Arizona Cosmetology statutes and rules; and

7. A cosmetology dictionary.

D. Each school shall maintain a complete file on all current curriculum requirements.

E. A school shall not pay a salary to an enrolled student other than a student instructor.

F. A licensed school may offer a postgraduate or advanced continuing education cosmetology course, including theory and lab, to students currently enrolled in the school or currently licensed individuals without a licensed instructor present.

1. A school shall not report post-graduate credit hours to the Board or apply the hours toward graduation.
2. Currently enrolled students shall not perform services upon a person without an instructor present.
3. A student file is not required for licensed individuals.
4. Each licensee shall have the licensee's current Board-issued license number onsite.

G. An individual licensed by the Board may re-enroll in a licensed school for a refresher course as a current student. Credit hours for training received shall be submitted by the school to the Board.

H. A school shall establish a periodic grading schedule and keep student transcripts current.

I. A school shall schedule a minimum of four hours of theory classes each week for each full-time student and a minimum of two hours of theory classes each week for each part-time student.

J. A school shall teach safety and infection control measures relating to each subject in conjunction with that subject.

K. A school shall not solicit students for enrollment at other school sites.

L. While teaching, instructors shall wear a tag indicating the instructor's name and courses taught.

M. A school shall ensure compliance with the following:

1. A student shall not attend school more than 56 hours in any one week.
2. A student shall only operate safe equipment in good repair.
3. A student of aesthetics, cosmetology, and nail technology shall perform services within the enrolled course, upon the public or fellow students, only in the presence of a licensed instructor and, except for shampooing, only after completing the basic training specified in R4-10-303, R4-10-304, and R4-10-305.
4. A school shall not prevent or discourage a student from making a complaint to the Board.
5. A school shall not dismiss a student from a scheduled theory instruction or written or practical examination to perform clinical services for the public;
6. While in school, each student shall wear a tag indicating the student's name and the course in which the student is enrolled; and
7. If the school has a distant classroom, the school shall ensure that equipment for each classroom is the same as that required for each course of instruction in the school; and:
   a. Private postsecondary facilities shall not extend the school facilities beyond .5 miles apart as verified by Global Positioning System map readings;
   b. Public educational facilities shall not extend the school beyond the school designated campus;
   c. A duplicate Board-issued school license shall be posted in each distant facility;
   d. Duplicate instructor licensees are not required; and
   e. Clinic, retail, all public services, and appointments by the public are prohibited.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Amended by final rulemaking at 12 A.A.R. 807, effective April 8, 2006 (Supp. 06-1).

R4-10-204. School Records

A. A school shall maintain a student's records at the school where the student is enrolled. The Board may inspect the records at any time the school is open.

B. When a student transfers from one school to another, the school from which the student is transferring shall:

1. Keep a copy of the student's transcript,
2. Forward one copy to the student and another copy to the Board within three days of the date of transfer, and
3. Withdraw the student on the school records and the monthly report submitted to the Board.

C. Each school shall keep:

1. A complete and accurate record of the time devoted by each student to the enrolled course of study;
2. A complete and accurate record that shows the school's basis for certification of the student hours. A school shall certify only those hours of training the student receives in that school or hours the school accepts as received in another state or country;
3. A complete and accurate individual student file for each student enrolled containing:
   a. Contract and enrollment agreement;
   b. Financial aid transcript;
   c. Proof of 10th grade equivalency for a student enrolled in an aesthetics, cosmetology, or nail technology course or proof of high school equivalency or 23 years of age for a student enrolled in an instructor course;
   d. Identification number;
   e. Proof of one year of licensed work experience for a student instructor;
   f. A statement signed by a school administrator and the student that provides a list of the supplies contained in the kit provided to the student. The contract shall set forth the contents of the kit including:
      i. The price of items contained in the kit;
      ii. When the items shall be distributed;
      iii. The manufacturer of the products;
      iv. The retail value of the kit; and

v. A statement that if substitutions occur after the contract is signed, the substitutions shall be of comparable value; and

g. A record of completed hours, including proof of cosmetology, nail technology, aesthetics, or instructor hours earned in another state or country and accepted by the school; and

4. Complete and accurate academic transcripts and attendance and hour records or time cards.

D. The school shall electronically deliver to the Board a complete and accurate monthly report no later than the 10th day of each month. The monthly report shall include:

1. For each student enrolled since the prior monthly report only:
   a. Name;
   b. Student identification number;
   c. Enrollment date;
   d. Address;
   e. Telephone number;
   f. Type of educational documentation that meets the requirements of R4-10-104;
   g. Proof of hours received from another Board-licensed school, or a school in another state, or country, and certified by the school, if applicable;
   h. Proof of crossover hours necessary to qualify for R4-10-306, if applicable; and
   i. Birth date.
2. The enrollment category of each student;
3. The name, license number, and work schedule of the instructor in charge of the school, and name of the custodian of records;
4. The name, license number, and work schedule of each instructor employed by the school;
5. The signature of the instructor who prepares and certifies that the report is correct;
6. The name of student instructors, the scheduled attendance, and the Board-issued license number for each student instructor;
7. For each demonstration given, the name of the demonstrator, the name of the observing instructor, the name of the process or product demonstrated, the number of students in attendance, and the name of the course in which the demonstration was given;
8. Hours received by each student for the prior month, the current month, and total cumulative hours. The school shall not amend total hours without satisfactory proof of error;
9. Signature of each student verifying approval of the certified hours;
10. The school's certification of the students who meet the graduation requirements of the school, including the day, month, and year of graduation; and
11. The notation "transferred," "withdrawn," or "leave of absence" for students who discontinue training, and the day, month, and year training was discontinued. The school shall provide certification to the student within one week of the hours earned by the student before the student withdraws or takes a leave of absence.

E. A school shall credit a student with additional hours earned after graduation if the student completes the required hours for graduation, registers for the Board examination, and stays in school until the date of the examination.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Amended by final rulemaking at 12 A.A.R. 807, effective April 8, 2006 (Supp. 06-1).

R4-10-205. Aesthetic School Requirements

A. Schools that provide aesthetics 600-hour training for students, 500-hour training for instructors, or both, shall provide the following minimum facilities, equipment, supplies, and materials in addition to that required by R4-10-203 and R4-10-204:

1. A work station for each student in attendance to perform aesthetics services to the public, each having;
   a. A facial chair or table;
   b. A table top that is 12" x 18" or larger;
   c. A dry, disinfected, covered container to store disinfected tools and instruments, and
   d. A labeled receptacle for contaminated tools or instruments.
2. One steamer machine for each group of four students in attendance during lab and two students in attendance during clinic;
3. One microdermabrasion machine to be used at a non-invasive level;
4. One magnifying lamp of at least 5 diopters for each group of two students in attendance during lab and each group of four students in attendance during clinic;
5. Cleansers;
6. Massage medium;
7. Toner;
8. Exfolients and masks; and
9. Depilatories.

B. Each school shall provide a student training kit for each enrolled aesthetics student. The kit shall contain at a minimum, the following:

1. One standard textbook for professional aestheticians;
2. One copy of Arizona cosmetology statutes and rules;
3. One disinfected, covered container to store disinfected tools and instruments as specified by R4-10-112; and
4. A container for contaminated tools or instruments.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Amended by final rulemaking at 12 A.A.R. 807, effective April 8, 2006 (Supp. 06-1).

R4-10-206. Cosmetology School Requirements

A. Schools that provide cosmetology 1600-hour training for students, 650-hour training for instructors, or both, shall provide the following minimum facilities, equipment, supplies, and materials in addition to that specified by R4-10-203 and R4-10-204:

1. A work station for each student in attendance performing cosmetology services to the public for a fee, each having:
   a. A mirror that is at least 18” by 30” when performing services on a client;
   b. A table top or counter;
   c. A client chair;
   d. A dry, disinfected, covered receptacle to store disinfected tools and instruments; and
   e. A container for contaminated tools or instruments;
2. One shampoo basin for each group of 10 students in attendance during lab or clinic instruction;
3. One hand-held hair dryer for each student in attendance during lab or clinic instruction;
4. One hooded dryer for each group of 20 students in attendance during lab or clinic instruction;
5. One high-frequency Tesla or violet-ray unit, including a facial and scalp electrode, for each group of 20 students in attendance during practical instruction;
6. Two electric clippers in the school;
7. Depilatories;
8. Chemical hair straighteners;
9. One nail technology table with a 12" x 18" or larger top for each group of 10 students in attendance during practical instruction;
10. A facial work station for each group of 10 students in attendance and receiving lab or clinic aesthetics instruction;
11. A receptacle, large enough to completely immerse two feet for each group of 10 students in attendance during lab or clinic nail technology instruction;
12. Two nail drills for filing and buffing in the school; and
13. Nail products for acrylics, gels, tips, wraps, and polishing.

B. Each school shall provide a student training kit for each enrolled student a nonreturnable student training kit. The kit shall contain at a minimum, the following:

1. One standard textbook for professional cosmetologists;
2. One copy of Arizona cosmetology statutes and rules;
3. One disinfected, covered container to store disinfected tools and instruments; and
4. A container for contaminated tools or instruments.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Amended by final rulemaking at 12 A.A.R. 807, effective April 8, 2006 (Supp. 06-1).

R4-10-207. Nail Technology School Requirements

A. A school that provides nail technology 600-hour training for students, 350-hour training for instructors, or both, shall provide the following minimum facilities, tools, instruments, equipment, supplies, and materials, in addition to those required by R4-10-203 and R4-10-204:

1. A work station to perform nail technology services for the public for each student in attendance containing:
   a. A nail technology table with a top 32” x 16” or larger;
   b. A client chair;
   c. A nail technology chair or stool;
   d. A disinfected, covered container to store disinfected tools and instruments as specified in R4-10-112;
   e. A container with wet disinfectant as specified in R4-10-112;
   f. A container for soiled tools or instruments as specified in R4-10-112;
   g. A waste receptacle as specified in R4-10-112; and
   h. A disinfectant for blood or body-fluid exposure as specified in R4-10-112.
2. One container large enough to completely immerse two feet, for every five students in attendance during practical training;
3. Nail products for acrylics, gels, tips, wraps, and polishing; and
4. One ultraviolet light.

B. Each enrolled nail technology student shall have a training kit containing:

1. One simulated hand;
2. Disinfected tools and instruments including pusher, nipper, file or porous emery boards, tweezer, nail brush, and finger bowl;
3. One covered container to store disinfected tools and implements as specified by R4-10-112;
4. A container for soiled tools and instruments as specified in R4-10-112;
5. A current instruction manual or textbook of nail technology and Arizona cosmetology laws and rules;
6. Artificial nail enhancement kit with remover, wrap kit, two dappen dishes, polish kit, nail forms, finishing tools and instruments, and one brush product applicator; and
7. One electric nail file.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Amended by final rulemaking at 11 A.A.R. 4239, effective December 5, 2005 (Supp. 05-4).

R4-10-208. Combined School Requirements

A. A licensed school shall ensure that the following hours are taught to a student enrolled in the specific curriculum before allowing the student to graduate:
1. Aesthetics course - 600 hours,
2. Aesthetics instructor course - 500 hours,
3. Cosmetology course - 1600 hours,
4. Cosmetology instructor course - 650 hours,
5. Nail technology course - 600 hours, and
6. Nail technology instructor course - 350 hours.

B. A school that provides training in all of the above courses shall have the minimum records, facilities, equipment, supplies, and materials required by:
1. R4-10-203,
2. R4-10-204,
3. R4-10-205 except subsection (A)(1) is one work station for each two aesthetics students in attendance,
4. R4-10-206, and
5. R4-10-207 except subsection (A)(1) is one work station for each two nail technology students in attendance.

C. A school that provides the curriculum specified in subsections (A)(3), (A)(4), (A)(5), and (A)(6) only shall have the minimum records, facilities, equipment, supplies, and materials required by:
1. R4-10-203,
2. R4-10-204,
3. R4-10-206, and
4. R4-10-207 except subsection (A)(1) is one work station for each two nail technology students in attendance.

D. A school that provides the curriculum specified in subsections (A)(1), (A)(2), (A)(3), and (A)(4) only shall have the minimum records, facilities, equipment, supplies, and materials required by:
1. R4-10-203,
2. R4-10-204,
3. R4-10-205 except subsection (A)(1) is one work station for each two aesthetics students in attendance, and
4. R4-10-206.

E. A school that provides the curriculum specified in subsections (A)(1), (A)(2), (A)(5) and (A)(6) only shall have the minimum records, facilities, equipment, supplies, and material required by:
1. R4-10-203,
2. R4-10-204,
3. R4-10-205, and
4. R4-10-207.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Amended by final rulemaking at 11 A.A.R. 4239, effective December 5, 2005 (Supp. 05-4).

R4-10-209. Demonstrators; Exclusions

A. A person who does not hold an instructor license shall not teach in a school but may demonstrate to enrolled students any process, product, or appliance when an instructor is present and observing the demonstration.

B. When demonstrating on a model, the demonstrations shall be confined to an explanation of the products, procedures, and appliances being promoted.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2).

ARTICLE 3. STUDENTS

R4-10-301. Instruction; Licensed Individuals

Licensed schools that provide instruction for licensed individuals pursuant to this Article shall:
1. Keep a record of the date, time, title, and name of the provider of the course along with the attendee's name and license number;
2. Ensure that the instruction consists of professional development related to scope of practice as specified by A.R.S. § 32-501; and
3. Ensure that hours are not granted toward licensing unless it is part of the approved course and provided by or in the presence of a licensed instructor.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Amended by final rulemaking at 14 A.A.R. 2083, effective July 5, 2008 (Supp. 08-2).

R4-10-302. Instructor Curriculum Required Hours

A. Each student in an aesthetics, cosmetology, or nail technology instructor course shall complete the number of hours listed in Table 1:

Table 1: Instructor Curriculum (in hours)

Subject	Aesthetics	Cosmetology	Nail Technology

1. Orientation and Arizona laws and rules	8	8	8
2. Theory, Preparation, and Practice Curriculum Development Developing and Using Educational Aids Presentation Principles (Practical and Written) Classroom Management Evaluation, Assessment, and Remediation Methods (Practical and Written) Diversity in learning (including cultural) Methods of Teaching Professional Development (including ethics) Alternative Learning [see subsection (B)]	405	405	270
3. Lab (clinic) oversight	87	237	72
4. Total Hours	500	650	350

B. Curriculum hours may be satisfied in part by completing a course at an accredited college or university described in R4-10-101(15)(c) and (d), for no more than nine credit hours for cosmetology or aesthetics and no more than six credit hours for nail technology and encompassing the subjects listed under Theory, Preparation, and Practice in subsection (A) with each college credit hour equaling no more than 30 clock hours.

C. All instruction given by a student instructor shall be under the direct supervision and observation of a licensed instructor.

D. A student instructor shall be counted as a student for the purpose of determining the maximum allowed ratio of 40 students during a theory class and 20 students during a lab or clinic for each licensed instructor in the school.

E. A student instructor shall not instruct students or check student services performed on the public until the student instructor has received at least 80 hours of basic instructor training.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Amended by final rulemaking at 11 A.A.R. 4239, effective December 5, 2005 (Supp. 05-4).

R4-10-303. Aesthetics Curriculum Required 600 Hours

A. Each student in an aesthetics course shall complete the following curriculum:

1. Theory of aesthetics, infection control, anatomy, physiology and histology of the body, diseases and disorders, and Arizona cosmetology laws and rules; and
2. Clinical and laboratory aesthetics including theory that involves all skin types:
   a. Principles and practices of infection control and safety;
   b. Recognition of diseases and the treatment of disorders of the skin;
   c. Interpersonal skills and professional ethics;
   d. Clinical and laboratory practice that includes face and body;
   e. Morphology and treatment of skin, including face and body, by hand and machine;
   f. Product pharmacology and chemistry interaction, formulation, composition, and hazards;
   g. Aesthetics machines, tools, and instruments and their related uses;
   h. Alternative skin technology;
   i. Pre- and post-client consultation, documentation, and analysis;
   j. Spa body modalities;
   k. Exfoliation modalities;
   l. Body and face massage and manipulations;
   m. Body and facial hair removal except by electrolysis;
   n. Introduction to electricity and light therapy for cosmetic purposes including laser/Intense Pulsed Light (IPL) procedures and devices;
   o. Cosmetic enhancement applications; and
   p. Required industry standards and ecology, including monitor duties.

B. An aesthetics school shall not receive remuneration for a student performing clinical services to the public until the student has received at least 120 hours of aesthetics training; and

C. Each student shall be evaluated for progress and provided suggested remediation of deficiencies.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Amended by final rulemaking at 11 A.A.R. 4239, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 2083, effective July 5, 2008 (Supp. 08-2).

R4-10-304. Cosmetology Curriculum Required 1600 Hours

A. Each student in a cosmetology course shall complete the following curriculum:

1. Theory of cosmetology, infection control, anatomy, physiology and histology of the body, electricity, diseases and disorders, and Arizona cosmetology laws and rules; and
2. Clinical and laboratory cosmetology including theory that involves nails, hair, and skin:
   a. Principles and practices of infection control and safety;
   b. Recognition of diseases and the treatment of disorders of the hair, skin, and nails;
   c. Morphology and treatment of hair, skin, and nails;
   d. Interpersonal skills and professional ethics;
   e. Product pharmacology and chemistry interaction, formulation, composition, and hazards;
   f. Cosmetology machines, tools, and instruments and their related uses;
   g. Chemical texturizing;
   h. Changing existing hair color;
   i. Hair and scalp care;
   j. Fundamentals of hairstyling including braiding and extensions;
   k. Body, scalp, and facial massage and manipulations;
   l. Hair cutting fundamentals;
   m. Fundamental aesthetics of the body and face;
   n. Fundamentals of nail technology;
   o. Clinical and laboratory practice that includes hair, skin, and nails;
   p. Alternative hair, skin, and nail technology;
   q. Pre- and post-client consultation, documentation, and analysis;
   r. Body and facial hair removal except by electrolysis;
   s. Introduction to electricity and light therapy for cosmetic purposes including laser/Intense Pulsed Light (IPL) procedures and devices;
   t. Cosmetology technology; and
   u. Required industry standards and ecology, including monitor duties.

B. A cosmetology school shall not receive remuneration for a student performing any clinical services, except shampooing, to the public until the student has received at least 300 hours of cosmetology training; and

C. Each student shall be evaluated for progress and provided suggested remediation of deficiencies.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Amended by final rulemaking at 11 A.A.R. 4239, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 2083, effective July 5, 2008 (Supp. 08-2).

R4-10-305. Nail Technology Curriculum Required 600 Hours

A. Each student in a nail technology course shall complete the following curriculum:

1. Theory of nail technology; infection control; diseases and disorders of the nails and skin; anatomy; physiology and histology of the limbs, nails, and skin structures; and Arizona state cosmetology laws and rules; and
2. Clinical and laboratory nail technology including theory that involves nails, skin, and limbs:
   a. Principles and practices of infection control and safety;
   b. Recognition of diseases and the treatment of disorders of the nail and skin;
   c. Massage and manipulation of the limbs;
   d. Interpersonal skills and professional ethics;
   e. Product pharmacology and chemistry interaction, formulation, composition, and hazards;
   f. Nail technology machines, tools, and instruments and their related uses;
   g. Clinical and laboratory practice that includes nails, skin, and limbs;
   h. Pre- and post-client consultation, documentation, and analysis;
   i. Manicuring, including use of nippers;
   j. Pedicuring, including use of nippers;
   k. Artificial nail enhancements (application and removal);
   l. Alternative nail technology;
   m. Electric file use;
   n. Pedicure spa modalities;
   o. Exfoliation modalities on limbs or the body; and
   p. Required industry standards and ecology, including monitor duties.

B. A nail technology school shall not receive remuneration for students performing clinical services to the public until the student has received at least 80 hours of nail technology; and

C. Each student shall be evaluated for progress and provided suggested remediation of deficiencies.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Amended by final rulemaking at 11 A.A.R. 4239, effective December 5, 2005 (Supp. 05-4).

R4-10-306. Curricula Hours

A. Hours of training received in an aesthetics, cosmetology, or nail technology course do not apply toward receiving an instructor's license.

B. Hours of training received in an instructor course do not apply toward receiving an aesthetician, cosmetologist, or nail technician license but may apply toward reactivation of an aesthetics, cosmetology, or nail technology license if the instructor hours are received after inactive status occurs.

C. The following hours may apply toward licensing:

1. 100% of the hours of training received in a nail technology course toward a cosmetologist license;
2. 100% of the hours of training received in an aesthetics course toward a cosmetologist license;
3. 100% of the hours of combined training received in an aesthetics course and a nail technology course toward a cosmetology license but the combined total shall not exceed 600 hours;
4. 15% of the hours of training received in a cosmetology course toward a nail technician license;
5. 15% of the hours of training received in a cosmetology course toward an aesthetician license;
6. 33% of the hours of training received in a nail technology course toward an aesthetics license;
7. 66% of the hours of training received in an aesthetics course toward a nail technology license;
8. 50% of the hours of training received in a barber course toward a cosmetologist license;
9. 200 hours of training received for a registered nurse (RN) or clinical nurse specialist (CNS) license toward an aesthetician license;
10. 100% of the hours of training received by a licensed cosmetologist in a nail technology instructor course toward an aesthetics instructor course; however, the remaining required hours shall be received in an aesthetics or cosmetology school;
11. 100% of the hours of training received by a licensed cosmetologist in a nail technology instructor course toward a cosmetology instructor course; however, the remaining required hours shall be received in a cosmetology school;
12. 100% of the hours of training received by a licensed cosmetologist in an aesthetics instructor course toward a cosmetology instructor course; however, the remaining required hours shall be received in a cosmetology school;
13. 100% of the hours of training received in a barber instructor course toward a cosmetology instructor course; however, the remaining required hours shall be received in a cosmetology school. One year of licensed barber experience is the same as one year of licensed cosmetology experience for the purpose of qualifying for the cosmetology instructor examination specified by A.R.S. § 32-531; and
14. Hours transferred to another course shall be used only once.

D. At the completion of a course of instruction, the cumulative hours for students shall, at a minimum, conform with R4-10-301, R4-10-302, R4-10-303, R4-10-304, R4-10-305, and R4-10-306 as applicable.

E. Infection control, disinfection procedures, and safety issues shall be taught with every subject and every procedure.

F. Alternative learning hours are hours that a school may authorize to enable a student to pursue knowledge of cosmetology in an alternative format or location other than a salon. A school shall not credit a student with more than 20% of the total hours required for graduation, earned during enrollment at the school, as alternative learning hours.

