

NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council or the Attorney General. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 23. BOARD OF PHARMACY

[R06-399]

PREAMBLE

- 1. Sections Affected**

R4-23-110	Amend
R4-23-410	Amend
R4-23-670	Amend
- 2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

Authorizing statutes: A.R.S. § 32-1904(A)(1)
Implementing statutes: A.R.S. § 32-1904(B)(3) and (5)
- 3. The effective date of the rules:**

December 4, 2006
- 4. A list of all previous notices appearing in the Register addressing the final rules:**

Notice of Rulemaking Docket Opening, 12 A.A.R. 693, March 3, 2006
Notice of Proposed Rulemaking, 12 A.A.R. 1310, April 21, 2006
- 5. The name and address of agency personnel with whom persons may communicate regarding the rules:**

Name: Dean Wright, Compliance Officer
Address: Board of Pharmacy
4425 W. Olive Ave., Suite 140
Glendale, AZ 85302
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- 6. An explanation of the rules, including the agency's reasons for initiating the rules:**

During the June 16, 2005 Board meeting, Board President Linda McCoy appointed a task force committee headed by Board members, Tom Van Hassel and Ridge Schmidt, to look at the 2004 changes made to *USP General Chapter 797 Pharmaceutical Compounding--Sterile Preparations* and recommend how the Board should address those changes in the pharmacy rules. The 797 Task Force Committee met four times: August 16, 2005, September 28, 2005, November 17, 2005, and January 26, 2006. The 797 Task Force Committee presented their recommended rule changes to the Board at the March 15, 2006 Board meeting. The amended rules are a result of the work of the 797 Task Force Committee. The amended rules amend R4-23-110 (Definitions) by adding new definitions for: ISO class 5 environment, ISO class 7 environment, prep area, standard-risk sterile pharmaceutical product, and substantial-risk sterile pharmaceutical product and delete the definition for class 100 environment. The amended rules amend R4-23-410 (Current Good Compounding Practices) and R4-23-670 (Sterile Pharmaceutical Products) to implement the recommendations of the 797 Task Force Committee. The amended rules make minor changes to R4-23-410 to require a compounding pharmacy to comply with its policies and procedures. The changes in R4-23-670 require an increase in the minimum square footage of the sterile pharmaceutical product compounding area from 60 square feet to 100 square feet and include a grandfather clause for existing pharmacies. Additional changes to R4-23-670 include changes to the required policies and procedures and new subsections describing the requirements for standard-risk and substantial-

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risk sterile pharmaceutical compounding. The rules will include format, style, and grammar necessary to comply with the current rules of the Secretary of State and Governor's Regulatory Review Council.

The Board believes that approval of these rules benefits the public and the pharmacy community by clearly establishing the overall standards for compounding and the specific standards for sterile pharmaceutical product compounding.

7. A reference to any study relevant to the rules that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

None

8. A showing of good cause why the rules are necessary to promote a statewide interest if the rules will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

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

The amended rules will impact the Board, pharmacies, pharmacists, and the public. The amended rules' impact on the Board will be the usual rulemaking-related costs which are minimal. The Board estimates the amended rules will have minimal to moderate economic impact on pharmacies, and pharmacists. Pharmacies must already have a minimum 60 square foot area for sterile pharmaceutical compounding within the pharmacy if the pharmacy compounds sterile pharmaceutical products. The amended rules will require that the sterile compounding area meet the new ISO Class 7 environment standard, and some pharmacies may need to upgrade their area to meet the new cleanroom standard which will have an economic impact on the pharmacy. The Board estimates the cost to upgrade will range from zero to less than \$10,000. The majority of the upgrades will involve simply adding HEPA filters to bring the area into compliance with the new cleanroom standard. The amended rules have no economic impact on the public.

The public, Board, pharmacies, and pharmacists benefit from rules that are clear, concise, and understandable. The amended rules benefit the public and the pharmacy community by clearly establishing the overall standards for compounding and the specific standards for sterile pharmaceutical product compounding.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

There are no substantial changes in the final rules from the proposed rules. There are minor changes to style, format, grammar, and punctuation requested by GRRC staff.

11. A summary of the comments made regarding the rules and the agency response to them:

A public hearing was held on May 15, 2006. Janet Elliott of the Arizona Community Pharmacy Committee attended the hearing and spoke in favor of the rulemaking. Ms. Elliott provided a written statement voicing the Arizona Community Pharmacy Committee's support of the rulemaking.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

ISO/T209 International Cleanroom Standards, specifically ANSI/IEEST/ISO-14644-1:1999; Cleanrooms and associated controlled environments--Part 1: Classification of air cleanliness, first edition dated May 1, 1999, and no future amendments or editions, located at A.A.C. R4-23-110 in the definitions for ISO Class 5 environment and ISO Class 7 environment.