G. A school that provides alternative format or location in subsection (F) shall include details of the format and location in the school policy and procedures in the school catalog.

H. Up to 16 hours of field trips may be granted toward licensing if the field trips for which those hours were granted are part of the approved course of instruction and are provided by or in the presence of a licensed instructor.

I. If a school physically closes while providing curricula in an alternative format or location or while conducting a field trip, the school shall:

1. Post a notice that is visible to the public and students; and
2. Send a notice to the Board indicating the times and location where the curricula is being conducted.

J. A student instructor may obtain lab (clinic) hours in a licensed school other than the licensed school in which the student instructor is enrolled if the student:

1. Has available proof of enrollment in a licensed school to show to a Board inspector, and
2. Earns no more than the lab (clinic) hours required by R4-10-302.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Amended by final rulemaking at 11 A.A.R. 4239, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 2083, effective July 5, 2008 (Supp. 08-2).

ARTICLE 4. SALONS

R4-10-401. Application for a Salon License

An applicant for a salon license shall submit:

1. An application on a form provided by the Board that contains:
   a. The applicant's name, address, telephone number, federal tax identification number, and signature;
   b. If the applicant is a partnership, each partner's name, address, and an identification of whether each is a limited or general partner;
   c. If a corporation, the state of incorporation and the name, title, and address of each officer of the corporation and the statutory agent;
   d. The name of the salon as registered with the Secretary of State;
   e. If a location change, the previous address;

f. A history of the salon including:
i. If the location was previously licensed by the Board, the name of the previous establishment;
ii. The name of each business operating at the salon address; and
iii. A statement of whether a cosmetology license of the applicant, any partner of the applicant, or any corporate officer has ever been suspended or revoked by any state or foreign country.

2. If a corporation, the articles of incorporation and a Certificate of Good Standing from the Corporation Commission;
3. If a partnership, a copy of the partnership agreement;
4. A signed statement that the establishment is in compliance with all Board statutes and rules and has all of the following in the salon:
a. Wet disinfectant;
b. A dry, closed, disinfected container to store disinfected tools and instruments;
c. A sink or shampoo bowl with hot and cold running water that is not also used as a dispensary or restroom sink as required by R4-10-403;
d. A station;
e. A restroom; and
f. Notice posted for activities performed in the salon but not regulated by the Board; and
5. The fee required in R4-10-102.

Historical Note

Adopted effective April 9, 1996 (Supp. 96-2). Section repealed; new Section adopted by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 12 A.A.R. 807, effective April 8, 2006 (Supp. 06-1).

R4-10-402. Changes Affecting a Salon License

A. An owner shall apply for a new salon license when:
1. The salon address changes;
2. The name of a salon changes;
3. The controlling ownership in the corporation is transferred or the corporation is reorganized; or
4. The corporation, limited liability company, or partnership has a change of any corporate officer, partner, or statutory agent.

B. The salon owner and manager shall ensure that a Board-issued license, indicating proper ownership, is posted in the salon before opening for business.

Historical Note

Former Section R4-10-402 renumbered to R4-10-403; new Section adopted by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 12 A.A.R. 807, effective April 8, 2006 (Supp. 06-1).

R4-10-403. Salon Requirements and Minimum Equipment

A. A salon shall perform services for the public according to the type of license issued.

B. Salons shall have enough equipment, materials, supplies, tools, and instruments to ensure infection control and safety for the public and employees.

C. Each salon shall have:
1. A work station for each employee or person using space within the salon; and
2. If the salon is a cosmetology salon, a minimum of one shampoo bowl and one hair dryer that may be a blow dryer, and if the salon is an aesthetics or nail technology salon, a minimum of one sink in addition to the restroom or dispensary sink.

D. Aestheticians, cosmetologists, and nail technicians shall have enough equipment, materials, supplies, tools, and instruments to ensure infection control at all times and disinfection between clients.

Historical Note

Adopted April 9, 1996 (Supp. 96-2). Former Section R4-10-403 renumbered to R4-10-404; new Section R4-10-403 renumbered from Section R4-10-402 by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 12 A.A.R. 807, effective April 8, 2006 (Supp. 06-1).

R4-10-404. Mobile Services

A. If mobile services are provided as an extension of a licensed salon the mobile service shall advertise using the licensed name of the salon. The licensed salon owner and manager shall ensure that the mobile services comply with the Board's statutes and rules.
1. A salon providing mobile cosmetology, nail technology, or aesthetics services shall post licenses as required by R4-10-111.
2. A salon shall make client appointments through the licensed salon using an appointment book that lists the appointments and locations where services are performed.
3. Mobile services are subject to inspection by the Board at any time.
4. If a retrofitted mobile vehicle is used to provide mobile services, the salon owner and manager shall ensure that the vehicle has the same equipment as specified by R4-10-403 and complies with safety and infection control requirements specified by R4-10-112.
5. If mobile services are provided in a location other than a retrofitted mobile vehicle, the salon owner and manager shall ensure that equipment is disinfected before use and stored as specified in R4-10-112.

B. If a retrofitted motor vehicle is used exclusively as a mobile facility that is dispatched from a business address, the owner and manager of the mobile facility shall:

1. Comply with all salon requirements;
2. Comply with all infection control and equipment requirements;
3. Maintain a complete and current list of appointment locations at the business address and display the list in a location listed on the salon application that is available to an inspector at all times when the retrofitted motor vehicle is open for business; and
4. Comply with other statutes and rules of the Board.

Historical Note

Adopted April 9, 1996 (Supp. 96-2). Former Section R4-10-404 renumbered to R4-10-405; new Section R4-10-404 renumbered from Section R4-10-403 by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 12 A.A.R. 807, effective April 8, 2006 (Supp. 06-1).

R4-10-405. Shampoo Assistants

A. People who are not licensed by the Board may be hired as shampoo assistants to shampoo and apply cream rinse to an individual's hair, comb the hair to remove tangles, and remove rollers and clippies.

B. Shampoo assistants shall not apply conditioners, reconstructors, hair color, permanent wave solution or neutralizer, or remove rods, tint, relaxers, or other solutions from the hair.

Historical Note

New Section R4-10-405 renumbered from Section R4-10-404 by final rulemaking at 5 A.A.R. 1791, effective May 18, 1999 (Supp. 99-2).

32-501. Definitions

In this chapter, unless the context otherwise requires:

1. "Aesthetician" means a person who is licensed to practice skin care pursuant to this chapter.

2. "Aesthetics" means any one or a combination of the following practices if they are performed for cosmetic purposes:

(a) Massaging, cleansing, stimulating, manipulating, exercising, beautifying or applying oils, creams, antiseptics, clays, lotions or other preparations, either by hand or by mechanical or electrical appliances.

(b) Arching eyebrows or tinting eyebrows and eyelashes.

(c) Removing superfluous hair by means other than electrolysis or threading.

3. "Board" means the board of cosmetology.

4. "Cosmetic purposes" means for the purpose of beautifying, preserving or conferring comeliness, excluding therapeutic massage and manipulations.

5. "Cosmetologist" means a person who is licensed to practice cosmetology pursuant to this chapter.

6. "Cosmetology" means any one or a combination of the following practices if they are performed for cosmetic purposes:

(a) Cutting, clipping or trimming hair.

(b) Massaging, cleansing, stimulating, manipulating, exercising, beautifying or applying oils, creams, antiseptics, clays, lotions or other preparations, either by hand or by mechanical or electrical appliances.

(c) Styling, arranging, dressing, curling, waving, permanent waving, straightening, cleansing, singeing, bleaching, dyeing, tinting, coloring or similarly treating hair.

(d) Arching eyebrows or tinting eyebrows and eyelashes.

(e) Removing superfluous hair by means other than electrolysis or threading.

(f) Nail technology.

7. "Electrical appliances" means devices that use electrical current and includes lasers and IPL devices as defined in section 32-516.

8. "Instructor" means a person who is licensed to teach cosmetology, aesthetics or nail technology, or any combination thereof, pursuant to this chapter.

9. "Nail technician" means a person who is licensed to practice nail technology pursuant to this chapter.

10. "Nail technology" means:

(a) Cutting, trimming, polishing, coloring, tinting, cleansing or otherwise treating a person's nails.

(b) Applying artificial nails.

(c) Massaging and cleaning a person's hands, arms, legs and feet.

11. "Salon" means any of the following:

(a) An establishment that is operated for the purpose of engaging in the practice of cosmetology, aesthetics or nail technology, or any combination of the listed practices.

(b) An establishment together with a retrofitted motor vehicle for exclusive use as a mobile facility for the purpose of engaging in the practice of cosmetology, aesthetics or nail technology, or any combination of the listed practices, that is operated and dispatched through the establishment.

(c) A retrofitted motor vehicle exclusively used as a mobile facility for the purpose of engaging in the practice of cosmetology, aesthetics or nail technology, or any combination of the listed practices that is operated and dispatched from a business that has a physical street address that is on file with the board.
12. "School" means an establishment that is operated for the purpose of teaching cosmetology, aesthetics or nail technology, or any combination of the listed practices.
13. "Threading" means a service that results in the removal of hair from its follicle from around the eyebrows and from other parts of the face with the use of a single strand of cotton thread and an over-the-counter astringent, if the service does not use chemicals of any kind, wax or any implements, instruments or tools to remove hair.

32-502. Board of cosmetology; appointment; qualifications; terms
A. A board of cosmetology is established consisting of the following seven members who are appointed by the governor:
1. Two cosmetologists who have been actively practicing in this state for at least three years immediately preceding appointment.
2. One nail technician who has been actively practicing in this state for at least three years immediately preceding appointment.
3. One instructor who has been actively practicing in this state for at least three years immediately preceding appointment.
4. One school owner.
5. One educator who does not represent the cosmetology or nail technology industry and is not involved in the manufacture of cosmetology or nail technology products.
6. One public member who is not and has never been associated with the cosmetology or nail technology industry, licensed as a cosmetologist or nail technician or involved in the manufacture of cosmetology or nail technology products.
B. The term of office for members is three years beginning and ending June 22.
C. The governor may remove board members for neglect of duty, malfeasance or misfeasance.

32-503. Organization; meetings; personnel; compensation [CHANGE]
A. The board shall annually elect a chairman, vice-chairman and secretary-treasurer from among its membership.
B. The board shall hold at least one regular meeting monthly and may hold other meetings at times and places it designates.
C. Subject to title 41, chapter 4, article 4, the board may employ the following personnel as it deems necessary to carry out the purposes of this chapter and designate their duties:
1. An executive director who shall have been a licensed cosmetologist for at least one of the five years immediately preceding employment.

2. A supervisor of examinations who is an instructor licensed pursuant to this chapter and has worked at least two of the five years immediately preceding employment as an instructor in a school licensed pursuant to this chapter.
3. Examiners who shall not be employed as instructors in any school licensed pursuant to this chapter.
4. Persons to provide investigative, professional and clerical assistance as the board deems necessary and may hire consultants to assist the board in the performance of its duties.
5. Other personnel.
D. Members of the board are eligible to receive compensation as determined pursuant to section 38-611 for each day of actual service in the business of the board. The board shall compensate its executive director and other personnel as determined pursuant to section 38-611.

32-504. Powers and duties
A. The board shall:
1. Adopt rules that are necessary and proper for the administration of this chapter, including sanitary and safety requirements for salons and schools and sanitary and safety standards for the practice of cosmetology, aesthetics and nail technology.
2. Administer and enforce this chapter and rules adopted pursuant to this chapter.
3. Either prepare, administer and grade practical and written examinations or contract with a national professional organization for cosmetology selected by the board to prepare, administer and grade practical and written examinations.
4. Make and maintain a record of its acts and proceedings, including the issuance, denial, renewal, suspension or revocation of licenses and public reproofs of licensees.
5. Evidence its official acts by the signature of the chairman or vice-chairman of the board or a representative designated by the board.
6. Keep records of the board open to public inspection at all reasonable times.
7. Make an annual report to the governor on or before October 1 of each year covering its official acts and financial transactions during the preceding fiscal year and making recommendations it deems necessary.
8. Prescribe minimum school curriculum requirements for cosmetologists, aestheticians, nail technicians and instructors.
9. Prescribe standards and requirements for the provision of salon services through mobile units and in customer locations.
B. The board may:
1. Inspect the premises of any salon or school during business hours.
2. Delegate authority to its executive director to issue licenses to applicants who meet the requirements of this chapter.

32-505. Board of cosmetology fund
A. The board of cosmetology fund is established. Except as provided in subsection C of this section, before the end of each calendar month, pursuant to sections 35-146 and 35-147, the board shall deposit ten per cent of all monies from whatever source which come into the possession of the board in the state general fund and deposit the remaining ninety per cent in the board of cosmetology fund.

B. Except as provided in section 32-573, subsection G, monies deposited in the board of cosmetology fund are subject to section 35-143.01.
C. Monies from civil penalties received pursuant to section 32-571 shall be deposited, pursuant to sections 35-146 and 35-147, in the state general fund.

32-506. Nonapplicability of chapter
This chapter does not apply to the following persons while in the proper discharge of their professional duties:
1. Practices done for the treatment of physical or mental ailments or disease by medical practitioners licensed pursuant to this title.
2. Commissioned physicians and surgeons serving in the armed forces of the United States or other federal agencies.
3. Persons licensed pursuant to chapter 3 or 12 of this title.
4. Students attending schools licensed pursuant to this chapter while they are on school premises during school hours.
5. Persons employed by theatrical groups who apply makeup, oils and cosmetics.
6. Persons who sell makeup, oils and cosmetics and who apply such products during the process of selling such products.
7. Shampoo assistants who shampoo hair under the direction of a cosmetologist licensed pursuant to this chapter.
8. Services performed by and for persons in the custody of the state department of corrections.
9. Persons who apply makeup, oils and cosmetics to patients in a hospital, nursing home or residential care institution with the consent of the patient and the hospital, nursing home or residential care institution.
10. Persons who provide a service that results in tension on hair strands or roots by twisting, wrapping, weaving, extending, locking or braiding, if the service does not include the application of dyes, reactive chemicals or other preparations to alter the color of the hair or to straighten, curl or alter the structure of the hair.
11. Persons who provide threading.
12. Persons who provide tanning services by means of airbrushing, tanning beds or spray tanning.

32-507. Fees [CHANGE]
A. The board shall establish and collect fees not to exceed the following:
1. Written examination, one hundred dollars.
2. Practical examination, one hundred dollars.
3. Application for initial personal license, forty-five dollars.
4. Application for personal reciprocity license, one hundred twelve dollars.
5. Application for salon license, one hundred twelve dollars.
6. Application for school license, six hundred dollars.
7. Application for certification of licensure or hours, thirty dollars.
8. Personal license renewal, thirty-eight dollars.
9. Personal license delinquent renewal, sixty dollars.
10. Salon license renewal, fifty dollars.
11. Salon license delinquent renewal, eighty dollars.
12. School license renewal, five hundred dollars.
13. School license delinquent renewal, six hundred dollars.

14. Delinquent penalties for each year or portion of a year for which the license was inactive.
15. Computer printouts of names of licenses, twenty-five cents per name.
16. Duplicate license, thirty dollars.
17. Dishonored checks, twenty dollars.
18. Copying charges, one dollar per page. For audiotapes, videotapes, computer discs or other mediums used for recording sounds, images or information, fifteen dollars per tape, disc or other medium.
19. Board administered educational classes, one hundred dollars.
20. Review of examination, fifty dollars.
21. Regrading of examinations, twenty-five dollars.
22. Service charges for persons who pay with alternative payment methods including credit cards, charge cards, debit cards and electronic transfers, not to exceed the cost of the alternative payment method.
B. The board may charge additional fees for:
1. Documents and publications provided by the board.
2. Services which the board deems appropriate to carry out its intent and purpose. These additional fees shall not exceed the costs of rendering the services.
C. The board shall only issue a duplicate license on receipt of a written request which states the reason for the request for a duplicate license.

32-510. Aestheticians; applications; qualifications
A person is entitled to receive an aesthetician's license if the person:
1. Submits to the board an application for an aesthetician's license on a form supplied by the board.
2. Completes and receives appropriate credits for at least two years of high school education or its equivalent as prescribed by the board in its rules and submits to the board satisfactory evidence that the person is at least sixteen years of age.
3. Submits to the board satisfactory evidence of either of the following:
(a) That the person is a graduate of an aesthetician school in another state or country that has substantially the same requirements as this state for schools licensed pursuant to this chapter.
(b) That the person is a graduate of an aesthetician course consisting of at least six hundred hours of training in a school licensed pursuant to this chapter.
4. Passes the examination for an aesthetician's license.
5. Pays the prescribed fees for an aesthetician's license.

32-511. Cosmetologist; applications; qualifications
A person is entitled to receive a cosmetologist license if the person:
1. Submits to the board an application for a cosmetologist license on a form supplied by the board.
2. Completes and receives appropriate credits for at least two years of high school education or its equivalent as prescribed by the board in its rules and submits satisfactory evidence that the person is at least sixteen years of age.
3. Submits to the board satisfactory evidence of either of the following:
(a) That the person is a graduate of a cosmetology course consisting of at least sixteen hundred hours of training in a school licensed pursuant to this chapter.

(b) That the person is a graduate of a cosmetology school in another state or country that had at the time of the person's graduation substantially the same requirements as this state for schools licensed pursuant to this chapter.
4. Passes the examination for a cosmetologist license.
5. Pays the prescribed fees.

32-512. Nail technician; applications; qualifications
A person is entitled to receive a license to practice nail technology if the person does all of the following:
1. Submits to the board an application for a nail technician license on a form supplied by the board.
2. Completes and receives appropriate credits for at least two years of high school education or its equivalent as prescribed by the board in its rules and submits satisfactory evidence that the person is at least sixteen years of age.
3. Submits to the board satisfactory evidence of either of the following:
(a) That the person graduated from a nail technology school in another state or country that had at the time of the person's graduation substantially the same requirements as this state for schools licensed pursuant to this chapter.
(b) That the person completed a nail technician course consisting of at least six hundred hours of training in a school licensed pursuant to this chapter.
4. Pays the prescribed fees for a nail technician license.
5. Passes the examination for a nail technician license.

32-513. Reciprocity
Notwithstanding sections 32-510, 32-511 and 32-512, a person is entitled to receive a cosmetologist, aesthetician or nail technician license if the person:
1. Submits to the board an application for a cosmetologist, aesthetician or nail technician license on a form supplied by the board.
2. Submits to the board satisfactory evidence that the person is licensed in another state or country.
3. Takes and completes a class relating to infection protection and law review that is provided by the board or its designee. The board shall determine the amount of the fees for the class. The applicant shall pay the fees directly to the board or its designee.
4. Pays the prescribed reciprocity license fees.

32-514. Examinations
A. The board or a national professional organization for cosmetology selected by the board shall administer written and practical examinations for a cosmetologist, aesthetician, nail technician or instructor license. The examinations shall test for requisite knowledge and skills in the technical application of cosmetology services.
B. The board or a national professional organization for cosmetology selected by the board shall inform each applicant of the examination results.
C. The board shall make an accurate record of each examination.

32-515. Reexaminations
A. An applicant who fails an examination for a license pursuant to this article is entitled to a reexamination.

B. If an applicant fails either part of the examination, the applicant shall only retake the part of the examination that the applicant failed.
C. If one year or more elapses between an applicant's initial examination and reexamination, the applicant shall take both the written and practical parts of the examination.
D. An applicant desiring to be reexamined shall:
1. Apply to the board, if the board is administering the examination, on forms it prescribes and furnishes or to a national professional organization selected by the board to administer the examination.
2. Pay the prescribed examination fee.

32-516. Aestheticians; cosmetologists; cosmetic laser and IPL device use; certification; fees; definitions
A. An aesthetician or a cosmetologist who wishes to perform cosmetic laser procedures and procedures using IPL devices must:
1. Apply for and receive a certificate from the agency.
2. Comply with the requirements of this section and agency rules.
3. Successfully complete forty hours of didactic training as required by agency rules at an agency-certified training program. The program shall provide a provisional certificate to the applicant verifying the successful completion of the didactic training.
4. For hair removal, complete hands-on training that is supervised by a health professional who is acting within the health professional's scope of practice or by a laser technician who has a minimum of one hundred hours of hands-on experience per procedure. The health professional or laser technician must be present in the room during twenty-four hours of hands-on use of lasers or IPL devices. The supervising health professional or laser technician shall verify that the aesthetician or cosmetologist has completed the training and supervision as prescribed by this section.
5. For other cosmetic laser and IPL device procedures, complete a minimum of an additional twenty-four hours of hands-on training of at least ten cosmetic procedures for each type of specific procedure that is supervised by a health professional who is acting within the health professional's scope of practice or by a laser technician who has a minimum of one hundred hours of hands-on experience per procedure. The health professional or laser technician must be present in the room during twenty-four hours of hands-on use of lasers or IPL devices. The supervising health professional or laser technician shall verify that the aesthetician or cosmetologist has completed the training and supervision as prescribed by this section.
6. Submit to the agency the provisional certificate from the training program and certification by the health professional or laser technician who directly supervised the applicant in the room during the hands-on training.
B. The agency shall issue a laser technician certificate authorizing the aesthetician or cosmetologist to use lasers and IPL devices if the applicant has completed the training for hair removal or lasers and IPL devices for other cosmetic procedures, as applicable, and shall maintain a current register of those laser technicians in good standing and whether certification is for hair removal only or other cosmetic procedures as well. The agency may establish a fee for the registration of

aestheticians or cosmetologists as laser technicians and the issuance of certificates pursuant to this subsection. The agency shall deposit monies collected pursuant to this subsection in the laser safety fund established by section 32-3234.
C. An aesthetician or a cosmetologist who has been certified as a laser technician by the agency may use a laser or IPL device:
1. For hair removal under the indirect supervision of a health professional whose scope of practice permits the supervision.
2. For cosmetic purposes other than hair removal if the aesthetician or cosmetologist is directly supervised by a health professional whose scope of practice permits the supervision and the aesthetician or cosmetologist has been certified in those procedures.
D. The board shall investigate any complaint from the public or from another board or agency regarding a licensed aesthetician or cosmetologist who performs cosmetic laser procedures or procedures using IPL devices pursuant to this section. The board shall report to the agency any complaint it receives about the training or performance of an aesthetician or a cosmetologist who is certified as a laser technician.
E. An aesthetician or a cosmetologist who used laser and IPL devices before November 24, 2009 may continue to do so if the aesthetician or cosmetologist received a certificate pursuant to this section before October 1, 2010.
F. For the purposes of this section:
1. "Agency" means the radiation regulatory agency.
2. "Directly supervised" means a health professional who is licensed in this state and whose scope of practice allows the supervision supervises the use of a laser or IPL device for cosmetic purposes while the health professional is present at the facility where and when the device is being used.
3. "Health professional" means a person who is licensed pursuant to either:
(a) Chapter 11, article 2 of this title and who specializes in oral and maxillofacial surgery.
(b) Chapter 13, 14, 15, 17 or 25 of this title.
4. "Indirect supervision" means supervision by a health professional who is licensed in this state, whose scope of practice allows the supervision and who is readily accessible by telecommunication.
5. "IPL device" means an intense pulse light class II surgical device certified in accordance with the standards of the agency for cosmetic procedures.
6. "Laser" means any device that can produce or amplify electromagnetic radiation with wavelengths in the range of one hundred eighty nanometers to one millimeter primarily by the process of controlled stimulated emission and certified in accordance with the standards for the agency for cosmetic procedures.
7. "Laser technician" means a person who is or has been certified by the agency pursuant to its rules and chapter 32, article 2 of this title.

32-517. License renewal
A. Except as provided in section 32-4301, a cosmetologist, aesthetician or nail technician shall renew his license on or before his birth date every year.
B. A cosmetologist, aesthetician or nail technician shall submit an application for renewal accompanied by the prescribed renewal fee in order to renew his license.

C. A cosmetologist, aesthetician or nail technician who fails to renew his license on or before his birth date shall also pay the prescribed delinquent renewal penalty in order to renew his license.

32-518. Inactive licenses; reactivation; suspension
A. A license that is not renewed pursuant to section 32-517 automatically reverts to inactive status.
B. A licensee may reactivate an inactive license:
1. If a license has been inactive for less than one year, by paying the prescribed delinquent renewal penalty.
2. If a license has been inactive for one year or more but less than ten years, by paying the prescribed delinquent renewal penalty and submitting proof of satisfying educational requirements prescribed by the board in its rules.
C. A license that has been inactive for ten years is automatically suspended.
D. A licensee shall not practice under an inactive license.

32-531. Instructor; applications; qualifications
A person is entitled to receive a license to teach cosmetology, aesthetics or nail technology in a school if the person does all of the following:
1. Submits to the board an application for an instructor license on a form prescribed by the board.
2. Holds a diploma from a high school or its equivalent as prescribed by the board in its rules and submits to the board satisfactory evidence that the person is at least sixteen years of age.
3. Is a licensed cosmetologist, aesthetician or nail technician and complies with either of the following:
(a) Has practiced for at least one year, has passed the school examination and has received the following hours of instructor training:
(i) For a cosmetologist instructor, six hundred fifty hours.
(ii) For an aesthetics instructor, five hundred hours.
(iii) For a nail technician instructor, three hundred fifty hours.
(b) Has five years of licensed industry experience within the ten years preceding the application and meets requirements as prescribed by the board in its rules.
4. Passes the examination for an instructor license.
5. Pays the prescribed fees.

32-532. Instructor reciprocity
Notwithstanding section 32-531, a person is entitled to receive a license to teach cosmetology, aesthetics or nail technology in a school if the person submits to the board an application for an instructor license on a form prescribed by the board, pays the prescribed fees and complies with one of the following:
1. Is a current licensed cosmetologist, aesthetician or nail technician instructor in another state or country.
2. Does all of the following:
(a) Holds a diploma from a high school or its equivalent as prescribed by the board in its rules and submits to the board satisfactory evidence that the person is at least sixteen years of age.

(b) Is a licensed cosmetologist, aesthetician or nail technician in another state or country.
(c) Completes instructor training in another state or country that has instructor education requirements that are at least substantially equivalent to those of this state.
(d) Passes the examination for an instructor license.
3. Does all of the following:
(a) Has five years of licensed industry experience within the ten years preceding application.
(b) Holds a high school diploma or its equivalent as prescribed by the board in its rules and submits to the board satisfactory evidence that the person is at least sixteen years of age.
(c) Meets requirements as prescribed by the board in its rules.
(d) Passes the examination for an instructor license.

32-533. Instructor examinations; reexaminations
A. An examination for an instructor license shall be written and practical.
B. The board shall inform each applicant of the applicant's examination results in writing.
C. The board shall make an accurate record of each examination.
D. An applicant who fails any part of the examination twice shall attend a school licensed pursuant to this chapter for two hundred fifty hours of instructor training.
E. An applicant desiring to be reexamined shall apply to the board on forms it prescribes and furnishes and pay the prescribed examination fee.

32-535. Instructor license renewal
A. Except as provided in section 32-4301, an instructor shall renew his license on or before his birth date every year.
B. An instructor shall submit an application for renewal accompanied by the prescribed renewal fee in order to renew his license.
C. An instructor who fails to renew his license on or before his birth date shall also pay the prescribed delinquent renewal penalty in order to renew his license.

32-536. Instructor practice; instruction
A. An instructor may practice in the category of practice he is licensed to practice in a salon licensed pursuant to this chapter.
B. An instructor shall teach only in the area he is licensed by the board to teach.

32-537. Instructor; inactive licenses; reactivation; suspension
A. An instructor license that is not renewed pursuant to section 32-535 automatically reverts to inactive status.
B. A licensee may reactivate an inactive license:
1. If a license has been inactive for less than one year, by paying the prescribed delinquent renewal penalty.
2. If a license has been inactive for one year or more but less than ten years, by paying the prescribed delinquent renewal penalty and submitting proof of satisfying educational requirements prescribed by the board in its rules.
C. A license that has been inactive for ten years is automatically suspended.

D. A licensee shall not practice under an inactive license.

32-541. Salon requirements
A. A person is entitled to receive a license to operate a salon if the person:
1. Submits to the board an application for a salon license on a form supplied by the board.
2. Pays the prescribed fee.
B. The safety and sanitary requirements specified by the board in its rules shall be requirements while a salon is operating.
C. Each salon shall have an individual designated as the manager of the salon.

32-542. Salon inspections
A. The board shall inspect all proposed salons to determine if all of the requirements are met. The board may issue a license to a salon pending inspection of the salon as it deems appropriate.
B. The board shall inspect salons on a regular basis as it deems necessary.

32-543. Required display
Salons shall display the following in a conspicuous location which is readily observable by any patron:
1. The current salon license.
2. The current licenses for cosmetologists, aestheticians or nail technicians practicing in the salon.
3. The latest inspection sheet.

32-544. Salon license renewal
A. Except as provided in section 32-4301, a salon license is renewable each year on or before the anniversary date of the first license by meeting all the requirements for a salon license and paying the prescribed renewal fee.
B. A salon owner who fails to renew the owner's salon license each year by the anniversary date of the license shall apply pursuant to section 32-541 and pay the prescribed fee and delinquent renewal penalty.

32-545. Change of ownership or location; change of trade name
A. A salon shall not change from the name of one licensee to another or from one location to another or change its trade name without filing a new application and paying the prescribed fee.
B. A salon owner shall notify the board in writing within ten days after any change of ownership of the salon or change in the salon's location or trade name and pay the prescribed fee.

32-551. School licenses; applications; requirements
A. A person is entitled to a license to operate a school if:
1. He pays the prescribed fee.
2. He furnishes a surety bond in the amount of ten thousand dollars approved by the board and executed by a corporate bonding company authorized to do business in this state. The bond shall be for the benefit of and subject to the claims of the

state for failure to comply with the requirements of this chapter and any student who fails to receive the full course of instruction required under this chapter.
3. He submits to the board under oath an application for a school license on a form supplied by the board and other documentation required by the board in its rules.
4. The proposed school passes an inspection by the board before it opens.
B. An incomplete application shall be returned to an applicant within thirty days after the board receives it with the causes for the return.

32-552. Change of ownership or location; change of trade name
A. A school shall not change from the name of one licensee to another or from one location to another or change its trade name without filing a new application and paying the prescribed fee.
B. A school owner shall notify the board in writing within ten days after any change of ownership of the school or change in the school's location or trade name, submit a new license application for the school and pay the prescribed fee.

32-553. Instruction staff
A. Instructors shall not apply their time to private practice with or without compensation in a school.
B. Students shall be under the constant supervision of an instructor.

32-554. Required display
Schools shall display the following in a conspicuous location:
1. The current school license.
2. The current licenses of instructors teaching in the school.
3. The latest inspection sheet.

32-555. Equipment
A school shall contain sufficient equipment as prescribed by the board in its rules.

32-556. Separation of schools from other businesses
A school of any type, including a cosmetology school or otherwise, shall not be conducted with any other business, including a salon. A school of any type, including a cosmetology school or otherwise, and another business shall be separated by walls of permanent construction and not have doors or openings between them. A cosmetology school may offer for sale cosmetology products and related articles.

32-557. Services for the public; restrictions
A. Students may render services to the public only under the direct supervision of an instructor.
B. The following notice shall be posted in a conspicuous place within the school in letters large enough to be read across the length of the room, "school of cosmetology - work done exclusively by students."
C. A student in a school shall not receive a salary or commission from the school for any cosmetology, aesthetics or nail technology services while he is enrolled in the school as a student.

D. A school shall post a price list for services rendered to the public which is large enough to be easily read from a distance of ten feet.

32-558. Student-school contracts
A private school is required to execute a contract between itself and a student in duplicate. The form of the contract shall be approved by the board. A contract between a school and a student shall bear the signature of a school official and the student or parent or guardian if the student is under eighteen years of age. A fully executed copy of the contract shall be given to the student and the school shall keep the original copy.

32-559. School catalogs
A. A private school shall submit a copy of its official catalog to the board for board approval.
B. A private school catalog shall contain the following:
1. Name and address of the school.
2. Date of publication.
3. Admission requirements and procedures used by the school.
4. Number of hours of training required for licensure.
5. A brief outline of the curriculum offered by the school.
6. A description of the school's general physical facilities and equipment.
7. Policies relating to tardiness, absences, make-up work, conduct, termination and other rules of the school.
8. The grading system, including a definition of credit units if any.
9. The type of document awarded on graduation from the school.

32-560. Transfer procedures
A student who desires to transfer from one school to another shall execute an application for transfer form prescribed by the board. The transferring school shall complete the application for transfer in triplicate and forward the requested information to the board within three days after the student executes the application for transfer.

32-561. Student records
A school shall keep records as prescribed by the board in its rules on file for each student enrolled or reenrolled in a school for a regular course, postgraduate course or additional hours.

32-562. School inspections
The board shall inspect schools on a regular basis as it deems necessary.

32-563. School closings
A. Within five days after a school closes it shall notify the board by certified mail of the closure.
B. Within ten days after a school closes it shall forward all student records to the board.

32-564. School license renewal

A. Except as provided in section 32-4301, school licenses are renewable on or before June 30 of every year by meeting all the requirements for a school license and paying the prescribed renewal fee.
B. A school owner who fails to renew his school license by June 30 of every year shall apply pursuant to section 32-551 and pay the prescribed fee and delinquent renewal penalty.

32-565. Schools; postsecondary education institutions
A school must be recognized as a postsecondary educational institution if both of the following apply:
1. The school admits as regular students only individuals who have earned a recognized high school diploma or the equivalent of a recognized high school diploma or who are beyond the age of compulsory education as provided by section 15-802.
2. The school is licensed by name by the board under this chapter to offer one or more training programs beyond the secondary school level.

32-571. Disciplinary action
The board may take any one or a combination of the following disciplinary actions:
1. Revoke a license.
2. Suspend a license.
3. Impose a civil penalty in an amount not to exceed two thousand dollars.
4. Impose probation requirements best adapted to protect the public safety, health and welfare including requirements for restitution payments to patrons.
5. Publicly reprove a licensee.
6. Issue a letter of concern.

32-572. Grounds for disciplinary action or refusal to issue or renew license; definition
A. The board may take disciplinary action or refuse to issue or renew a license for any of the following causes:
1. Continued performance of cosmetology, aesthetics or nail technology services by a person knowingly having an infectious or communicable disease.
2. Conviction of a crime.
3. Commission of an act involving dishonesty, fraud or deceit with the intent to substantially benefit oneself or another or substantially injure another.
4. Malpractice or incompetency.
5. Knowingly advertising by means of false, misleading, deceptive or fraudulent statements through communication media.
6. Violating any provision of this chapter or any rule adopted pursuant to this chapter.
7. Making oral or written false statements to the board.
8. Repeated failure to correct infractions of safety and sanitary requirements prescribed by the board in its rules.
9. Failing to comply with an order of the board.
B. A conviction of a crime or act shall not be a cause of refusal to issue or renew a license unless the crime or act is substantially related to the qualifications, functions or duties of the license for which application is made.

C. The expiration, cancellation, suspension or revocation of a license or a licensee's voluntary surrender of a license does not deprive the board of jurisdiction to do any of the following:
1. Proceed with an investigation of a licensee.
2. Proceed with an action or disciplinary proceeding against a licensee.
3. Suspend or revoke a license.
4. Deny the renewal or right of renewal of a license.
D. For the purposes of this section, "conviction" means a plea or verdict of guilty or a conviction following a plea of no contest.

32-573. Procedure for disciplinary action; appeal
A. The board on its own motion may investigate any information that appears to show the existence of any of the causes set forth in section 32-572. The board shall investigate the report of any person that appears to show the existence of any of the causes set forth in section 32-572. A person who reports pursuant to this section and who provides the information in good faith is not subject to liability for civil damages as a result.
B. If, after completing its investigation, the board finds that the evidence is not of sufficient seriousness to merit direct action against a license, it may take either of the following actions:
1. Dismiss if, in the opinion of the board, the evidence is without merit.
2. File a letter of concern if, in the opinion of the board, while there is insufficient evidence to support direct action against the license there is sufficient evidence for the board to notify the licensee that continuation of the activities that led to the information or report being made to the board may result in action against the licensee's license.
C. If, in the opinion of the board, it appears the information or report is or may be true, the board shall request an informal interview with the licensee concerned. The interview shall be requested by the board in writing, stating the reasons for the interview and setting a date not less than ten days from the date of the notice for conducting the interview.
D. If, after an informal interview, the board finds that the evidence warrants suspension or revocation of a license issued pursuant to this chapter, imposition of a civil penalty or public reproof or if the licensee under investigation refuses to attend the informal interview, a complaint shall be issued and formal proceedings shall be initiated. All proceedings pursuant to this subsection shall be conducted in accordance with title 41, chapter 6, article 10.
E. A licensee who has been notified pursuant to subsection D of this section of charges pending against the licensee shall file with the board an answer in writing to the charges not more than thirty days after the licensee receives the complaint. If the licensee fails to answer in writing within this time, it is deemed an admission by the licensee of the acts charged in the complaint and the board may take disciplinary action allowed by this chapter without a hearing.
F. If the board finds that the evidence is not of sufficient seriousness to merit suspension or revocation of a license issued pursuant to this chapter, imposition of a civil penalty or public reproof it may take the following actions:
1. Dismiss if, in the opinion of the board, the evidence is without merit.

2. File a letter of concern if, in the opinion of the board, while there is insufficient evidence to support direct action against the license there is sufficient evidence for the board to notify the licensee that continuation of the activities which led to the information or report being made to the board may result in action against the licensee's license.
3. Impose probation requirements.
G. If a licensee violates this chapter or a rule adopted pursuant to this chapter, the board may assess the licensee with the board's reasonable costs and expenses, including attorney fees, incurred in conducting the investigation and administrative hearing. All monies collected pursuant to this subsection shall be deposited, pursuant to sections 35-146 and 35-147, in a separate account in the board of cosmetology fund established by section 32-505. The board may only use these monies to defray its expenses in connection with investigation related training and education, disciplinary investigations and all costs related to administrative hearings. Notwithstanding section 35-143.01 the separate account monies may be spent without legislative appropriation.
H. 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.

32-574. Unlawful acts; violation; classification
A. A person shall not:
1. Perform or attempt to perform cosmetology, aesthetics or nail technology without a license in that category issued pursuant to this chapter, or practice in a category in which the person does not hold a license.
2. Display a sign or in any way advertise or hold oneself out as a cosmetologist, aesthetician or nail technician or as being engaged in the practice or business of cosmetology, aesthetics or nail technology without being licensed pursuant to this chapter.
3. Knowingly make a false statement on an application for a license pursuant to this chapter.
4. Permit an employee or another person under the person's supervision or control to perform cosmetology, aesthetics or nail technology without a license issued pursuant to this chapter.
5. Practice or attempt to practice cosmetology, aesthetics or nail technology in any place other than in a salon licensed pursuant to this chapter unless the person is requested by a customer to go to a place other than a salon licensed pursuant to this chapter and is sent to the customer from the salon, except that a person who is licensed pursuant to this chapter may practice, without the salon's request, cosmetology, aesthetics or nail technology in a health care facility, hospital, residential care institution, nursing home or residence of a person requiring home care because of an illness, infirmity or disability.
6. Obtain or attempt to obtain a license by the use of money other than the prescribed fees or any other thing of value or by fraudulent misrepresentation.
7. Provide any service to a person having a visible disease, pediculosis or open sores suggesting a communicable disease until the person furnishes a statement signed by a physician licensed pursuant to chapter 13 or 17 of this title stating that the disease or condition is not in an infectious, contagious or communicable stage.
8. Operate a salon or school without being licensed pursuant to this chapter.

9. Violate any provision of this chapter or any rule adopted pursuant to this chapter.
10. Ignore or fail to comply with a board subpoena.
11. Use the title of "aesthetician", "cosmetologist" or "nail technician" or any other title or term likely to be confused with "aesthetician", "cosmetologist" or "nail technician" in any advertisement, statement or publication unless that person is licensed pursuant to this chapter.
B. An instructor shall not render cosmetology, aesthetics or nail technology services in a school unless the services are directly incidental to the instruction of students.
C. A person who violates this section is guilty of a class 1 misdemeanor.

32-575. Injunctions
The board, the attorney general, a county attorney or any other person may apply to the superior court in the county in which acts or practices of any person which constitute a violation of this chapter or the rules adopted pursuant to this chapter are alleged to have occurred for an order enjoining those acts or practices.

32-576. Confidentiality
A. Examination materials, records of examination grading and performance and transcripts of educational institutions are confidential and are not subject to inspection pursuant to title 39, chapter 1, article 2.
B. All investigation files are confidential and are not subject to inspection pursuant to title 39, chapter 1, article 2 until the matter is final. The licensee shall be informed of the investigation. The public may obtain information that discloses that an investigation is being conducted and the general nature of the investigation.

G-2

ARIZONA DEPARTMENT OF ECONOMIC SECURITY (F-16-0602)

Title 6, Chapter 5, Article 65, Department Adoption Functions and Procedures for Providing Adoption Services; Article 66, Adoption Services; Article 67, Adoption Subsidy; Article 69, Child Placing Agency Licensing Standards; Article 70, Adoption Agency Licensing; Article 74, Licensing Process and Licensing Requirements for Child Welfare Agencies; Article 75, Appeal and Hearing Procedures for Adverse Action Against Family Foster Homes, Adoption Agencies, Family Child Care Home Providers, and Persons Listed on the Child Care Resource and Referral System; Article 80, Interstate Compact on the Placement of Children

GOVERNOR'S REGULATORY REVIEW COUNCIL
ANALYSIS OF FIVE-YEAR-REVIEW REPORT

MEETING DATE: August 2, 2016 **AGENDA ITEM: G-2**

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

FROM: Matthew Rippentrop, Legal Intern

DATE: July 15, 2016

SUBJECT: **ARIZONA DEPARTMENT OF ECONOMIC SECURITY (F-16-0602)**
Title 6, Chapter 5, Article 65, Department Adoption Functions and Procedures for Providing Adoption Services; Article 66, Adoption Services; Article 67, Adoption Subsidy; Article 69, Child Placing Agency Licensing Standards; Article 70, Adoption Agency Licensing; Article 74, Licensing Process and Licensing Requirements for Child Welfare Agencies; Article 75, Appeal and Hearing Procedures for Adverse Action Against Family Foster Homes, Adoption Agencies, Family Child Care Home Providers, and Persons Listed on the Child Care Resource and Referral System; Article 80, Interstate Compact on the Placement of Children

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COMMENTS ON THE FIVE-YEAR-REVIEW REPORT

Purpose of the Agency and Number of Rules in the Report

The purpose of the Arizona Department of Economic Security (Department) is "to provide social services, welfare programs, vocational rehabilitation and employment services and... developmental disability programs." Laws 2008, Ch. 104, § 3.

In 2014, the Department of Child Safety (DCS) was created with responsibilities and authority over the functions governed by Articles 65, 66, 67, 69, 70, 74, and 80. Articles 65, 66, 67, 70, and 80 have not been reviewed and have expired. As Articles 69 and 74 are currently under the purview of DCS and are not subject to review by the Department, this report is limited to review of Article 75.

A.A.C. Title 6, Chapter 5, Article 75 contains 20 rules relating to how the Department governs certain hearing and appeals procedures.

Year Each Rule was Last Amended or Newly Made

All of the rules were adopted effective June 4, 1998.

Proposed Action

The Department does not propose any action on the rules at this time due to higher rulemaking priorities. The Department has worked with the Governor's office and identified 16 high-priority rulemakings. As of March of this year, six of these rulemakings have been formally approved, with verbal approval received for six more. The Amendments to Article 75 were not included in these approved rulemakings. The Department plans to keep the amendments to Article 75 on its list of rulemakings in the context of its rulemaking priorities.

Substantive or Procedural Concerns

None.

Analysis of the Agency's Report Pursuant to Criteria in A.R.S. § 41-1056 and R1-6-301:

1. **Has the agency certified that it is in compliance with A.R.S. § 41-1091?**

Yes. The Department certifies it is in compliance with A.R.S. § 41-1091.

2. **Has the agency analyzed whether the rules are authorized by statute?**

Yes. A.R.S. § 41-1954(A)(3) provides the Department shall "[a]dopt rules it deems necessary or desirable to further the objectives and programs of the department." The Department indicates A.R.S. §§ 8-126, 8-503(A)(4)(b), 8-506, 41-1967, 46-134(10), and 46-807(C) provide specific authority. A.R.S. § 8-506 provides the Department may "deny the application or suspend or revoke the license of any foster home" in willful violation of the proscribed provisions or failure to maintain adequate standards of care.

3. **Has the agency received any written criticisms of the rules during the last five years, including any written analysis questioning whether the rules are based on valid scientific or reliable principles or methods?**

The Department indicates it has not received any written criticism of the rules during the last five years.

4. **Has the agency analyzed the current enforcement status of the rules?**

The Department indicates the rules are currently enforced.

5. **Has the agency analyzed the rules' consistency with other rules and statutes?**

Yes. The Department indicates all the rules are consistent with state and federal rules, with the exception of Section 7501, 7506, and 7514. Section 7501 contains an incorrect reference to R6-5-5201(29). Section 7506 is inconsistent with R6-5-5227 "Adverse Action; Notice Effective Date" concerning under which circumstances the Department may take immediate action when the party has appealed the adverse action. The two rules should be reconciled with consideration

of a provision for emergency action by the Department when warranted. Section 7514 is inconsistent with policy and procedure, providing a 10-day window for filing a request to reopen proceedings, where the Office of Appeals currently provides a 15-day window.

6. **Has the agency analyzed the rules' effectiveness in achieving their objectives?**

Yes. The Department indicates Sections 7501, 7502, 7507, 7515, 7516, and 7518 could be made more effective. Changes would include updating language, reflecting the shift in functions and responsibilities to DCS, and reflecting current practices of the Office of Appeals.

7. **Has the agency analyzed whether the rules are clear, concise, and understandable?**

Yes. The Department indicates Sections 7514, 7515, 7516, and 7518 are not clear because they are outdated due to the shifting of responsibilities and duties to DCS.

8. **Stringency of the Rules:**

   a. **Are the rules more stringent than corresponding federal law?**

The Department indicates the rules are consistent with federal law Section 658H. Criminal Background Checks of the Child Care and Development Block Grant Act of 2014.

   b. **If so, is there statutory authority to exceed the requirements of federal law?**

Not applicable.

9. **For rules adopted after July 29, 2010:**

The rules were last amended in 1998.

   a. **Do the rules require issuance of a regulatory permit, license or agency authorization?**

Not applicable.

   b. **If so, are the general permit requirements of A.R.S. § 41-1037 met or does an exception apply?**

Not applicable.

10. **Has the agency indicated whether it completed the course of action identified in the previous five-year-review report?**

No. The Department did not complete the course of action identified in the previous five-year-review report. The Department states that amendments were put on hold under subsequent moratoriums, as the Department prioritized other high priority rulemakings in Chapter 5.

Conclusion

The Department does not propose any action to be taken on the rules and instead plans to keep Article 75 amendments on their rulemakings list in the context of other rulemaking priorities. The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Staff recommends the report be approved.

GOVERNOR'S REGULATORY REVIEW COUNCIL
M E M O R A N D U M

MEETING DATE: August 2, 2016 **AGENDA ITEM: G-2**

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

FROM: GRRC Economic Team

DATE: July 15, 2016

SUBJECT: **ARIZONA DEPARTMENT OF ECONOMIC SECURITY (F-16-0602)**
Title 6, Chapter 5, Article 65, Department Adoption Functions and Procedures for Providing Adoption Services; Article 66, Adoption Services; Article 67, Adoption Subsidy; Article 69, Child Placing Agency Licensing Standards; Article 70, Adoption Agency Licensing; Article 74, Licensing Process and Licensing Requirements for Child Welfare Agencies; Article 75, Appeal and Hearing Procedures for Adverse Action Against Family Foster Homes, Adoption Agencies, Family Child Care Home Providers, and Persons Listed on the Child Care Resource and Referral System; Article 80, Interstate Compact on the Placement of Children

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I reviewed the five-year-review report's economic, small business, and consumer impact comparison for compliance with A.R.S. § 41-1056 and make the following comments.

1. Economic Impact Comparison

The economic, small business, and consumer impact statement (EIS) from the most recent rulemaking was available for all of the rules contained in the five-year-review report.

The rules in Title 6, Chapter 5 address details regarding social services. Article 75 covers the appeal and hearing procedures for adverse action against people and organizations listed on the Child Care Resource and Referral System.

The Department indicates that some of the definitions and rules (specifically R6-5-7501, 7502, and 7507) ought to be updated to reflect the shift in responsibilities to the DCS. The Department also stated that R6-5-7502, R6-5-7507, R6-5-7515, R6-5-7516, and R6-5-7518 could be revised to be more effective.

Only the analysis of R6-5-7515 mentioned costs, as the Department states that the Office of Appeals may charge a fee for providing transcripts of hearings at a rate of $0.15/page.

2. Has the agency determined that the rules impose the least burden and costs to persons regulated by the rules?

The Department reports that each of the rules imposes the least burden and cost on regulated individuals, including paperwork and compliance costs.

3. Was an analysis submitted to the agency under A.R.S. § 41-1056(A)(7)?

No analysis was submitted to the agency by another person that compares the rules' impact on this state's business competitiveness to the impact on businesses in other states under A.R.S. § 41-1056(A)(7).

4. Conclusion

After review, staff concludes that the report complies with A.R.S. § 41-1056 and recommends approval.

DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

Douglas A. Ducey
Governor

Timothy Jeffries
Director

March 28, 2016

Nicole A. Ong, Council Chair
Governor's Regulatory Review Council
Department of Administration
100 North 15th Avenue, Suite 402
Phoenix, Arizona 85007

Re: Five-year Review Report for A.A.C. Title 6, Chapter 5, Department of Economic Security – Social Services, Articles 65, 66, 67, 69, 70, 74, 75, 80

Dear Ms. Ong:

Enclosed is the Department of Economic Security's Five-year Review Report on the above reference Articles. Included in the report are copies of the authorizing statutes and rules, along with any available economic impact statements.

Pursuant to A.R.S. § 41-1056(A) and A.A.C. R1-6-301(C)(4), The Department certifies that it is in compliance with A.R.S. § 41-1091. The Department has not reviewed the rules in the following Articles, and intends to let them expire under A.R.S. § 41-1056(J): Article 65, Article 66, Article 67, Article 70, and Article 80.

Thank you for your attention to this report. If you have any questions, or require more information, please contact me at (602) 542-6555. The Department will be present at the Council meetings to respond to any questions the Council members may have about the report.

Sincerely,

Robert Hobbs
Lead Rules Analyst
(as Director's designee)

Enclosures

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Arizona Department of Economic Security

Five-year Review Report

Title 6. Economic Security

Chapter 5. Department of Economic Security - Social Services

Article 65.

Department Adoption Functions and Procedures for Providing Adoption Services

Article 66.

Adoption Services

Article 67.

Adoption Subsidy

Article 69.

Child Placing Agency Licensing Standards

Article 70.

Adoption Agency Licensing

Article 74.

Licensing Process and Licensing Requirements for Child Welfare Agencies Operating Residential Group Care Facilities and Outdoor Experience Programs

Article 75.

Appeal and Hearing Procedures for Adverse Action Against Family Foster Homes, Adoption Agencies, Family Child Care Home Providers, and Persons Listed on the Child Care Resource and Referral System

Article 80.

Interstate Compact on the Placement of Children

March 31, 2016

INTRODUCTION

A. GENERAL

A.R.S. § 8-451, effective May 29, 2014, created the Department of Child Safety (DCS) to which the responsibilities and authority for the functions governed by Articles 65, 66, 67, 69, 70, 74, and 80 were transferred. Therefore, the rules reviewed in this report are limited to the rules which govern actions of and parties regulated by the Department of Economic Security (Department) as contained in A.A.C., Title 6, Article 75.

The Rules in Article 75 are currently used by the Department to govern certain hearing and appeals procedures. There are no fees or other out-of-pocket costs associated with the filing of an appeal or participation in the hearing process. Therefore, the cost to appellants from participation is limited to the time and effort needed to appeal the adverse determination and attend the hearing. Article 75 remains unchanged since the last 5-year review report.

B. RULES NOT REVIEWED IN THIS REPORT

The Department did not review the rules in the following Articles, and intends that they expire because they concern functions of the Department of Child Safety and have been replaced by rules that have been promulgated by the Department of Child Safety:

Article 65.	Department Adoption Functions and Procedures for Providing Adoption Services
Article 66.	Adoption Services
Article 67.	Adoption Subsidy
Article 70.	Adoption Agency Licensing
Article 80.	Interstate Compact on the Placement of Children

ANALYSIS OF RULES

A. STATUTORY AUTHORITY

General: A.R.S. § 41-1954(A)(3)

Specific: A.R.S. §§ 8-503(A)(4)(b); 8-506; 8-126; 41-1967; 46-134(10); 46-807(C)

B. OBJECTIVE

ARTICLE 75. APPEAL AND HEARING PROCEDURES FOR ADVERSE ACTION AGAINST FAMILY FOSTER HOMES, ADOPTION AGENCIES, FAMILY CHILD CARE HOME PROVIDERS, AND PERSONS LISTED ON THE CHILD CARE RESOURCE AND REFERRAL SYSTEM

R6-5-7501. Definitions

The objective of this rule is to promote and ensure uniform understanding of the terminology used by the Department. The purpose of this rule is to clearly define the terms contained in the Article.

R6-5-7502. Entitlement to a Hearing; Appealable Action

The objective of this rule is to indicate the opportunity for licensees to obtain a hearing to challenge adverse actions and to specify actions that are not appealable. The purpose of this rule is to convey appeal rights and clarify which Department actions have no associated appeal rights.

R6-5-7503. Computation of Time

The objective of this rule is to specify the method of computing time for purposes of determining the timeliness of submissions from licensees and providers to the Department and mailings from the Department to licensees and providers. The purpose of this rule is to clarify how days are counted in determining whether an appeal of an adverse action is considered timely.

R6-5-7504. Request for Hearing: Form; Time Limits; Presumptions

The objective of this rule is to specify the time period and the formal and procedural requirements for filing an appeal, and the circumstances that will excuse the late filing of an appeal. The purpose of this rule is to clearly convey what constitutes a timely and proper appeal and to set forth requirements for an appellant to establish good cause for an otherwise late-filed appeal to be considered timely.

R6-5-7505. Administration: Transmittal of Appeal

The objective of this rule is to establish a time lapse requirement for Department administrations to forward notification of appeals to the Office of Appeals so appeals can be disposed of expeditiously in accordance with A.A.C. R6-5-7516. The purpose of this rule is to assure that appeals are received and processed efficiently so they may be scheduled for hearing without undue delay.

R6-5-7506. Stay of Adverse Action Pending Appeal

The objective of this rule is to convey the general requirement that the Department will not carry out the adverse action until certain requirements are met and to specify under what circumstances

an adverse action may be carried out before finality attaches to the adverse action notice. The purpose of this rule is to clarify whether, and under what circumstances, the Department may take action prior to the expiration of a party's appeal period.

R6-5-7507. Hearings: Location; Notice; Time

The objective of this rule is to specify when hearings are to be scheduled, the contents of the hearing notice and when the notice of hearing is to be sent to the parties. The purpose of this rule is to establish guidelines and time frames for the scheduling of hearings and to assure the parties have sufficient and proper notice of the hearing issue(s) and the circumstances under which the hearing will be held.

R6-5-7508. Rescheduling the Hearing

The objective of this rule is to specify the manner of requesting postponements, the grounds for granting postponements, and the procedures and time frames that apply to rescheduled hearings. The purpose of this rule is to provide guidance to the parties on the process for requesting a hearing postponement, the grounds under which such a request would be granted, and to specify how and when the hearing would be rescheduled.

R6-5-7509. Hearing Officer: Duties and Qualifications

The objective of this rule is to specify the qualifications and the duties of the hearing officer. The purpose of this rule is to assure that all hearing officers are duly qualified for that role and that each performs consistent functions in the course of any proceeding before him or her.

R6-5-7510. Change of Hearing Officer; Challenges for Cause

The objective of this rule is to specify the procedures and grounds that apply to peremptory challenges and challenges for cause of the hearing officer. The purpose of this rule is to establish the procedure for a party to object to any particular hearing officer, and set forth the reasons for which they legally may challenge the participation of a particular hearing officer.

R6-5-7511. Subpoenas

The objective of this rule is to specify the procedures that apply to requesting, ruling on, and serving subpoenas. The purpose of this rule is to explain to a party how and when to request a subpoena; what criteria a hearing officer will use to grant or deny such a request; and how a subpoena is to be served.

R6-5-7512. Parties' Rights

The objective of this rule is to specify the rights of the parties in the hearing process. The purpose of this rule is to fully inform the hearing parties of their rights in the course of an appeal proceeding.

R6-5-7513. Withdrawal of an Appeal

The objective of this rule is to specify the procedure for requesting and processing the withdrawal of an appeal. The purpose of this rule is to inform parties of their right to withdraw any appeal, how to do so, and that the matter will be dismissed.

R6-5-7514. Failure to Appear; Default; Reopening

The objective of this rule is to specify the procedures for entering a default when the appellant fails to appear at the scheduled hearing. The rule also sets forth the procedures, time frames, and grounds for reopening a case once a default has been entered. The purpose of this rule is to establish that an appeal will be dismissed if the appellant does not appear, and to set forth a process, and time frames for the non-appearing party to request the matter be reopened. It also includes the grounds upon which a request to reopen a matter may be granted.

R6-5-7515. Hearing Proceedings

The objective of this rule is to specify procedures applying to a variety of hearing related matters including burden of proof, admissibility of evidence, the hearing record, and closing and opening statements by the parties. The purpose of this rule is to clarify the procedures used in appeal hearings to assist parties to properly prepare for and to fully participate in the process.

R6-5-7516. Hearing Decision

The objective of this rule is to specify time frames for the issuance of the hearing officer's decision, the required contents of the decision, and the procedures for delivering the decision to the parties. The purpose of this rule is to inform the parties of the time and method for receiving a decision, and the necessary information which must be included in that decision.

R6-5-7517. Effect of the Decision

The objective of this rule is to specify when a decision adverse to the appellant shall be effective.

The purpose of this rule is to clarify when the Department may act upon the decision of the hearing officer if the adverse action is affirmed and what the Department must do if the adverse action is reversed.

R6-5-7518. Further Administrative Appeal

The objective of this rule is to specify procedures for appeal of a hearing officer decision to the DES Appeals Board. The purpose of this rule is to set forth the procedures and time frames which a party must follow to have the hearing officer's decision reviewed by the Appeals Board.

R6-5-7519. Appeals Board

The objective of this rule is to specify procedures for review of hearing officer decisions before the Appeals Board. The purpose of this rule is to clarify the responsibilities and processes of the Appeals Board with respect to any further appeals filed from a hearing officer's decision.

R6-5-7520. Judicial Review

The objective of this rule is to specify procedures for seeking judicial review of a decision by the Appeals Board. The purpose of this rule is to explain to the parties their rights to judicial review of an adverse Appeals Board decision and to clarify the procedures which must be followed.

C. EFFECTIVENESS

With the exception of the issues raised below, the rules in Article 75 are effective in meeting their objectives.

ARTICLE 75. APPEAL AND HEARING PROCEDURES FOR ADVERSE ACTION AGAINST FAMILY FOSTER HOMES, ADOPTION AGENCIES, FAMILY CHILD CARE HOME PROVIDERS, AND PERSONS LISTED ON THE CHILD CARE RESOURCE AND REFERRAL SYSTEM

The Title of the Article would be more effective if it was revised to reflect that the functions and responsibilities pertaining to family foster homes and adoption agencies have been assumed by DCS. The appeals and hearing procedures for these DCS functions are now regulated by 21AAC1, Article 3.

R6-5-7501. Definitions

Subsections 1. "Adverse action", 2."Adminstration", 9."Division of Children, Youth, and Families", 11. "Foster parent", and 13.)"Licensee" are no longer accurate and should be revised due to the assumption of certain functions and responsibilities by DCS.

R6-5-7502. Entitlement to a Hearing; Appealable Action

Subsections (B) and (C) would be more effective if updated to reflect the assumption of certain functions and responsibilities by DCS.

R6 –5-7507. Hearings: Location; Notice; Time

There are several elements of this rule that would be more effective with revision. Subsection (B) should be revised to omit references to adverse actions relative to foster parent licensure as

that function and responsibility has been assumed by DCS. Subsections (C) and (D) would be more effective if language was revised to reflect the current practice with respect to time limits. Subsection (D) would be more effective if it were revised to reflect current practice which allows the Department to use a variety of effective methods to record proceedings.

R6-5-7515. Hearing Proceedings

Two subsections of this rule should be updated to improve their effectiveness. Subsection (D) would be more effective if it were revised to reflect current practice which allows the Department to use a variety of effective methods to record proceedings. Subsection (E) would be more effective if the language was changed to reflect current practice. Current practice is that the Office of Appeals may charge a fee for providing a copy of the hearing recording. In cases where the Office of Appeals has prepared a transcript, the Office of Appeals may charge a fee of $0.15 per page for providing a copy of the transcript.

R6-5-7516. Hearing Decision

Subsection (C) would be more effective if the language was changed to reflect the ability of the Office of Appeals to, upon written request or recorded consent, electronically transmit a copy of a hearing decision.

R6-5-7518. Further Administrative Appeal

Subsection (B) would be more effective with the inclusion of a bullet point #4 stating that a petition for review may be filed by mail, by fax, or by Internet. The rule would be more effective with the elimination of subsections (C) and (D) to align with current practice that

includes various methods for maintaining a record of a hearing and for receiving a petition for review.

D. CONSISTENCY

The rules in Article 75 are consistent with state and federal law and Department policy, with the following exceptions:

- R6-5-7501, Definitions, item 10 contains an incorrect reference to R6-5-5201(29) that should be rectified.
- R6-5-7506, Stay of Adverse Action Pending Appeal, is inconsistent with R6-5-5227, Adverse Action; Notice Effective Date. R6-5-5227 provides that the Department may take immediate action in some circumstances when an adverse action notice is sent, or in other circumstances, the adverse action becomes effective 20 days later. R6-5-7506 provides that the Department may *not* take action, except under certain other circumstances, once an appeal has been filed, until the appeal is resolved. The two rules should be reconciled with consideration of a provision for emergency action by the Department when warranted even if an appeal is pending.
- R6-5-7514, Failure to Appear; Default; Reopening, subsection (C) is inconsistent with policy and procedure, because the Office of Appeals currently gives a non-appearing party 15 days to file a request to reopen in these types of cases.

E. ENFORCEMENT POLICY

The Department enforces these rules as they do not conflict with corresponding federal statute or regulations.

F. CLEAR, CONCISE, AND UNDERSTANDABLE

R6-5-7514, R6-5-7515, R6-5-7516 and R6-5-7518 are not clear, concise, and understandable, because they are outdated.

G. WRITTEN CRITICISMS

No written criticisms or filed grievances, appeals, letters or complaints have been received.

H. ECONOMIC IMPACT COMPARISON

The economic impact of the rules in Article 75 is consistent with the impact anticipated at the time of rulemaking. The impact statement from the time of the rulemaking is included in this packet.

The Office of Appeals is authorized by Arizona Revised Statutes to establish appeal tribunals to hear and decide appeals for adverse actions described in Article 75. The Office of Appeals is funded through both federal and state appropriations. Listed below are the estimated costs incurred by the Office of Appeals in SFY 15 in conjunction with the Article 75 hearings at the Office of Appeals and Appeals Board:

0.03 FTE (57 Staff Hours)

$2,563.42 in Personnel Costs (65% Federal funds; 35% State funds)

Staff hours and other expenses are inconsequential for this case load as it consists of less than 0.3% of the total public assistance staffing and costs.

I. BUSINESS COMPETITIVENESS ANALYSIS

The Department did not receive a business competitive analysis from a member of the public during the process of preparing this report.

J. COURSE OF ACTION FROM PREVIOUS FIVE-YEAR REVIEW REPORT

In the previous Five-year Review Report approved by Council in October 2011, the Department indicated its plan to make minor amendments to several rules identified in Article 75. At the time of the 2011 report, a regulatory moratorium was in place and the Department anticipated

submitting a rule package to Council within 18 months of the expiration of the moratorium, or of being granted an exception from the moratorium.

The moratorium that was in place expired and was replaced by a series of subsequent regulatory moratoriums. The Department has worked closely with the Office of the Governor to identify regulatory priorities and obtain moratorium exceptions as needed and allowed. No changes have been made to Article 75 since the previous Five-year Review Report. The Department did complete multiple rulemakings for other high priority Articles in Chapter 5.

K. DETERMINATION OF BURDEN AND COSTS

With the amendments proposed in this report, the Department believes that the rules would impose the least burden and costs to persons regulated by these rules, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objectives.

L. CORRESPONDING FEDERAL LAW

The rules in Article 75 are neither more burdensome than, nor in conflict with, corresponding federal statutes and regulations.

M. COMPLIANCE WITH A.R.S. § 41-1037

The Department has determined that A.R.S. § 41-1037 does not apply to these rules, because the Department is not proposing a new rule or an amendment to an existing rule that requires the issuance of a regulatory permit, license or agency authorization.

N. PROPOSED ACTION

All Department rulemaking was placed on hold as a result of Executive Order 2016-03 that became effective on February 10, 2016. In response, the Department requested permission to proceed with 16 high priority rulemakings that align with the justifications detailed in the Executive Order. As of March 24, 2016 six of the rulemakings have been formally approved and verbal approval has been received for six more (with written approval to follow). The amendments to Article 75 were not included in the Department's initial request. The Department will keep the amendments to Article 75 on its list of rulemakings to consider within the constraints of the Executive Order and the context of its rulemaking priorities.

R6-5-7441. Child's Service Plan: Preparation; Review; Planning Participants
R6-5-7442. Discharge; Discharge Summary
R6-5-7443. Personal Care of Children
R6-5-7444. Children's Clothing and Personal Belongings
R6-5-7445. Children's Money; Restitution
R6-5-7446. Nutrition, Menus, and Food Service
R6-5-7447. Sleeping Arrangements
R6-5-7448. Visitation, Outings, Mail, and Telephones
R6-5-7449. Educational and Vocational Services; Work Assignments
R6-5-7450. Recreation, Leisure, Cultural Activities, and Community Interaction
R6-5-7451. Religion, Culture, and Ethnic Heritage
R6-5-7452. Medical and Health Care
R6-5-7453. Medications
R6-5-7454. Storage of Medications
R6-5-7455. Children's Medical and Dental Records
R6-5-7456. Behavior Management
R6-5-7457. Body Searches
R6-5-7458. Buildings; Grounds; Water Supply
R6-5-7459. Building Interior
R6-5-7460. Kitchens; Food Preparation; and Dining Areas
R6-5-7461. Sleeping Areas and Furnishings
R6-5-7462. Bathrooms
R6-5-7463. Other Facility Space; Staff Quarters
R6-5-7464. Fire, Emergency, and Fire Prevention
R6-5-7465. General Safety
R6-5-7466. Swimming Areas
R6-5-7467. Access; Transportation; Outings
R6-5-7468. Special Provisions for Shelter Care Facilities
R6-5-7469. Special Provisions and Exemptions for Outdoor Experience Programs
R6-5-7470. Planning Requirements for Outdoor Experience Programs
R6-5-7471. Special Physical Environment and Safety Requirements for Outdoor Experience Programs
Appendix 1.

ARTICLE 75. APPEAL AND HEARING PROCEDURES FOR ADVERSE ACTION AGAINST FAMILY FOSTER HOMES, ADOPTION AGENCIES, FAMILY CHILD CARE HOME PROVIDERS, AND PERSONS LISTED ON THE CHILD CARE RESOURCE AND REFERRAL SYSTEM

New Article 75, consisting of Sections R6-5-7501 through R6-5-7508, adopted effective June 4, 1998 (98-2).

Former Article 75, consisting of Sections R6-5-7501 through R6-5-7508, repealed effective November 8, 1982.

Section
R6-5-7501. Definitions
R6-5-7502. Entitlement to a Hearing; Appealable Action
R6-5-7503. Computation of Time
R6-5-7504. Request for Hearing: Form; Time Limits; Presumptions
R6-5-7505. Administration: Transmittal of Appeal
R6-5-7506. Stay of Adverse Action Pending Appeal
R6-5-7507. Hearings: Location; Notice; Time
R6-5-7508. Rescheduling the Hearing
R6-5-7509. Hearing Officer: Duties and Qualifications
R6-5-7510. Change of Hearing Officer; Challenges for Cause
R6-5-7511. Subpoenas
R6-5-7512. Parties' Rights
R6-5-7513. Withdrawal of an Appeal
R6-5-7514. Failure to Appear; Default; Reopening
R6-5-7515. Hearing Proceedings
R6-5-7516. Hearing Decision
R6-5-7517. Effect of the Decision
R6-5-7518. Further Administrative Appeal
R6-5-7519. Appeals Board
R6-5-7520. Judicial Review

ARTICLE 76. REPEALED

Article 76, consisting of Sections R6-5-7601 through R6-5-7639, repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 77. REPEALED

Former Article 77 consisting of Sections R6-5-7701 through R6-5-7704 repealed effective November 8, 1982.

ARTICLE 78. REPEALED

Former Article 78 consisting of Sections R6-5-7801 through R6-5-7804 repealed effective November 8, 1982.

ARTICLE 79. REPEALED

Former Article 79 consisting of Sections R6-5-7901 through R6-5-7913 repealed effective November 8, 1982.

ARTICLE 80. INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

Section
R6-5-8001. Goals
R6-5-8002. Objectives
R6-5-8003. Authority
R6-5-8004. Definitions
R6-5-8005. Placement Agreement
R6-5-8006. Financial Responsibility
R6-5-8007. Eligibility
R6-5-8008. Placement Approval
R6-5-8009. Case Management
R6-5-8010. Terminating the Service

ARTICLE 81. REPEALED

Former Article 81 consisting of Sections R6-5-8101 through R6-5-8104 repealed effective November 8, 1982.

ARTICLE 82. REPEALED

Former Article 82 consisting of Sections R6-5-8201 through R6-5-8204 repealed effective November 8, 1982.

ARTICLE 83. REPEALED

Article 83, consisting of Sections R6-5-8301 through R6-5-8308, repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 84. REPEALED

Former Article 84 consisting of Sections R6-5-8401 through R6-5-8404 repealed effective November 8, 1982.

ARTICLE 85. REPEALED

Former Article 85 consisting of Sections R6-5-8501 through R6-5-8508 repealed effective November 8, 1982.

ARTICLE 86. REPEALED

Article 86, consisting of Sections R6-5-8601 through R6-5-8604, repealed effective December 17, 1993 (Supp. 93-4).

Article 86 consisting of Sections R6-5-8601 through R6-5-8604 adopted effective March 8, 1979.

Former Article 86 consisting of Sections R6-5-8601 through R6-5-8611 repealed effective March 8, 1979.

	treatment	healthy living environment
2. Accreditation	JCAHO; COA; CARF	COA; Never JCAHO for this specific facility seeking licensure
3. Nursing Services	Integrated into services	Occasional use
4. On-campus educational services	Primarily seriously emotionally disturbed (SED); occasional regular education	Primarily regular education & learning disabilities; occasional SED
5. Population served	Described as psychiatrically disordered; seriously emotionally disturbed; psychologically disturbed	Described as behavior disordered, delinquent, dependent, neglected, undersocialized
6. Self-description	Behavioral Health Program Psychiatric Facility Psychosocial orientation	Child Welfare Agency; Social Services Agency;
Educational		orientation; Re-education
7. Primary source of referrals	Psychologists; psychiatrists; Insurance companies; CHAMPUS; RBHA's	DES; Juvenile courts; Juvenile Corrections; RBHA's as transition or with wrap-around
8. Counseling, psychological, psychiatric services	Routinely provided to all clients	Provided only on an "as-needed" basis
9. Location of behavioral health services	Within the program	Usually in office of contracted practitioner
10. Behavioral health practitioners	Employees or contractors	Usually contracted services; may be contractor from another program or agency
11. Case work services	Social workers, if any, are only part of professional staff	Social workers are primary part of professional staff
12. Staff titles; direct care workers	Behavioral health technicians; psychiatric technicians; psychiatric nurses	House parents; child care workers; teaching parents

Historical Note

Appendix 1 adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

ARTICLE 75. APPEAL AND HEARING PROCEDURES FOR ADVERSE ACTION AGAINST FAMILY FOSTER HOMES, ADOPTION AGENCIES, FAMILY CHILD CARE HOME PROVIDERS, AND PERSONS LISTED ON THE CHILD CARE RESOURCE AND REFERRAL SYSTEM

R6-5-7501. Definitions

The following definitions apply in this Article.

1. "Adverse action" means:
   a. Denial, suspension, or revocation of a child care provider's certification, an adoption agency license, or a foster home license; and
   b. Exclusion from the child care resource and referral system described in A.R.S. § 41-1967.
2. "Administration" means the Department organizational unit responsible for taking adverse action which is the subject of an appeal. "Administration" includes the Division of Children, Youth, and Families and the Child Care Administration.
3. "Adoption agency" has the meaning ascribed to "agency" in A.R.S. § 8-101(2).
4. "Appeals Board" means the Department's independent, quasi-judicial, administrative appellate body, established under A.R.S. § 23-672, and authorized to review adminis-

trative decisions issued by hearing officers as prescribed in A.R.S. § 41-1992(D).

5. "Appellant" means a person who seeks a hearing with the Office of Appeals to challenge adverse action taken by the Department.
6. "Child Care Administration" means the administrative unit within the Department which is responsible for certification and supervision of family child care home providers and administration of the Child Care Resource and Referral System.
7. "Child Care Resource and Referral System," which is sometimes referred to as "CCR&R," means the child care provider information system which the Department administers under A.R.S. § 41-1967.
8. "Department" means the Arizona Department of Economic Security.
9. "Division of Children, Youth, and Families" means the administrative unit in the Department responsible for licensing foster homes and adoption agencies.
10. "Family child care home provider" has the meaning prescribed in R6-5-5201(29).
11. "Foster parent" has the meaning prescribed in A.R.S. § 8-501(A)(5).
12. "Hearing officer" means an individual appointed by the Department Director under A.R.S. § 41-1992(A) to conduct hearings when an appellant challenges adverse action.
13. "Licensee" means a person:
    a. Applying for a license as, or currently licensed as, a foster parent or an adoption agency;
    b. Applying for certification as, or certified as, a family child care home provider; or
    c. Listed on the Child Care Resource and Referral System.
14. "Office of Appeals" means the Department's independent, quasi-judicial, administrative hearing body which includes hearing officers appointed under A.R.S. § 41-1992(A).
15. "Person" means a natural person, partnership, joint venture, company, corporation, firm, association, society, or institution.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7502. Entitlement to a Hearing; Appealable Action

A. A licensee who disputes adverse action may obtain an administrative hearing to challenge the action as provided in this Article.
B. The following actions are not appealable:
    1. An adverse action resulting from a uniform change in federal or state law, unless the Department has misapplied the law to the person seeking the hearing;
    2. Failure to clear a fingerprint check or criminal history check;
    3. Imposition of noncompliance status as prescribed in R6-5-7035;
    4. Imposition of a corrective action plan as prescribed in R6-5-5818;
    5. Removal of a child from a placement;
    6. Failure to enter into a contract with a particular licensee or to place a child with a particular licensee; and
    7. Imposition of a provisional license as prescribed in A.R.S. § 8-509(D).
C. Findings made in a Child Protective Services ("CPS") investigation are not appealable under this Article. A person may hearing to determine whether the delay in submission is appeal findings made in a CPS investigation of a licensee as prescribed in A.R.S. § 8-546.12.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7503. Computation of Time

A. In computing any time period,
    1. The term "day" means a calendar day;
    2. The term "work day" means Monday through Friday, excluding Arizona state holidays;
    3. The date of the act, event, notice, or default from which a designated time period begins to run is not counted as part of the time period; and
    4. The last day of the designated time period is counted, unless it is a Saturday, Sunday, or Arizona state holiday.
B. A document mailed by the Department is deemed given to the addressee on the date mailed to the addressee's last known address. The mailing date is presumed to be the date shown on the document, unless the facts show otherwise.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7504. Request for Hearing: Form; Time Limits; Presumptions

A. Except as otherwise provided in R6-5-5010(A) and R6-5-5227, a person who wishes to appeal an adverse action shall file a written request for hearing with the Administration within 20 days of the date on the notice or letter advising the person of the adverse action. The Administration shall provide a form for this purpose, and, upon request, shall help an appellant fill out the form.
B. An appellant shall include the following information in the request for hearing:
    1. Name, address, and telephone number, and, if applicable, telefacsimile number of the person subject to the adverse action;
    2. Identification of the Administration initiating the adverse action;
    3. A description of the adverse action which is the subject of the appeal;
    4. The date of the notice of adverse action; and
    5. A statement explaining why the adverse action is unauthorized, unlawful, or an abuse of discretion.
C. The Department shall not deny an appeal solely because the request does not include all the information listed in subsection (B), so long as the request contains sufficient information for the Department to determine the identity of the appellant and the issue on appeal.
D. A request for hearing is deemed filed:
    1. On the mailing date, as shown by the postmark, if sent first-class mail, postage prepaid, through the United States Postal Service to the Department; or
    2. On the date actually received by the Department, if not mailed as provided in subsection (D)(1).
E. The Department may determine that a document was timely filed if the sender of the document can demonstrate that the delay in submission was due to any of the following reasons:
    1. Department error or misinformation,
    2. Delay or other action by the United States Postal Service, or
    3. Delay caused by the appellant changing mailing addresses at a time when the appellant had no duty to notify the Administration of the change.
F. When the Office of Appeals receives a request for hearing that was not timely filed, the Office of Appeals shall schedule a excused as provided in subsection (E).

G. An appellant whose appeal is denied as untimely may petition for review as provided in R6-5-7518.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7505. Administration: Transmittal of Appeal
An Administration that receives a request for appeal shall send the Office of Appeals a copy of the request and the adverse action notice within two work days of receipt of the request.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7506. Stay of Adverse Action Pending Appeal
A. The Department shall not carry out the adverse action until the time for appeal has run, except as otherwise provided in subsection (C), and in the following circumstances:
   1. The appellant expressly waives the delay of action; or
   2. The appellant
      a. Is subject to the same adverse action for reasons other than those that are the subject of the current adverse action notice, and
      b. Received notice of and failed to timely appeal the adverse action being imposed for reasons other than those that are the subject of the current notice.
B. If an appellant timely appeals an adverse action as provided in R6-5-7504, the Department shall not carry out the adverse action until a hearing officer issues a decision affirming the adverse action, except as otherwise provided in subsection (C), and in the following circumstances:
   1. The appellant expressly waives the delay of action;
   2. The appellant
      a. Is subject to the same adverse action for reasons other than those that are the subject of the current adverse action notice; and
      b. Received notice of and failed to timely appeal the adverse action being imposed for reasons other than those that are the subject of the current notice;
   3. The appeal challenges an action that is not appealable according to R6-5-7502(B);
   4. The appellant withdraws the request for hearing; or
   5. The appellant fails to appear for the hearing.
C. The Department may summarily suspend a license, a certificate, or registration on the CCR & R, as provided in A.R.S. § 41-1064(C).

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7507. Hearings: Location; Notice; Time
A. The Office of Appeals shall schedule the hearing. The Office of Appeals may schedule a telephonic hearing or permit a witness to appear telephonically.
B. Unless the parties stipulate to another hearing date, the Office of Appeals shall schedule the hearing as follows:
   1. For appeals of adverse action against a foster parent, within 10 days of the date the Department receives the appellant's request for hearing, as required by A.R.S. § 8-506; and
   2. For all other appeals, no earlier than 20 days from the date the Department receives the appellant's request for hearing.
C. The Office of Appeals shall mail a notice of hearing to all interested parties at least 20 days before the scheduled hearing date, except where the hearing is scheduled within the 10-day period specified in subsection (B)(1). For hearings scheduled within the 10-day period, the Office of Appeals shall notify the parties telephonically and send written notice at the earliest date practicable.
D. The notice of hearing shall be in writing and shall include the following information:
   1. The date, time, and place of the hearing;
   2. The name of the hearing officer;
   3. A general statement of the issues involved in the case;
   4. A statement listing the parties' rights, as specified in R6-5-7511; and
   5. A general statement of the hearing procedures.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7508. Rescheduling the Hearing
A. An appellant may ask for postponement of a hearing by calling or writing the Office of Appeals and providing good cause as to why the hearing should be postponed. Good cause exists where circumstances beyond the appellant's reasonable control make it difficult or burdensome for the appellant to attend the hearing on the scheduled date.
B. Except in emergency circumstances, the appellant shall ensure that the Office of Appeals receives the request for postponement at least five work days before the scheduled hearing date. The Office of Appeals may deny an untimely request. Emergency circumstances mean circumstances
   1. Beyond the reasonable control of the party;
   2. Which did not arise until after the five-day period; and
   3. Which could not reasonably have been anticipated.
C. When the Office of Appeals reschedules a hearing under this Section or R6-5-7514, the Office of Appeals shall notify all interested parties, in writing, prior to the hearing. The 20-day notice requirement in R6-5-7507(C) does not apply to rescheduled hearings.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7509. Hearing Officer: Duties and Qualifications
A. An impartial hearing officer in the Office of Appeals shall conduct all hearings.
B. The hearing officer shall:
   1. Administer oaths and affirmations;
   2. Regulate and conduct hearings in an orderly and dignified manner that avoids unnecessary repetition and affords due process to all participants;
   3. Ensure that all relevant issues are considered;
   4. Exclude irrelevant evidence from the record;
   5. Request, receive, and incorporate into the record, relevant evidence;
   6. Upon compliance with the requirements of R6-5-7511, subpoena witnesses or documents needed for the hearing;
   7. Open, conduct, and close the hearing;
   8. Rule on the admissibility of evidence offered at the hearing;
   9. Direct the order of proof at the hearing;
   10. Upon the request of a party, or on the hearing officer's own motion, and for good cause shown, take action the hearing officer deems necessary for the proper disposition of an appeal, including the following:
      a. Disqualify himself or herself from the case;
      b. Continue the hearing to a future date or time;
      c. Prior to the entry of a final decision, reopen the hearing to take additional evidence;
      d. Deny or dismiss an appeal or request for hearing in accordance with the provisions of this Article; and
      e. Exclude non-party witnesses from the hearing room; and

11. Issue a written decision resolving the appeal.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7510. Change of Hearing Officer; Challenges for Cause

A. A party may request a change of hearing officer as prescribed in A.R.S. § 41-1992(B) by filing an affidavit which shall include:
   1. The case name and number;
   2. The hearing officer assigned to the case; and
   3. The name and signature of the party requesting the change.

B. The party requesting the change shall file the affidavit with the Office of Appeals and send a copy to all other parties at least five days before the scheduled hearing date.

C. Unless a party is challenging a hearing officer for cause as provided in subsection (D), a party may request only one change of hearing officer.

D. At any time before a hearing officer renders a decision, a party may challenge a hearing officer on the grounds that the hearing officer is not impartial or disinterested in the case.

E. A party who brings a challenge for cause shall file a request as provided in subsection (A) and send a copy of the request to all other parties. The request shall explain the reason why the assigned hearing officer is not impartial or disinterested.

F. The hearing officer being challenged for cause may hear and decide the challenge unless:
   1. A party specifically requests that another hearing officer make the determination, or
   2. The assigned hearing officer disqualifies himself or herself from the decision.

G. The Office of Appeals shall transfer the case to another hearing officer when:
   1. A party requests a change as provided in subsections (A) through (C), or
   2. A hearing officer is removed for cause as provided in subsections (D) through (F).

H. The Office of Appeals shall send the parties written notice of the new hearing officer assignment.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7511. Subpoenas

A. A party who wishes to have a witness testify at a hearing, or to offer a particular document or item in evidence, shall first attempt to obtain the witness or evidence by voluntary means. Department documents are available to the appellant as prescribed in R6-5-7512(2).

B. If the party cannot procure the voluntary attendance of the witness or production of the evidence, the party may ask the hearing officer assigned to the case to issue a subpoena for a witness, document, or other physical evidence.

C. The party seeking the subpoena shall send the hearing officer a written request for a subpoena. The request shall include:
   1. The case name and number;
   2. The name of the party requesting the subpoena;
   3. The name and address of any person to be subpoenaed, with a description of the subject matter of the witness's anticipated testimony;
   4. A description of any documents or physical evidence to be subpoenaed, including the title, appearance, and location of the item, and the name and address of the person in possession of the item; and
   5. A description of the party's efforts to obtain the witness or evidence by voluntary means.

D. A party who wants a subpoena shall ask for the subpoena at least five days before the scheduled hearing date.

E. The hearing officer shall deny the request if the witness's testimony or the physical evidence is not relevant to an issue in the case or is cumulative.

F. The Office of Appeals shall prepare all subpoenas and serve them by certified mail, return receipt requested, except that the Office of Appeals may serve subpoenas to state employees who are appearing in the course of their state employment, by regular mail, hand-delivery, or state courier service.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7512. Parties' Rights

A party to a hearing has the following rights:
   1. The right to request a postponement of the hearing, as provided in this Article;
   2. The right to copy, before or during the hearing, any documents in the Department's file on the appellant, and documents the Department may use at the hearing, except documents shielded by the attorney-client or work-product privilege, or as otherwise prohibited by federal or state confidentiality laws;
   3. The right to request a change of hearing officer as provided in A.R.S. § 41-1992(B) and R6-5-7510;
   4. The right to request subpoenas for witnesses and evidence as provided in R6-5-7511;
   5. The right to present the case in person or through an authorized representative, subject to any limitations prescribed in the Rules of the Supreme Court of Arizona, Rule 31(a);
   6. The right to present evidence and to cross-examine witnesses; and
   7. The right to further appeal, as provided in R6-5-7518 and R6-5-7520, if dissatisfied with an Office of Appeals' decision.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7513. Withdrawal of an Appeal

A. An appellant may withdraw an appeal at any time prior to the scheduled hearing by signing a written statement expressing the intent to withdraw. The Department shall make a withdrawal form available for this purpose. An appellant may also orally withdraw an appeal on the open record.

B. Upon receipt of a withdrawal request signed by the appellant or the appellant's representative, or a statement of withdrawal made on the record, the Office of Appeals shall dismiss the appeal.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7514. Failure to Appear; Default; Reopening

A. If an appellant fails to appear at the scheduled hearing, the hearing officer shall:
   1. Enter a default and issue a decision dismissing the appeal, except as provided in subsection (B);
   2. Rule summarily on the available record; or
   3. Adjourn the hearing to a later date and time.

B. The hearing officer shall not enter a default if the appellant notifies the Office of Appeals, before the scheduled time of hearing, that the appellant cannot attend the hearing, due to good cause, and still desires a hearing or wishes to have the matter considered on the available record.

C. No later than 10 days after a scheduled hearing date at which a party failed to appear, the non-appearing party may file a

request to reopen the proceedings. The request shall be in writing and shall demonstrate good cause for the party's failure to appear.

D. The hearing officer may decide the issue of good cause on the available record or may set the matter for briefing or for hearing.

E. If the hearing officer finds that the party had good cause for non-appearance, the hearing officer shall reopen the proceedings and schedule a de novo hearing with notice to all interested parties as prescribed in R6-5-7508(C).

F. Good cause exists where the non-appearing party demonstrates excusable neglect for both the failure to appear and the failure to timely notify the hearing officer. "Excusable neglect" has the meaning applied to "excusable neglect" as that term is used in Arizona Rules of Civil Procedure, Rule 60(c).

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7515. Hearing Proceedings

A. The hearing is a de novo proceeding. The Department has the initial burden of going forward with evidence to support the adverse action being appealed.

B. To prevail, the appellant shall prove, by a preponderance of the evidence, that the Department's action was unauthorized, unlawful, or an abuse of discretion.

C. The Arizona Rules of Evidence do not apply at the hearing. The hearing officer may admit and give probative effect to evidence as prescribed in A.R.S. § 23-674(D).

D. The Office of Appeals shall tape record all hearings or record the hearing by other stenographic means. The Department need not transcribe the proceedings unless a transcription is required for further administrative or judicial proceedings.

E. The Office of Appeals charges a fee of 15¢ per page for providing a transcript. A party may obtain a waiver of the fee by submitting an affidavit stating that the party cannot afford to pay for the transcript.

F. A party may, at his or her own expense, arrange to have a court reporter present to transcribe the hearing.

G. The hearing officer shall call the hearing to order and dispose of any pre-hearing motions or issues.

H. With the consent of the hearing officer, the parties may stipulate to factual findings or legal conclusions.

I. Upon request and with the consent of the hearing officer, a party may make opening and closing statements. The hearing officer shall consider any statements as argument and not evidence. Unless the hearing officer allows a longer period of time, a statement shall not exceed three minutes.

J. A party may testify, present evidence, and cross-examine adverse witnesses. The hearing officer may also take witness testimony or admit documentary or physical evidence on his or her own motion.

K. The hearing officer shall keep a complete record of all proceedings in connection with an appeal and shall exclude any irrelevant evidence.

L. The hearing officer may require the parties to submit memoranda on issues in the case if the hearing officer finds that the memoranda would assist the hearing officer in deciding the case. The hearing officer shall establish a briefing schedule for any required memoranda.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7516. Hearing Decision

A. No later than 60 days after the date the appellant files a request for hearing with the Department, the hearing officer shall render a decision based solely on the evidence and testimony produced at the hearing, and the applicable law. The 60-day time limit is extended for any delay caused by the appellant.

B. The hearing decision shall include:
   1. Findings of fact concerning the issue on appeal;
   2. Citations to the law and authority applicable to the issue on appeal;
   3. A statement of the conclusions derived from the controlling facts and law, and the reasons for the conclusions;
   4. The name of the hearing officer;
   5. The date of the decision; and
   6. A statement of further appeal rights and the time period for exercising those rights.

C. The Office of Appeals shall mail a copy of the decision to each party's representative, or to the party if the party is unrepresented.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7517. Effect of the Decision

A. If the hearing officer affirms the adverse action against the appellant, the adverse action is effective on the mailing date of the hearing officer's decision. The adverse action remains effective until the appellant appeals and obtains a higher administrative or judicial decision reversing or vacating the hearing officer's decision.

B. If the hearing officer reverses the Administration's decision to take adverse action, the Administration shall not take the action unless and until the Appeals Board or Arizona Court of Appeals issues a decision affirming the adverse action.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7518. Further Administrative Appeal

A. A party may appeal an adverse decision issued by a hearing officer to the Department's Appeals Board, as prescribed in A.R.S. § 41-1992(C) and (D), by filing a written petition for review with the Office of Appeals within 15 days of the mailing date of the hearing officer's decision.

B. The petition for review shall:
   1. Be in writing,
   2. Describe why the party disagrees with the hearing officer's decision, and
   3. Be signed and dated by the party or the party's representative.

C. The party petitioning for review shall mail a copy of the petition to all other parties.

D. The Office of Appeals shall have the proceedings of the hearing below transcribed for the Appeals Board.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7519. Appeals Board

A. The Appeals Board shall conduct proceedings in accordance with A.R.S. § 41-1992(D) and A.R.S. § 23-672.

B. Following notice to the parties, the Appeals Board may receive additional evidence or hold a hearing if the Appeals Board finds that additional information would help in deciding the appeal. The Board may also remand the case to the Office of Appeals for rehearing, specifying the nature of the additional evidence required, or any further issues to be considered.

C. The Appeals Board shall decide the appeal based solely on the record of proceedings before the hearing officer and any further evidence or testimony presented to the Board.

D. The Appeals Board shall issue, and mail to all parties, a final written decision affirming, reversing, setting aside, or modifying the hearing officer's decision. The Board's decision shall

specify the parties' rights to further review and the time for filing a request for review.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7520. Judicial Review
Any party adversely affected by an Appeals Board decision may seek judicial review as prescribed in A.R.S. § 41-1993.

Historical Note
Adopted effective June 4, 1998 (Supp. 98-2).

ARTICLE 76. REPEALED

R6-5-7601. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7602. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7603. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7604. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).

R6-5-7605. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7606. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7607. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7608. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7609. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7610. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7611. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7612. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7613. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7614. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7615. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7616. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7617. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7618. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7619. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7620. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7621. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7622. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7623. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7624. Repealed

Historical Note
Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

Arizona Department of Economic Security
Five-year Review Report
Title 6. Economic Security
Chapter 5. Department of Economic Security – Social Services
Articles 65, 66, 67, 69, 70, 74, 75, 80

STATUTES

A.R.S. § 41-1954(A). **Powers and duties**

A. In addition to the powers and duties of the agencies listed in section 41-1953, subsection E, the department shall:

1. Administer the following services:

(a) Employment services, including manpower programs and work training, field operations, technical services, unemployment compensation, community work and training and other related functions in furtherance of programs under the social security act, as amended, the Wagner-Peyser act, as amended, the federal unemployment tax act, as amended, 33 United States Code, the family support act of 1988 (P.L. 100-485) and other related federal acts and titles.

(b) Individual and family services, which shall include a section on aging, services to children, youth and adults and other related functions in furtherance of social service programs under the social security act, as amended, title IV, except parts B and E, grants to states for aid and services to needy families with children and for child-welfare services, title XX, grants to states for services, the older Americans act, as amended, the family support act of 1988 (P.L. 100-485) and other related federal acts and titles.

(c) Income maintenance services, including categorical assistance programs, special services unit, child support collection services, establishment of paternity services, maintenance and operation of a state case registry of child support orders, a state directory of new hires, a support payment clearinghouse and other related functions in furtherance of programs under the social security act, title IV, grants to states for aid and services to needy families with children and for child-welfare services, title XX, grants to states for services, as amended, and other related federal acts and titles.

(d) Rehabilitation services, including vocational rehabilitation services and sections for the blind and visually impaired, communication disorders, correctional rehabilitation and other related functions in furtherance of programs under the vocational rehabilitation act, as amended, the Randolph-Sheppard act, as amended, and other related federal acts and titles.

(e) Administrative services, including the coordination of program evaluation and research, interagency program coordination and in-service training, planning, grants, development and management, information, legislative liaison, budget, licensing and other related functions.

(f) Manpower planning, including a state manpower planning council for the purposes of the federal-state-local cooperative manpower planning system and other related functions in furtherance of programs under the comprehensive employment and training act of 1973, as amended, and other related federal acts and titles.

(g) Economic opportunity services, including the furtherance of programs prescribed under the economic opportunity act of 1967, as amended, and other related federal acts and titles.

(h) Intellectual disability and other developmental disability programs, with emphasis on referral and purchase of services. The program shall include educational, rehabilitation, treatment and training services and other related functions in furtherance of programs under the developmental disabilities services and facilities construction act, Public Law 91-517, and other related federal acts and titles.
(i) Nonmedical home and community based services and functions, including department designated case management, housekeeping services, chore services, home health aid, personal care, visiting nurse services, adult day care or adult day health, respite sitter care, attendant care, home delivered meals and other related services and functions.
2. Provide a coordinated system of initial intake, screening, evaluation and referral of persons served by the department.
3. Adopt rules it deems necessary or desirable to further the objectives and programs of the department.
4. Formulate policies, plans and programs to effectuate the missions and purposes of the department.
5. Employ and determine the conditions of employment and prescribe the duties and powers of administrative, professional, technical, secretarial, clerical and other persons subject to chapter 4, article 4 and, as applicable, article 5 of this title as may be necessary in the performance of its duties, contract for the services of outside advisors, consultants and aides as may be reasonably necessary and reimburse department volunteers, designated by the director, for expenses in transporting clients of the department on official business.
6. Make contracts and incur obligations within the general scope of its activities and operations subject to the availability of funds.
7. Contract with or assist other departments, agencies and institutions of the state, local and federal governments in the furtherance of its purposes, objectives and programs.
8. Be designated as the single state agency for the purposes of administering and in furtherance of each federally supported state plan.
9. Accept and disburse grants, matching funds and direct payments from public or private agencies for the conduct of programs that are consistent with the overall purposes and objectives of the department.
10. Provide information and advice on request by local, state and federal agencies and by private citizens, business enterprises and community organizations on matters within the scope of its duties subject to the departmental rules on the confidentiality of information.
11. Establish and maintain separate financial accounts as required by federal law or regulations.
12. Advise and make recommendations to the governor and the legislature on all matters concerning its objectives.
13. Have an official seal that shall be judicially noticed.
14. Annually estimate the current year's population of each county, city and town in this state, using the periodic census conducted by the United States department of commerce, or its successor agency, as the basis for such estimates and deliver such estimates to the economic estimates commission before December 15.
15. Estimate the population of any newly annexed areas of a political subdivision as of July 1 of the fiscal year in which the annexation occurs and deliver such estimates as promptly as is feasible after the annexation occurs to the economic estimates commission.
16. Establish and maintain a statewide program of services for persons who are both hearing impaired and visually impaired and coordinate appropriate services with other agencies and

organizations to avoid duplication of these services and to increase efficiency. The department of economic security shall enter into agreements for the utilization of the personnel and facilities of the department of economic security, the department of health services and other appropriate agencies and organizations in providing these services.
17. Establish and charge fees for deposit in the department of economic security prelayoff assistance services fund to employers who voluntarily participate in the services of the department that provide job service and retraining for persons who have been or are about to be laid off from employment. The department shall charge only those fees necessary to cover the costs of administering the job service and retraining services.
18. Establish a focal point for addressing the issue of hunger in Arizona and provide coordination and assistance to public and private nonprofit organizations that aid hungry persons and families throughout this state. Specifically such activities shall include:
(a) Collecting and disseminating information regarding the location and availability of surplus food for distribution to needy persons, the availability of surplus food for donation to charity food bank organizations, and the needs of charity food bank organizations for surplus food.
(b) Coordinating the activities of federal, state, local and private nonprofit organizations that provide food assistance to the hungry.
(c) Accepting and disbursing federal monies, and any state monies appropriated by the legislature, to private nonprofit organizations in support of the collection, receipt, handling, storage and distribution of donated or surplus food items.
(d) Providing technical assistance to private nonprofit organizations that provide or intend to provide services to the hungry.
(e) Developing a state plan on hunger that, at a minimum, identifies the magnitude of the hunger problem in this state, the characteristics of the population in need, the availability and location of charity food banks and the potential sources of surplus food, assesses the effectiveness of the donated food collection and distribution network and other efforts to alleviate the hunger problem, and recommends goals and strategies to improve the status of the hungry. The state plan on hunger shall be incorporated into the department's state comprehensive plan prepared pursuant to section 41-1956.
(f) Establishing a special purpose advisory council on hunger pursuant to section 41-1981.
19. Establish an office to address the issue of homelessness and to provide coordination and assistance to public and private nonprofit organizations that prevent homelessness or aid homeless individuals and families throughout this state. These activities shall include:
(a) Promoting and participating in planning for the prevention of homelessness and the development of services to homeless persons.
(b) Identifying and developing strategies for resolving barriers in state agency service delivery systems that inhibit the provision and coordination of appropriate services to homeless persons and persons in danger of being homeless.
(c) Assisting in the coordination of the activities of federal, state and local governments and the private sector that prevent homelessness or provide assistance to homeless people.
(d) Assisting in obtaining and increasing funding from all appropriate sources to prevent homelessness or assist in alleviating homelessness.
(e) Serving as a clearinghouse on information regarding funding and services available to assist homeless persons and persons in danger of being homeless.
(f) Developing an annual state comprehensive homeless assistance plan to prevent and alleviate homelessness.

(g) Submitting an annual report to the governor, the president of the senate and the speaker of the house of representatives on the status of homelessness and efforts to prevent and alleviate homelessness.
20. Cooperate with the Arizona-Mexico commission in the governor's office and with researchers at universities in this state to collect data and conduct projects in the United States and Mexico on issues that are within the scope of the department's duties and that relate to quality of life, trade and economic development in this state in a manner that will help the Arizona-Mexico commission to assess and enhance the economic competitiveness of this state and of the Arizona-Mexico region.
21. Exchange information, including case specific information, and cooperate with the department of child safety for the administration of the department of child safety's programs.

8-503. Powers and duties

A. The division shall:
1. Exercise supervision over all child welfare agencies.
2. Advise and cooperate with the governing boards of all child welfare agencies.
3. Assist the staffs of all child welfare agencies by giving advice on progressive methods and procedures of child care and improvement of services.
4. Establish rules, regulations, and standards for:
(a) Licensing of child welfare agencies.
(b) Licensing of foster homes.
(c) Classifications of foster homes as:
(i) Receiving foster homes.
(ii) Regular foster homes.
(iii) Special classes of foster homes as are needed according to the types of problems involved.
(iv) Group foster homes.
(d) Certifying each foster home according to one or more of the categories prescribed in subdivision (c) of this paragraph.
(e) Initial and ongoing foster parent training programs.
(f) The method of approving foster parent training programs.
(g) Uniform amounts of payment for all foster homes according to certification. However, variations in uniform amounts of payments may be allowed for foster homes based on consideration of geographical location or age or mental or physical condition of a foster child.
(h) Renewal of licenses of child welfare agencies and foster homes.
(i) Form and content of investigations, reports and studies concerning disposition of children and foster home placement.
5. Establish a program of counseling and rehabilitation of parents whose children have been placed in foster homes.
6. Establish foster parent training programs or contract with other agencies, institutions or groups for the provision of such programs to foster parents. Foster parent training programs shall be established in at least the following areas:
(a) Initial and ongoing training as a foster parent for a regular or group foster home.
(b) Initial and ongoing training as a foster parent for a special foster home.
7. Regulate the importation and exportation of children.

8. In conjunction with the department of education and the department of juvenile corrections, develop and implement a uniform budget format to be submitted by licensed child welfare agencies. The budget format shall be developed in such a manner that, at a minimum, residential and educational instructional costs are separate and distinct budgetary items.
9. Beginning October 1, 1983, establish as a goal that, at any given time, not more than fifty per cent of the total number of children whose maintenance is subsidized by title IV, part E of the social security act, as amended, shall be in foster care in excess of twenty-four consecutive months. The division shall establish through regulations appropriate procedures to achieve the goal.
B. Except as provided in section 8-514.01, large group settings for children, group homes for children and child developmental foster homes which have one or more residents who are clients of the department with developmental disabilities shall be licensed pursuant to title 36, chapter 5.1, article 3. Rules, regulations and standards adopted pursuant to subsection A, paragraph 4 of this section shall not apply to group homes for children or child developmental foster homes licensed pursuant to title 36, chapter 5.1, article 3.

8-506. Denial, suspension or revocation of license; foster home; hearing

The division may deny the application or suspend or revoke the license of any foster home for wilful violation of any provision of this article or failure to maintain the standards of the care prescribed by the division. Written notice of the grounds of the suspension or the proposed denial or revocation shall be given to the applicant or holder of the license. A copy of the written notice of the suspension or the proposed denial or revocation shall be forwarded to the agency that recommended the foster home for licensing. Within twenty-five days after the mailing date of the written notice of proposed denial, revocation or suspension, the applicant or holder may request a hearing in accordance with the rules of the division. If the hearing is requested it shall be held within ten days of the request, at which time the applicant or holder shall have the right to present testimony and confront witnesses.

8-126. Licensure and regulation of agencies

The division shall:
1. License agencies on an annual basis subject to renewal. Before issuing a license, the division shall investigate the activities of the agency, its financial stability, the character and training of its personnel and the adequacy of the agency's intended services to ensure the welfare of parents and children using the services of the agency. If the agency meets the standards established by the division, a license shall be issued.
2. Provide for oversight of agencies.
3. Assist the staffs of all agencies by giving advice on methods and procedures.
4. Establish rules for:
(a) Licensing agencies, including professional licensing, and suspending, revoking and denying licenses.
(b) Annual renewal of agency licenses.
(c) The form and content of investigations, reports and studies concerning adoption placements.

(d) Reasonable fees chargeable by the division to agencies for licensure and renewal of licenses.
(e) Reasonable and authorized fees chargeable to any person for services in connection with an adoption and payments, disbursements or commitments of anything of value made or agreed to be made to or for the benefit of a birth parent by any person in connection with an adoption.
(f) Conducting reviews and making reports pursuant to section 8-114, subsection E.

41-1967. Child care resource and referral system; immunity

A. The department shall establish and maintain a statewide child care resource and referral system, including a child care home provider registry, through community-based organizations to:
1. Provide families with:
(a) Information on all types of child care.
(b) Referrals to child care providers and programs.
(c) Information about child care resources and services.
(d) Information about choosing child care.
(e) Information about registered child care home providers.
2. Assist child care providers and programs with:
(a) Information on training related to child care issues.
(b) Technical assistance that relates to initiating or providing child care services.
(c) Parent referrals.
(d) Becoming registered as a child care home provider.
3. Coordinate with the community to:
(a) Develop statistics of the demand for and supply of child care.
(b) Maintain ongoing relationships with all local groups interested in child care.
B. The child care resource and referral system shall:
1. Identify all available child care providers and programs through coordination with public and private agencies.
2. Collect in a uniform method provider information for the referral database that includes:
(a) The type of program.
(b) The hours of service.
(c) The ages of children served.
(d) Fees for service.
(e) The licensure, certification and registration status of providers.
(f) Other significant provider and program information.
3. Establish and maintain a referral process that responds to parental need for information. The child care resource and referral system shall make referrals to child care providers and programs that:
(a) Promote parental choice and meet the needs of families.
(b) Are included in the resource and referral database.
4. Collect in a uniform method family information for the referral database that includes the:
(a) Number of calls and contacts.
(b) Ages of children in need of care.
(c) Days and times of care requested.
(d) Type of care requested.

(e) Special needs and requests made by the family.
(f) Reason that the care is needed.
5. Provide outreach services that include:
(a) Efforts to reach parents and providers in local communities.
(b) Involvement in the local communities.
(c) Publication of services through all available media sources, agencies and other appropriate channels.
(d) Public awareness information to parents and providers about the child care home provider registry and the benefits of using the registry or becoming registered.
6. Provide technical assistance to existing and prospective child care providers and programs that include:
(a) Information on all aspects of initiating new child care services including child care regulations, zoning, program and budget development and assistance in finding information from other sources.
(b) Educational information and resources that assist existing child care providers and programs to better serve the children and parents in their community.
(c) Local coordination of existing child care and child related services.
7. Establish and maintain a child care home provider registry that includes:
(a) Child care home providers that are registered pursuant to section 41-1967.01.
(b) A complaint tracking system that contains written complaints concerning providers and written provider responses. The complaints and responses are available to the public.
(c) A system for notifying a provider that is excluded or removed from the registry that the provider may appeal directly to the entity making the determination resulting in the exclusion or removal.
(d) Information provided by registered providers relating to the services provided and child care environment.
C. The following child care providers are eligible to be considered for inclusion in the child care resource and referral database, unless barred by other provisions of law:
1. Child care providers licensed or certified by a government agency that is authorized by law to license, certify or approve child care providers.
2. Child care home providers that are registered pursuant to section 41-1967.01. These providers shall submit and amend when necessary sworn, written statements to the department or its designees, on forms approved by the department, attesting that the provider is not subject to exclusion or removal from the child care resource and referral database under any of the grounds specified in subsection E of this section.
D. Child care providers identified in subsection C, paragraph 1 of this section may be excluded or removed from the child care resource and referral database whenever the provider's license or certification is revoked, terminated or suspended, or when a child care facility is closed for cause.
E. Child care home providers identified in subsection C, paragraph 2 of this section may be excluded or removed from the child care home provider registry and the child care resource and referral database if:
1. The provider fails to obtain a fingerprint clearance card or the provider's fingerprint clearance card is revoked or suspended.

2. The provider has been denied a license to operate a facility for the care of children or had a license or certificate to operate a facility revoked or has been removed for cause from participation in the child and adult food program in this state or in any other state or jurisdiction.
3. The provider, the provider's employees or any person eighteen years of age or older who resides in the provider's child care facility has been convicted of or is awaiting trial on any of the criminal offenses listed in section 41-1758.07, subsections B and C in this state or similar criminal offenses in any other state or jurisdiction.
4. The provider, the provider's employees or any person who resides in the provider's child care facility has been the subject of an investigation where a report of child abuse or neglect has been substantiated by the department of child safety or a child safety services agency or a law enforcement agency in this state or in any other state or jurisdiction.
5. The provider fails to maintain current training and certification in first aid and infant and child cardiopulmonary resuscitation.
6. The provider fails to enclose a pool pursuant to section 36-1681, subsections A, B and C.
7. The provider fails to separately store firearms and ammunition under lock and key or combination lock.
F. This section and section 41-1967.01 do not create an affirmative obligation on the part of any state agency or any child care resource and referral agency to review, monitor or investigate child care providers and programs.
G. Neither this state nor its officers or employees, acting within the scope of their employment, are liable for any damage or injury caused by their conduct pursuant to this section or section 41-1967.01, except for gross negligence or conduct intended to cause injury.
H. Neither a child care resource and referral agency nor its officers and employees, acting within the scope of their employment, are liable for any damage or injury caused by their conduct pursuant to this section or section 41-1967.01, except for gross negligence or conduct intended to cause injury.
I. The department shall adopt rules that are consistent with the terms of this section.

46-134. Powers and duties; expenditure; limitation

The state department shall:
1. Administer all forms of public relief and assistance except those that by law are administered by other departments, agencies or boards.
2. Develop a section of rehabilitation for the visually impaired that shall include a sight conservation section, a vocational rehabilitation section in accordance with the federal vocational rehabilitation act, a vending stand section in accordance with the federal Randolph-Sheppard act and an adjustment service section that shall include rehabilitation teaching and other social services deemed necessary, and shall cooperate with similar agencies already established. The administrative officer and staff of the section for the blind and visually impaired shall be employed only in the work of that section.
3. Assist other departments, agencies and institutions of the state and federal governments, when requested, by performing services in conformity with the purposes of this title.
4. Act as agent of the federal government in furtherance of any functions of the state department.
5. Carry on research and compile statistics relating to the entire public welfare program throughout this state, including all phases of dependency and defectiveness.
6. Cooperate with the superior court in cases of delinquency and related problems.

7. Develop plans in cooperation with other public and private agencies for the prevention and treatment of conditions giving rise to public welfare and social security problems.
8. Make necessary expenditures in connection with the duties specified in paragraphs 5, 6, 7, 13 and 14 of this subsection.
9. Have the power to apply for, accept, receive and expend public and private gifts or grants of money or property on the terms and conditions as may be imposed by the donor and for any purpose provided for by this chapter.
10. Make rules, and take action necessary or desirable to carry out the provisions of this title, that are not inconsistent with this title.
11. Administer any additional welfare functions required by law.
12. If a tribal government elects to operate a cash assistance program in compliance with the requirements of the United States department of health and human services, with the review of the joint legislative budget committee, provide matching monies at a rate that is consistent with the applicable fiscal year budget and that is not more than the state matching rate for the aid to families with dependent children program as it existed on July 1, 1994.
13. Furnish a federal, state or local law enforcement officer, at the request of the officer, with the current address of any recipient if the officer furnishes the agency with the name of the recipient and notifies the agency that the recipient is a fugitive felon or a probation, parole or community supervision violator or has information that is necessary for the officer to conduct the official duties of the officer and the location or apprehension of the recipient is within these official duties.
14. In conjunction with Indian tribal governments, request a federal waiver from the United States department of agriculture that will allow tribal governments that perform eligibility determinations for temporary assistance for needy families programs to perform the food stamp eligibility determinations for persons who apply for services pursuant to section 36-2901, paragraph 6, subdivision (a). If the waiver is approved, the state shall provide the state matching monies for the administrative costs associated with the food stamp eligibility based on federal guidelines. As part of the waiver, the department shall recoup from a tribal government all federal fiscal sanctions that result from inaccurate eligibility determinations.

46-807. Certification of family child care home and in-home providers; hearing

A. The department shall establish health, safety and training standards for the certification of child care home providers and in-home providers.
B. All child care personnel shall be fingerprinted according to section 41-1964.
C. The department may deny the application or suspend or revoke the certification of a child care home or in-home provider for violation of any provisions of law or failure to maintain the standards of care. Written notice of the grounds of suspension or the proposed denial or revocation shall be given to the applicant or provider. The applicant or provider has a right to request a hearing on the suspension, denial or revocation of a certification, and a hearing shall be held pursuant to title 41, chapter 14, article 3 and according to rules of the department.

G-3

ARIZONA BOARD OF EXECUTIVE CLEMENCY (F-16-0801)

Title 5, Chapter 4, Article 1, General Provisions; Article 2, Pardon; Article 3, Rescission or Revocation

GOVERNOR'S REGULATORY REVIEW COUNCIL
ANALYSIS OF FIVE-YEAR REVIEW REPORT

MEETING DATE: August 2, 2016 **AGENDA ITEM: G-3**

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

FROM: Preston Knight, Legal Intern

DATE: July 15, 2016

SUBJECT: **ARIZONA BOARD OF EXECUTIVE CLEMENCY (F-16-0801)**
Title 5, Chapter 4, Article 1, General Provisions; Article 2, Pardon; and Article 3, Rescission or Revocation.

COMMENTS ON THE FIVE-YEAR-REVIEW REPORT

Purpose of the Agency and Number of Rules in the Report

The purpose of the Arizona Board of Executive Clemency (Board) is "to recommend and grant commutations, pardons, reprieves and absolute discharge and to grant or revoke paroles." Laws 2015, Ch. 53, § 3.

This five-year-review report covers five rules in A.A.C. Title 5, Chapter 4 which outline general provisions, pardon procedures, and rescission and revocation procedures for the Board.

Article Contents, Including the Subject Matter of Each Rule in the Report

Article 1 contains two rules which provide definitions for the chapter and Board hearings requirements.

Article 2 contains one rule which addresses pardons.

Article 3 contains two rules which address rescission and revocation hearings.

Year that Each Rule was Last Amended or Newly Made

The rules were newly made on April 5, 2008.

Proposed Action

None.

Summary of Reasons for the Proposed Action

The Board indicates the rules are effective, are consistent with other rules and statutes, are enforced as written, and are clear, concise, and understandable.

Exemption or Request and Approval for Exception from the Moratorium

The Board does not plan to request an exception from the moratorium.

Substantive or Procedural Concerns

None.

Analysis of the agency's report pursuant to criteria in A.R.S. § 41-1056 and R1-6-301:

1. **Has the agency certified that it is in compliance with A.R.S. § 41-1091?**

Yes. The Board has certified that it is in compliance with A.R.S. § 41-1091.

2. **Has the agency analyzed the rules' effectiveness in achieving their objectives?**

Yes. The Board indicates the rules are effective in achieving their objectives.

3. **Has the agency received any written criticisms of the rules during the last five years, including any written analysis questioning whether the rules are based on valid scientific or reliable principles or methods?**

No. The Board indicates that it has received no written criticisms during the last five years.

4. **Has the agency analyzed whether the rules are authorized by statute?**

Yes. The Board provides general statutory authority for the rules reviewed. Under A.R.S. § 34-401(G), the Board may "adopt rules, not inconsistent with law, as it deems proper for the conduct of its business. The Board may from time to time amend or change the rules and publish and distribute the rules as provided by the administrative procedures act."

The Board also provides specific statutory authority for these rules. The Board cites to A.R.S. §§ 1-301, 31-401, 31-402, 31-415, 31-442, 38-431, 41-1604.06, and 41-1604.09 for the rules in A.A.C. Title 5, Chapter 4.

5. **Has the agency analyzed the rules' consistency with other rules and statutes?**

Yes. The Board indicates that the rules are consistent with federal statutes and state statutes and rules.

6. **Has the agency analyzed the current enforcement status of the rules?**

Yes. The Board indicates that the rules are enforced as written.

7. **Has the agency analyzed whether the rules are clear, concise, and understandable?**

Yes. The Board indicates the rules are clear, concise, and understandable.

8. **Stringency of the Rules:**

   a. **Are the rules more stringent than corresponding federal law?**

Not applicable.

   b. **If so, is there statutory authority to exceed the requirements of federal law?**

Not applicable.

9. **For rules adopted after July 29, 2010:**

   a. **Do the rules require issuance of a regulatory permit, license or agency authorization?**

Not applicable. The rules do not require issuance of a regulatory permit, license or agency authorization.

   b. **If so, are the general permit requirements of A.R.S. § 41-1037 met or does an exception apply?**

Not applicable.

10. **Has the agency indicated whether it completed the course of action identified in the previous five-year-review report?**

Not applicable. There was no proposed action in the previous five-year-review report.

11. **Has the agency included a proposed course of action?**

No. The Board has determined no action is required at this time.

Conclusion

The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. This analyst recommends that the report be approved.

GOVERNOR'S REGULATORY REVIEW COUNCIL
M E M O R A N D U M

MEETING DATE: August 2, 2016 **AGENDA ITEM: G-3**

TO: Members of the Governor's Regulatory Review Council

FROM: GRRC Economic Team

DATE : July 15, 2016

SUBJECT: **ARIZONA BOARD OF EXECUTIVE CLEMENCY (F-16-0801)**
Title 5, Chapter 4, Article 1, General Provisions; Article 2, Pardon; and Article 3, Rescission or Revocation.

I reviewed the five-year-review report's economic, small business, and consumer impact comparison for compliance with A.R.S. § 41-1056 and make the following comments.

1. Economic Impact Comparison

The economic, small business, and consumer impact statement (EIS) from the most recent rulemaking was available for all of the rules contained in the five-year-review report.

The rules address the definitions and rules relating to the Board of Executive Clemency (Board). Article 1 addresses general provisions, Article 2 discusses pardons, and Article 3 describes regulation around recession and revocation hearings. All other articles were repealed in 1997 or earlier.

In 2015, forty-seven applications for pardon were submitted to the Board, which chose to recommend 14 of them. According to the previously submitted EIS, the Governor granted pardons to two, denied three, and has not acted on the remaining recommended pardons.

The Board is funded by the general fund, which will spend $344,565 in 2016, or 30% of its allocated budget for the Board.

2. Has the agency determined that the rules impose the least burden and costs to persons regulated by the rules?

The Board indicates that the rules impose the least burden and cost on regulated individuals. According to the Board's five year review report, the only cost for individuals applying for pardon is for postage to return documents to the Board.

3. Was an analysis submitted to the agency under A.R.S. § 41-1056(A)(7)?

No analysis was submitted to the agency by another person that compares the rules' impact on this state's business competitiveness to the impact on businesses in other states under A.R.S. § 41-1056(A)(7).

4. Conclusion

After review, staff concludes that the report complies with A.R.S. § 41-1056 and recommends approval.

Douglas A. Ducey
Governor

Terry L. Adriance
Executive Director

Ellen Kirschbaum
Chairman

ARIZONA BOARD OF EXECUTIVE CLEMENCY

May 26, 2016

Governor's Regulatory Review Council Attention:
Chairwoman Nicole A. Ong
100 North 15th Avenue, Ste. 402
Phoenix, AZ 85007

RE: FIVE-YEAR REVIEW REPORT MAY, 2016

Pursuant to A.R.S. § 41-1056, the Board of Executive Clemency has conducted a review of its Title 5, Chapter 4 Rules and Articles. AZBOEC now submits the Five Year Review Report for your review and approval.

Should there be any questions or concerns in relation to this report, please contact me directly at (602) 542-5648.

Sincerely,

Terry L. Adriance

Terry L. Adriance
Executive Director
(602) 542-5648
tadriance@azboec.gov

Attachment A

FIVE YEAR REVIEW REPORT

TITLE 5

CHAPTER 4. THE ARIZONA BOARD OF EXECUTIVE CLEMENCY

ARTICLES 1, 2 & 3

May 2016

FIVE YEAR REVIEW REPORT

TITLE 5

CHAPTER 4.BOARD OF EXECUTIVE CLEMENCY

ARTICLES 1, 2 & 3

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3. ANALYSIS OF INDIVIDUAL RULES Page 5
4. CURRENT RULES Attachment A

FIVE-YEAR REVIEW SUMMARY

The Arizona Board of Executive Clemency (Board) was first established in 1901 as the Board of Control. In 1913 the Board of Control's name was changed to the Board of Pardons and Paroles. The Board acted under that name until 1994 when the Board's name was changed to the Board of Executive Clemency. Board membership has fluctuated between three and seven members, but currently has five members. The Board's mission is to protect public safety and contribute to a fair and effective justice system by ensuring that persons who remain a threat to society remain incarcerated and those who no longer present a risk are released to become productive citizens. In addition, the Board recommends to the Governor only those executive clemency actions which are in the best interest and safety of the citizens of Arizona.

A.R.S. Title 31, Chapter 3, Articles 1 through 7 detail the Board's operating authority and duties. The Board implements its statutes with 3 rules that are located in A.A.C. Title 5, Chapter 4, Articles 1, 2, and 3. The rules included in this report were made as new rules and became effective April 5, 2008.

The Board is exempt from the Administrative Procedure Act under A.R.S. 41-1005(A) for rules related to inmates. Some provisions of the rules reviewed relate to inmates but the Board is reviewing all rules together for consistency.

INFORMATION THAT IS IDENTICAL FOR ALL THE RULES

4. *Consistency of the rule with state and federal statutes and rules*

   The Board has determined that the rules are consistent with state and federal statutes and rules and a listing of the statutes or rules used in determining the consistency are as follows:

   A.R.S. Title 31, Chapter 3, Articles 1 through 7

   A.R.S. §1-301

   A.R.S. §38-431

   A.R.S. §41-1005A

   A.R.S. §41-1604.06; 41-1604.09

   Federal Law: Morrissey vs. Brewer, 408 U.S. 471(Due process requires notice and opportunity to respond before revocation of parole)

5. *Status of enforcement policy*

   All rules are currently being enforced, and the Board has not encountered any problems with enforcement.

6. *Analysis of clarity, conciseness, and understandability*

   The Board has reviewed each rule and has determined that the rules are clear, concise, and understandable.

7. *Written criticisms of the rules received within the last five years*

   The Board has not received any written criticisms of any of the rules within the last five years.

9. *Economic, small business, and consumer impact comparison*

Type Hearing/No. Hearings Held	FY 2006	FY 2011	FY 2016
Pardons	23	64	21
Rescission/Revocation	2,708	2,518	2,339

As was previously determined in 2006 and 2011 analyses, the Board maintains that the Board, the Department of Public Safety (DPS), the Federal Bureau of Investigation (FBI), and any individual seeking an executive clemency action would bear the cost of implementation of the rules. The Board determined that the actual cost incurred by each of these entities due to this action is minimal. The Board continues to agree with these analyses, and the actual cost incurred by each of these named entities is minimal.

For pardons, the Board continues to maintain that costs to the Board include copying a pardon application and postage for mailing to an applicant. The FBI and DPS conduct a criminal inquiry on applicants. The costs for conducting these inquiries are appropriated to each agency on the federal and state levels. The cost to an individual applying for a pardon is for postage to return documents to the Board. The Board continues to agree with this analysis.

The results of the analysis indicate that the Board bears minimal paper costs to initiate a rescission or revocation hearing. The Board continues to agree with this analysis.

The definitions make the rules understandable to a reader while providing consistent interpretation of the word being defined. There have been no costs associated with implementing this rule. The Board continues to agree with this analysis.

10. *Analysis submitted to the agency by another person comparing rules' impact on businesses*

The Board has not received any analyses submitted by another person that compares the rules' impact on Arizona's business competitiveness to the impact on businesses in other states.

11. *Completion of course of action indicated in the previous five-year review report*

No course of action was proposed in the previous report, and accordingly, not action has been taken on the rules in the past five years.

12. *Determination that the rules impose the least burden and costs to persons regulated by the rule*

The Board has determined that all of the rules impose the least burden and costs to persons regulated by the rules, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

13. *Analysis of stringency compared to federal laws*

The rules are not related to federal laws.

14. *For rules adopted after July 28, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rule complies with section 41-1037*

The rules do not require the issuance of a regulatory permit, license, or agency authorization.

15. *Course of action*

The Board has reviewed each rule and believes there is no need to submit any of the rules to the GRRC to amend, repeal, or make a new rule.

ANALYSIS OF INDIVIDUAL RULES

ARTICLE 1. GENERAL PROVISIONS

R5-4-101. Definitions

1. *General and specific statutes authorizing the rule*

General: A.R.S. §31-401

Specific: A.R.S. §31-401 (A), A.R.S. §1-301

2. *Objective*

The objective of the rule is to define terms and phrases to make the rules understandable to a reader, achieve clarity in the rules without needless repetition, and afford consistent interpretation.

3. *Analysis of the effectiveness of the rule in achieving the objective*

The Board has determined that the rule is effective in achieving the objective.

R5-4-102. Board Hearings

1. *General and specific statutes authorizing the rule*

General: A.R.S. §31-401

Specific: A.R.S. §38-431

2. *Objective*

The objective of the rule is to lay out essential procedural elements applicable to all types of hearings. The Board shall ensure all hearings are open to the public as required by statute, conduct a hearing in an informal manner unless otherwise provided by law, and allow an inmate to be represented by counsel at a hearing.

3. *Analysis of the effectiveness of the rule in achieving the objective*

The Board has determined that the rule is effective in achieving the objective.

ARTICLE 2. PARDON

R5-4-201. Pardon

1. *General and specific statutes authorizing the rule*

   General: A.R.S. §31-401

   Specific: A.R.S. §31-442

2. *Objective*

   The objective of the rule is to set forth the process of applying for and being considered by the Board for pardon recommendation.

3. *Analysis of the effectiveness of the rule in achieving the objective*

   The Board has determined that the rule is effective in achieving the objective as the rule outlines the specific steps of the Pardon process, beginning with the inmate application process. The Board believes the rule is concise as stated.

ARTICLE 3. RESCISSION OR REVOCATION

R5-4-301. Rescission Hearings

1. *General and specific statutes authorizing the rule*

   General: A.R.S. §31-401 (G)

   Specific: A.R.S. §31-401

   A.R.S. §31-402 (C)

   A.R.S. §31-415

   A.R.S. §38-431

   A.R.S. §41-1604.06; 41-1604.09

   Federal Law: Morrissey vs. Brewer, 408 U.S. 471(Due process requires notice and opportunity to respond before revocation of parole)

2. *Objective*

   The objective of the rule is to state

   a. The process for initiating, scheduling, and conducting a rescission hearing
   b. The actions that may be taken at the close of a rescission hearing.

3. *Analysis of the effectiveness of the rule in achieving the objective*

   The Board has determined that the rule is effective in achieving the objective.

R5-4-302. Revocation Hearings

1. *General and specific statutes authorizing the rule*

General: A.R.S. §31-401 (G)

Specific: A.R.S. §31-401

A.R.S. §31-402 (C)

A.R.S. §31-415

A.R.S. §38-431

A.R.S. §41-1604.06; 41-1604.09

Federal Law: Morrissey vs. Brewer, 408 U.S. 471(Due process requires notice and opportunity to respond before revocation of parole)

2. *Objective*

The objective of the rule is to state

a. The process for initiating, scheduling, and conducting a revocation hearing
b. The actions that may be taken at the close of a revocation hearing.

3. *Analysis of the effectiveness of the rule in achieving the objective*

The Board has determined that the rule is effective in achieving the objective.

ATTACHMENT - A

TITLE 5. CORRECTIONS

CHAPTER 4. BOARD OF EXECUTIVE CLEMENCY

(Authority: A.R.S. § 31-401 et seq.)

Article 1 through Article 7 consisting of Sections R5-4-101 through R5-4-705 adopted effective June 26, 1980.

Former Article 1 consisting of Sections R5-4-01, R5-4-03 through R5-4-09 repealed effective June 26, 1980.

ARTICLE 1. GENERAL PROVISIONS

Section
R5-4-101. Definitions
R5-4-102. Board Hearings
R5-4-103. Repealed
R5-4-104. Repealed
R5-4-105. Repealed
R5-4-106. Repealed
R5-4-107. Repealed
R5-4-108. Repealed
R5-4-109. Repealed

ARTICLE 2. PARDON

Article 2, consisting of Section R5-4-201, adopted effective September 22, 1997 (Supp. 97-3).

Article 2, consisting of Sections R5-4-201 and R5-4-202, repealed effective May 31, 1991 (Supp. 91-2).

Section
R5-4-201. Pardon

ARTICLE 3. RECISSION OR REVOCATION

Article 3, consisting of Sections R5-4-301 and R5-4-302, adopted effective September 22, 1997 (Supp. 97-3).

Article 3, consisting of Sections R5-4-301 thru R5-4-306, repealed effective May 31, 1991 (Supp. 91-2).

Section
R5-4-301. Rescission Hearings
R5-4-302. Revocation Hearings

ARTICLE 4. REPEALED

Article 4, consisting of Sections R5-4-401 thru R5-4-404, repealed effective May 31, 1991 (Supp. 91-2).

ARTICLE 5. REPEALED

Article 5, Section R5-4-501 repealed effective May 31, 1991 (Supp. 91-2); Sections R5-4-502 and R5-4-503 repealed effective September 22, 1997 (Supp. 97-3).

R5-4-501. Repealed
R5-4-502. Repealed
R5-4-503. Repealed

ARTICLE 6. REPEALED

Article 6, consisting of Sections R5-4-601 thru R5-4-603, repealed effective September 22, 1997 (Supp. 97-3).

R5-4-601. Repealed
R5-4-602. Repealed
R5-4-603. Repealed

ARTICLE 7. REPEALED

Article 7, Sections R5-4-701 thru R5-4-704 repealed effective May 31, 1991 (Supp. 91-2); Section R5-4-705 repealed effective September 22, 1997 (Supp. 97-3).

R5-4-701. Repealed
R5-4-702. Repealed
R5-4-703. Repealed
R5-4-704. Repealed
R5-4-705. Repealed

ARTICLE 8. REPEALED

Article 8, Sections R5-4-801 thru R5-4-806 repealed effective May 31, 1991 (Supp. 91-2); Section R5-4-807 repealed effective September 22, 1997 (Supp. 97-3).

Article 8 consisting of Sections R5-4-801 through R5-4-807 adopted effective October 17, 1984.

Former Article 8 consisting of Sections R5-4-801 through R5-4-808 adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5).

R5-4-801. Repealed
R5-4-802. Repealed
R5-4-803. Repealed
R5-4-804. Repealed
R5-4-805. Repealed
R5-4-806. Repealed
R5-4-807. Repealed

ARTICLE 1. GENERAL PROVISIONS

R5-4-101. Definitions

In this Chapter, unless otherwise specified:

1. "Applicant" means an individual who asks the governor to grant a pardon.
2. "Board" means the Arizona Board of Executive Clemency, as established by A.R.S. § 31-401(A).
3. "Department" means the Arizona Department of Corrections.
4. "Good cause" means a reason that the Board determines is substantial enough to afford a legal excuse.
5. "Inmate" means an individual who is under the jurisdiction of the Department, including an individual in custody or on parole, home arrest, work furlough, or community supervision.
6. "Pardon" means an action by the governor that absolves an individual of the legal consequences of a crime for which the individual was convicted.
7. "Presiding Officer" means either the Chairperson of the Board or the Chairperson of a Board panel assigned to conduct a hearing.
8. "Release" means parole, home arrest, work furlough, or community supervision.
9. "Rescission" means an act of the Board that voids a previously made release decision before the inmate is released.
10. "Request to rescind" means a document asking the Board for a rescission.
11. "Revocation" means an act by the Board that terminates an inmate's release because of a violation of a release condition.
12. "Street time" means the interval between when an inmate is released on parole and the parole is revoked or completed.
13. "Warrant" means a document that specifies an alleged violation of a condition of a release.
14. "Work day" means every day except Saturdays, Sundays, and state holidays listed at A.R.S. § 1-301.

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2). New Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 14 A.A.R. 529, effective April 5, 2008 (Supp. 08-1).

R5-4-102. Board Hearings

A. The Board shall ensure that all hearings are open to the public as required by A.R.S. § 38-431 et seq.
B. Unless otherwise provided by law, the Board shall conduct a hearing in an informal manner without adherence to the rules of evidence required in a judicial proceeding.
C. The Board shall allow an inmate to be represented by counsel at a hearing.

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 14 A.A.R. 529, effective April 5, 2008 (Supp. 08-1).

R5-4-103. Repealed

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-104. Repealed

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-105. Repealed

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-106. Repealed

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-107. Repealed

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-108. Repealed

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-109. Repealed

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

ARTICLE 2. PARDON

R5-4-201. Pardon

A. Unless prohibited by law, an individual who was convicted of an Arizona felony offense may apply for a pardon.
B. To apply for a pardon, an eligible individual shall submit to the Board a completed application form obtained from the Board.
C. In addition to the application form required under subsection (B), an applicant shall submit other information and documents that the Board requests to assist it in deciding whether to recommend a pardon.
D. If an inmate applies for a pardon, the Board shall request that the Department review the application and verify whether the inmate is eligible to apply for the pardon.
E. After receiving a complete application from an eligible applicant, the Board shall schedule a hearing and provide advance written notice to the applicant of the date and location of the hearing.
F. At the hearing, the Board shall take one of the following actions:
   1. Vote to deny recommending that the governor grant a pardon and notify the applicant in writing of the Board's decision within 10 work days.
   2. Vote to recommend that the governor grant a pardon and notify the applicant in writing of the Board's decision within 10 work days.
G. If the Board votes to recommend a pardon, the Presiding Officer shall designate a Board member to prepare and send to the governor a letter of recommendation. The letter of recommendation may include a statement of individual Board members' reasons for voting to recommend a pardon. Board members who voted not to recommend a pardon may prepare and send letters of dissent to the governor.
H. If the governor denies a pardon, the Board shall notify the applicant in writing of the governor's decision within 10 work days after receiving notice of the governor's decision.
I. If the Board votes not to recommend a pardon for an applicant or if the governor denies a pardon, the applicant shall not apply again for a pardon for three years from the date of the Board's decision.

Historical Note
Former Section R5-4-201 repealed effective May 31, 1991 (Supp. 91-2). New Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 14 A.A.R. 529, effective April 5, 2008 (Supp. 08-1).

ARTICLE 3. RECISSION OR REVOCATION

R5-4-301. Rescission Hearings

A. An officer of the Department or a member of the Board may initiate the rescission process by submitting to the Board a request to rescind a previously made release decision that:
   1. Alleges:
      a. The inmate to be released has violated the law,
      b. The inmate to be released has violated a disciplinary rule of the Department,
      c. The inmate to be released is not able to meet a condition of release, or
      d. The Board lacked accurate or complete information when the Board made the release decision, and
   2. Includes a list of documents and items to be offered as evidence and witnesses who will be called to testify.
B. After the Board receives a completed request to rescind, the Board shall schedule a rescission hearing unless a hearing officer designated by the Board to conduct a probable cause hearing determines there is no probable cause for the requested rescission, in which case, the request to rescind is deemed denied. The Board shall provide advance notice of the date and location of the rescission hearing to the inmate and the Department.
C. The Board shall conduct the rescission hearing. The inmate may request that the hearing be continued for good cause. The Board may continue the hearing for good cause at any time.
D. At the close of the rescission hearing, the Board shall take one of the following actions:

1. Find that the allegation in the request to rescind is not true, deny the request to rescind, and allow to stand the Board's previous decision to grant release to the inmate.
2. Find that one or more of the allegations in the request to rescind are true and void the Board's previous decision to grant release to the inmate. The Department shall continue to hold the inmate in secure custody as provided by law.
3. Find that one or more of the allegations in the request to rescind are true but allow to stand the Board's previous decision to grant release to the inmate with or without additional conditions.

Historical Note

Former Section R5-4-301 repealed effective May 31, 1991 (Supp. 91-2). New Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 14 A.A.R. 529, effective April 5, 2008 (Supp. 08-1).

R5-4-302. Revocation Hearings

A. An officer of the Department or a member of the Board may initiate the revocation process by requesting that the Department issue to the Board a warrant that:
   1. Alleges an inmate violated a condition of the inmate's release; and
   2. Lists documents and items to be offered as evidence and witnesses who will be called to testify.

B. After the Department executes the warrant and it is determined there is probable cause to believe the inmate violated a condition of the inmate's release or the inmate waives a probable cause hearing, the Board shall schedule a revocation hearing. The Board shall provide advance notice of the date and location of the revocation hearing to the inmate and the Department.

C. The Board shall conduct the revocation hearing. The inmate may request that the hearing be continued for good cause. The Board may continue the hearing for good cause at any time.

D. At the close of the revocation hearing, the Board shall take one of the following actions:
   1. Find that each allegation in the warrant is not true and direct, in writing, that the Department release the inmate from secure custody to parole, home arrest, work furlough, or community supervision status.
   2. Find that one or more of the allegations in the warrant are true and revoke the inmate's release. The Department shall immediately place the inmate in secure custody and hold the inmate as provided by law.
   3. In the case of an inmate on parole, find that one or more of the allegations in the warrant are true and revoke the inmate's parole but place the inmate on home arrest. The Department shall hold the inmate in secure custody pending the inmate's release on home arrest.
   4. In the case of an inmate on parole, work furlough, home arrest, or community supervision, find that one or more of the allegations in the warrant are true but reinstate the inmate's release with or without additional conditions.

E. If the Board revokes an inmate's parole status under subsection (D)(2) or (D)(3), the Board may determine whether the circumstances merit forfeiture of some or all street-time credits earned by the inmate while on parole.

Historical Note

Former Section R5-4-302 repealed effective May 31, 1991 (Supp. 91-2). New Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 14 A.A.R. 529, effective April 5, 2008 (Supp. 08-1).

R5-4-303. Repealed

Historical Note

Former Section R5-4-303 repealed effective May 31, 1991 (Supp. 91-2).

R5-4-304. Repealed

Historical Note

Former Section R5-4-304 repealed effective May 31, 1991 (Supp. 91-2).

R5-4-305. Repealed

Historical Note

Former Section R5-4-305 repealed effective May 31, 1991 (Supp. 91-2).

R5-4-306. Repealed

Historical Note

Former Section R5-4-306 repealed effective May 31, 1991 (Supp. 91-2).

ARTICLE 4. REPEALED

Article 4, consisting of Sections R5-4-401 thru R5-4-404, repealed effective May 31, 1991 (Supp. 91-2).

ARTICLE 5. REPEALED

R5-4-501. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-502. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective September 22, 1997 (Supp. 97-3).

R5-4-503. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective September 22, 1997 (Supp. 97-3).

ARTICLE 6. REPEALED

R5-4-601. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective September 22, 1997 (Supp. 97-3).

R5-4-602. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective September 22, 1997 (Supp. 97-3).

R5-4-603. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective September 22, 1997 (Supp. 97-3).

ARTICLE 7. REPEALED

R5-4-701. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-702. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-703. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-704. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-705. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective September 22, 1997 (Supp. 97-3).

ARTICLE 8. REPEALED

R5-4-801. Repealed

Historical Note

Adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Permanent rule adopted effective October 17, 1984 (Supp. 84-5). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-802. Repealed

Historical Note

Adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Permanent rule adopted effective October 17, 1984 (Supp. 84-5). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-803. Repealed

Historical Note

Adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Permanent rule adopted effective October 17, 1984 (Supp. 84-5). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-804. Repealed

Historical Note

Adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Permanent rule adopted effective October 17, 1984 (Supp. 84-5). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-805. Repealed

Historical Note

Adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Permanent rule adopted effective October 17, 1984 (Supp. 84-5). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-806. Repealed

Historical Note

Adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Permanent rule adopted effective October 17, 1984 (Supp. 84-5). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-807. Repealed

Historical Note

Adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Permanent rule adopted effective October 17, 1984 (Supp. 84-5). Repealed effective September 22, 1997 (Supp. 97-3).

TITLE 5. CORRECTIONS

CHAPTER 4. BOARD OF EXECUTIVE CLEMENCY

(Authority: A.R.S. § 31-401 et seq.)

Article 1 through Article 7 consisting of Sections R5-4-101 through R5-4-705 adopted effective June 26, 1980.

Former Article 1 consisting of Sections R5-4-01, R5-4-03 through R5-4-09 repealed effective June 26, 1980.

ARTICLE 1. GENERAL PROVISIONS

Section
R5-4-101. Definitions
R5-4-102. Board Hearings
R5-4-103. Repealed
R5-4-104. Repealed
R5-4-105. Repealed
R5-4-106. Repealed
R5-4-107. Repealed
R5-4-108. Repealed
R5-4-109. Repealed

ARTICLE 2. PARDON

Article 2, consisting of Section R5-4-201, adopted effective September 22, 1997 (Supp. 97-3).

Article 2, consisting of Sections R5-4-201 and R5-4-202, repealed effective May 31, 1991 (Supp. 91-2).

Section
R5-4-201. Pardon

ARTICLE 3. RECISSION OR REVOCATION

Article 3, consisting of Sections R5-4-301 and R5-4-302, adopted effective September 22, 1997 (Supp. 97-3).

Article 3, consisting of Sections R5-4-301 thru R5-4-306, repealed effective May 31, 1991 (Supp. 91-2).

Section
R5-4-301. Rescission Hearings
R5-4-302. Revocation Hearings

ARTICLE 4. REPEALED

Article 4, consisting of Sections R5-4-401 thru R5-4-404, repealed effective May 31, 1991 (Supp. 91-2).

ARTICLE 5. REPEALED

Article 5, Section R5-4-501 repealed effective May 31, 1991 (Supp. 91-2); Sections R5-4-502 and R5-4-503 repealed effective September 22, 1997 (Supp. 97-3).

R5-4-501. Repealed
R5-4-502. Repealed
R5-4-503. Repealed

ARTICLE 6. REPEALED

Article 6, consisting of Sections R5-4-601 thru R5-4-603, repealed effective September 22, 1997 (Supp. 97-3).

R5-4-601. Repealed
R5-4-602. Repealed
R5-4-603. Repealed

ARTICLE 7. REPEALED

Article 7, Sections R5-4-701 thru R5-4-704 repealed effective May 31, 1991 (Supp. 91-2); Section R5-4-705 repealed effective September 22, 1997 (Supp. 97-3).

R5-4-701. Repealed
R5-4-702. Repealed
R5-4-703. Repealed
R5-4-704. Repealed
R5-4-705. Repealed

ARTICLE 8. REPEALED

Article 8, Sections R5-4-801 thru R5-4-806 repealed effective May 31, 1991 (Supp. 91-2); Section R5-4-807 repealed effective September 22, 1997 (Supp. 97-3).

Article 8 consisting of Sections R5-4-801 through R5-4-807 adopted effective October 17, 1984.

Former Article 8 consisting of Sections R5-4-801 through R5-4-808 adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5).

R5-4-801. Repealed
R5-4-802. Repealed
R5-4-803. Repealed
R5-4-804. Repealed
R5-4-805. Repealed
R5-4-806. Repealed
R5-4-807. Repealed

ARTICLE 1. GENERAL PROVISIONS

R5-4-101. Definitions

In this Chapter, unless otherwise specified:

1. "Applicant" means an individual who asks the governor to grant a pardon.
2. "Board" means the Arizona Board of Executive Clemency, as established by A.R.S. § 31-401(A).
3. "Department" means the Arizona Department of Corrections.
4. "Good cause" means a reason that the Board determines is substantial enough to afford a legal excuse.
5. "Inmate" means an individual who is under the jurisdiction of the Department, including an individual in custody or on parole, home arrest, work furlough, or community supervision.
6. "Pardon" means an action by the governor that absolves an individual of the legal consequences of a crime for which the individual was convicted.
7. "Presiding Officer" means either the Chairperson of the Board or the Chairperson of a Board panel assigned to conduct a hearing.
8. "Release" means parole, home arrest, work furlough, or community supervision.
9. "Rescission" means an act of the Board that voids a previously made release decision before the inmate is released.
10. "Request to rescind" means a document asking the Board for a rescission.
11. "Revocation" means an act by the Board that terminates an inmate's release because of a violation of a release condition.
12. "Street time" means the interval between when an inmate is released on parole and the parole is revoked or completed.
13. "Warrant" means a document that specifies an alleged violation of a condition of a release.
14. "Work day" means every day except Saturdays, Sundays, and state holidays listed at A.R.S. § 1-301.

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2). New Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 14 A.A.R. 529, effective April 5, 2008 (Supp. 08-1).

R5-4-102. Board Hearings

A. The Board shall ensure that all hearings are open to the public as required by A.R.S. § 38-431 et seq.

B. Unless otherwise provided by law, the Board shall conduct a hearing in an informal manner without adherence to the rules of evidence required in a judicial proceeding.

C. The Board shall allow an inmate to be represented by counsel at a hearing.

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 14 A.A.R. 529, effective April 5, 2008 (Supp. 08-1).

R5-4-103. Repealed

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-104. Repealed

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-105. Repealed

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-106. Repealed

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-107. Repealed

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-108. Repealed

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-109. Repealed

Historical Note
Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

ARTICLE 2. PARDON

R5-4-201. Pardon

A. Unless prohibited by law, an individual who was convicted of an Arizona felony offense may apply for a pardon.

B. To apply for a pardon, an eligible individual shall submit to the Board a completed application form obtained from the Board.

C. In addition to the application form required under subsection (B), an applicant shall submit other information and documents that the Board requests to assist it in deciding whether to recommend a pardon.

D. If an inmate applies for a pardon, the Board shall request that the Department review the application and verify whether the inmate is eligible to apply for the pardon.

E. After receiving a complete application from an eligible applicant, the Board shall schedule a hearing and provide advance written notice to the applicant of the date and location of the hearing.

F. At the hearing, the Board shall take one of the following actions:
1. Vote to deny recommending that the governor grant a pardon and notify the applicant in writing of the Board's decision within 10 work days.
2. Vote to recommend that the governor grant a pardon and notify the applicant in writing of the Board's decision within 10 work days.

G. If the Board votes to recommend a pardon, the Presiding Officer shall designate a Board member to prepare and send to the governor a letter of recommendation. The letter of recommendation may include a statement of individual Board members' reasons for voting to recommend a pardon. Board members who voted not to recommend a pardon may prepare and send letters of dissent to the governor.

H. If the governor denies a pardon, the Board shall notify the applicant in writing of the governor's decision within 10 work days after receiving notice of the governor's decision.

I. If the Board votes not to recommend a pardon for an applicant or if the governor denies a pardon, the applicant shall not apply again for a pardon for three years from the date of the Board's decision.

Historical Note
Former Section R5-4-201 repealed effective May 31, 1991 (Supp. 91-2). New Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 14 A.A.R. 529, effective April 5, 2008 (Supp. 08-1).

ARTICLE 3. RECISSION OR REVOCATION

R5-4-301. Rescission Hearings

A. An officer of the Department or a member of the Board may initiate the rescission process by submitting to the Board a request to rescind a previously made release decision that:
1. Alleges:
   a. The inmate to be released has violated the law,
   b. The inmate to be released has violated a disciplinary rule of the Department,
   c. The inmate to be released is not able to meet a condition of release, or
   d. The Board lacked accurate or complete information when the Board made the release decision, and
2. Includes a list of documents and items to be offered as evidence and witnesses who will be called to testify.

B. After the Board receives a completed request to rescind, the Board shall schedule a rescission hearing unless a hearing officer designated by the Board to conduct a probable cause hearing determines there is no probable cause for the requested rescission, in which case, the request to rescind is deemed denied. The Board shall provide advance notice of the date and location of the rescission hearing to the inmate and the Department.

C. The Board shall conduct the rescission hearing. The inmate may request that the hearing be continued for good cause. The Board may continue the hearing for good cause at any time.

D. At the close of the rescission hearing, the Board shall take one of the following actions:

1. Find that the allegation in the request to rescind is not true, deny the request to rescind, and allow to stand the Board's previous decision to grant release to the inmate.
2. Find that one or more of the allegations in the request to rescind are true and void the Board's previous decision to grant release to the inmate. The Department shall continue to hold the inmate in secure custody as provided by law.
3. Find that one or more of the allegations in the request to rescind are true but allow to stand the Board's previous decision to grant release to the inmate with or without additional conditions.

Historical Note

Former Section R5-4-301 repealed effective May 31, 1991 (Supp. 91-2). New Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 14 A.A.R. 529, effective April 5, 2008 (Supp. 08-1).

R5-4-302. Revocation Hearings

A. An officer of the Department or a member of the Board may initiate the revocation process by requesting that the Department issue to the Board a warrant that:
1. Alleges an inmate violated a condition of the inmate's release; and
2. Lists documents and items to be offered as evidence and witnesses who will be called to testify.

B. After the Department executes the warrant and it is determined there is probable cause to believe the inmate violated a condition of the inmate's release or the inmate waives a probable cause hearing, the Board shall schedule a revocation hearing. The Board shall provide advance notice of the date and location of the revocation hearing to the inmate and the Department.

C. The Board shall conduct the revocation hearing. The inmate may request that the hearing be continued for good cause. The Board may continue the hearing for good cause at any time.

D. At the close of the revocation hearing, the Board shall take one of the following actions:
1. Find that each allegation in the warrant is not true and direct, in writing, that the Department release the inmate from secure custody to parole, home arrest, work furlough, or community supervision status.
2. Find that one or more of the allegations in the warrant are true and revoke the inmate's release. The Department shall immediately place the inmate in secure custody and hold the inmate as provided by law.
3. In the case of an inmate on parole, find that one or more of the allegations in the warrant are true and revoke the inmate's parole but place the inmate on home arrest. The Department shall hold the inmate in secure custody pending the inmate's release on home arrest.
4. In the case of an inmate on parole, work furlough, home arrest, or community supervision, find that one or more of the allegations in the warrant are true but reinstate the inmate's release with or without additional conditions.

E. If the Board revokes an inmate's parole status under subsection (D)(2) or (D)(3), the Board may determine whether the circumstances merit forfeiture of some or all street-time credits earned by the inmate while on parole.

Historical Note

Former Section R5-4-302 repealed effective May 31, 1991 (Supp. 91-2). New Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 14 A.A.R. 529, effective April 5, 2008 (Supp. 08-1).

R5-4-303. Repealed

Historical Note

Former Section R5-4-303 repealed effective May 31, 1991 (Supp. 91-2).

R5-4-304. Repealed

Historical Note

Former Section R5-4-304 repealed effective May 31, 1991 (Supp. 91-2).

R5-4-305. Repealed

Historical Note

Former Section R5-4-305 repealed effective May 31, 1991 (Supp. 91-2).

R5-4-306. Repealed

Historical Note

Former Section R5-4-306 repealed effective May 31, 1991 (Supp. 91-2).

ARTICLE 4. REPEALED

Article 4, consisting of Sections R5-4-401 thru R5-4-404, repealed effective May 31, 1991 (Supp. 91-2).

ARTICLE 5. REPEALED

R5-4-501. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-502. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective September 22, 1997 (Supp. 97-3).

R5-4-503. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective September 22, 1997 (Supp. 97-3).

ARTICLE 6. REPEALED

R5-4-601. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective September 22, 1997 (Supp. 97-3).

R5-4-602. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective September 22, 1997 (Supp. 97-3).

R5-4-603. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective September 22, 1997 (Supp. 97-3).

ARTICLE 7. REPEALED

R5-4-701. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-702. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-703. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-704. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-705. Repealed

Historical Note

Adopted effective June 26, 1980 (Supp. 80-3). Repealed effective September 22, 1997 (Supp. 97-3).

ARTICLE 8. REPEALED

R5-4-801. Repealed

Historical Note

Adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Permanent rule adopted effective October 17, 1984 (Supp. 84-5). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-802. Repealed

Historical Note

Adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Permanent rule adopted effective October 17, 1984 (Supp. 84-5). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-803. Repealed

Historical Note

Adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Permanent rule adopted effective October 17, 1984 (Supp. 84-5). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-804. Repealed

Historical Note

Adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Permanent rule adopted effective October 17, 1984 (Supp. 84-5). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-805. Repealed

Historical Note

Adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Permanent rule adopted effective October 17, 1984 (Supp. 84-5). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-806. Repealed

Historical Note

Adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Permanent rule adopted effective October 17, 1984 (Supp. 84-5). Repealed effective May 31, 1991 (Supp. 91-2).

R5-4-807. Repealed

Historical Note

Adopted as an emergency effective June 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Permanent rule adopted effective October 17, 1984 (Supp. 84-5). Repealed effective September 22, 1997 (Supp. 97-3).

31-401. Board of executive clemency; qualifications; appointment; officers; quorum; meeting

A. The board of executive clemency is established consisting of five members who are appointed by the governor pursuant to this subsection and section 38-211.

B. The members of the board shall be compensated on an hourly basis and are not eligible for paid leave. Beginning from and after December 31, 2013, members of the board are eligible for any benefits that are provided to state employees pursuant to section 38-651. A member who is acting as the executive director shall be compensated pursuant to subsection K of this section. Each member shall be appointed on the basis of broad professional or educational qualifications and experience and shall have demonstrated an interest in the state's correctional program. No more than two members from the same professional discipline shall be members of the board at the same time.

C. Each member appointed to the board shall complete a four week course relating to the duties and activities of the board. The course shall be designed and administered by the chairman of the board and shall be conducted by the office of the board of executive clemency and the office of the attorney general. The course shall include training in all statutes that pertain to the board and participation in a decision making workshop.

D. Members shall be appointed for a term of five years to expire on the third Monday in January of the appropriate year.

E. A member of the board may be removed by the governor for cause.

F. The governor shall select a member of the board as chairman. The chairman shall select other officers as are advisable. The term of the chairman is two years, except that the chairman may be removed as chairman at the pleasure of the governor. If a board member's term expires while the member is serving as chairman, the chair shall be deemed vacant and a new chairman shall be selected.

G. The board may adopt rules, not inconsistent with law, as it deems proper for the conduct of its business. The board may from time to time amend or change the rules and publish and distribute the rules as provided by the administrative procedures act.

H. The board shall meet at least once a month at the state prison and at other times or places as the board deems necessary.

I. The presence of three members of the board constitutes a quorum, except that the chairman may designate that the presence of two members of the board constitutes a quorum.

J. If two members of the board constitute a quorum pursuant to subsection I of this section and the two members do not concur on the action under consideration, the chairman of the board, if the chairman is not one of the members who constituted the quorum and after reviewing the information considered by the two members, shall cast the deciding vote. If the chairman of the board is one of the two members constituting a quorum at a hearing under subsection I of this section, and there is not concurrence on the action under consideration, the action fails.

K. The board shall employ an executive director whose compensation shall be determined pursuant to section 38-611. The chairman of the board may act as the executive director.

38-431. Definitions

In this article, unless the context otherwise requires:

1. "Advisory committee" or "subcommittee" means any entity, however designated, that is officially established, on motion and order of a public body or by the presiding officer of the public body, and whose members have been appointed for the specific purpose of making a recommendation concerning a decision to be made or considered or a course of conduct to be taken or considered by the public body.

2. "Executive session" means a gathering of a quorum of members of a public body from which the public is excluded for one or more of the reasons prescribed in section 38-431.03. In addition to the members of the public body, officers, appointees and employees as provided in section 38-431.03 and the auditor general as provided in section 41-1279.04, only individuals whose presence is reasonably necessary in order for the public body to carry out its executive session responsibilities may attend the executive session.

3. "Legal action" means a collective decision, commitment or promise made by a public body pursuant to the constitution, the public body's charter, bylaws or specified scope of appointment and the laws of this state.

4. "Meeting" means the gathering, in person or through technological devices, of a quorum of members of a public body at which they discuss, propose or take legal action, including any deliberations by a quorum with respect to such action.

5. "Political subdivision" means all political subdivisions of this state, including without limitation all counties, cities and towns, school districts and special districts.

6. "Public body" means the legislature, all boards and commissions of this state or political subdivisions, all multimember governing bodies of departments, agencies, institutions and instrumentalities of this state or political subdivisions, including without limitation all corporations and other instrumentalities whose boards of directors are appointed or elected by this state or political subdivision. Public body includes all quasi-judicial bodies and all standing, special or advisory committees or subcommittees of, or appointed by, the public body. Public body includes all commissions and other public entities established by the Arizona Constitution or by way of ballot initiative, including the independent redistricting commission, and this article applies except and only to the extent that specific constitutional provisions supersede this article.

7. "Quasi-judicial body" means a public body, other than a court of law, possessing the power to hold hearings on disputed matters between a private person and a public agency and to make decisions in the general manner of a court regarding such disputed claims.