14. Were these rules previously approved as emergency rules?

No

15. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 23. BOARD OF PHARMACY

ARTICLE 1. ADMINISTRATION

Section
R4-23-110. Definitions

ARTICLE 4. PROFESSIONAL PRACTICES

Section
R4-23-410. Current Good Compounding Practices

ARTICLE 6. PERMITS AND DISTRIBUTION OF DRUGS

Section
R4-23-670. Sterile Pharmaceutical Products

ARTICLE 1. ADMINISTRATION

R4-23-110. Definitions

In addition to definitions in A.R.S. § 32-1901, the following definitions apply to 4 A.A.C. 23:

- “Active ingredient” No change
- “Alternate physician” No change
- “Approved course in pharmacy law” No change
- “Approved Provider” No change
- “Authentication of product history” No change
- “Batch” No change
- “Beyond-use date” No change
- “Biological safety cabinet” No change
- “Care-giver” No change
- ~~“Class 100 environment” means an atmospheric environment in compliance with the Federal Standard 209 Clean Room and Work Station Requirements: Controlled Environment, publication FED STD 209D, U.S. Government Services Administration 450 Golden Gate Avenue, San Francisco, CA, June 15, 1988 edition which includes January 28, 1991, changes, (and no future amendments or editions), incorporated by reference and on file with the office of the Secretary of State.~~
- “Community pharmacy” No change
- “Component” No change
- “Compounding and dispensing counter” No change
- “Computer system” No change
- “Computer system audit” No change
- “Contact hour” No change
- “Container” No change
- “Continuing education” No change
- “Continuing education activity” No change
- “Continuing education unit” or “CEU” No change
- “Correctional facility” No change
- “CRT” No change
- “Current good compounding practices” No change
- “Current good manufacturing practice” No change
- “Cytotoxic” No change
- “Day” No change
- “DEA” No change
- “Delinquent license” No change
- “Dietary supplement” No change
- “Dispensing pharmacist” No change
- “Drug sample” No change
- “Drug therapy management” No change
- “Drug therapy management agreement” No change
- “Eligible patient” No change
- “Extreme emergency” No change
- “FDA” No change
- “Immediate notice” No change
- “Inactive ingredient” No change
- “Internal test assessment” No change
- “ISO Class 5 environment” means an atmospheric environment that complies with the ISO/TC209 International Clean-room Standards, specifically ANSI/IES/ISO-14644-1:1999: Cleanrooms and associated controlled environments--Part 1: Classification of air cleanliness, first edition dated May 1, 1999, (and no future amendments or editions), incorporated by reference and on file in the Board office.
- “ISO Class 7 environment” means an atmospheric environment that complies with the ISO/TC209 International Clean-

room Standards, specifically ANSI/IES/ISO-14644-1:1999: Cleanrooms and associated controlled environments--Part 1: Classification of air cleanliness, first edition dated May 1, 1999, (and no future amendments or editions), incorporated by reference and on file in the Board office.

- “Limited-service correctional pharmacy” No change
- “Limited-service long-term care pharmacy” No change
- “Limited-service mail-order pharmacy” No change
- “Limited-service nuclear pharmacy” No change
- “Limited-service pharmacy permittee” No change
- “Limited-service sterile pharmaceutical products pharmacy” No change
- “Long-term care consultant pharmacist” No change
- “Long-term care facility” or “LTCF” No change
- “Lot” No change
- “Lot number” or “control number” No change
- “Materials approval unit” No change
- “Mediated instruction” No change
- “MPJE” No change
- “NABP” No change
- “NABPLEX” No change
- “NAPLEX” No change
- “Other designated personnel” No change
- “Outpatient” No change
- “Outpatient setting” No change
- “Patient profile” No change
- “Pharmaceutical patient care services” No change
- “Pharmaceutical product” No change
- “Pharmacist-administered immunizations training program” No change
- “Pharmacy counter working area” No change
- “Pharmacy law continuing education” No change
- “Pharmacy permittee” No change
- “Prepackaged drug” No change

“Prep area” means a specified area either within an ISO class 7 environment or adjacent to but outside an ISO class 7 environment that:

Allows the assembling of necessary drugs, supplies, and equipment for compounding sterile pharmaceutical products, but does not allow the use of paper products such as boxes or bulk drug storage;

Allows personnel to don personnel protective clothing, such as gown, gloves, head cover, and booties before entering the clean compounding area; and

Is a room or a specified area within a room, such as an area specified by a line on the floor.

- “Proprietor” No change
- “Provider pharmacy” No change
- “Radiopharmaceutical” No change
- “Radiopharmaceutical quality assurance” No change
- “Radiopharmaceutical services” No change
- “Red C stamp” No change
- “Refill” No change
- “Remodel” No change
- “Remote drug storage area” No change
- “Resident” No change
- “Responsible person” No change
- “Score transfer” No change
- “Sight-readable” No change
- “Single-drug audit” No change
- “Single-drug usage report” No change
- “Standard-risk sterile pharmaceutical product” means a sterile pharmaceutical product compounded from sterile commercial drugs using sterile commercial devices or a sterile pharmaceutical odc or ophthalmic product compounded from non-sterile ingredients.
- “Sterile pharmaceutical product” No change
- “Strength” No change
- “Substantial-risk sterile pharmaceutical product” means a sterile pharmaceutical product compounded as a parenteral or injectable dosage form from non-sterile ingredients.

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- “Supervision” No change
- “Supervisory physician” No change
- “Supplying” No change
- “Support personnel” No change
- “Transfill” No change
- “Wholesale distribution” No change
- “Wholesale distributor” No change

ARTICLE 4. PROFESSIONAL PRACTICES

R4-23-410. Current Good Compounding Practices

- A. No change
- B. A pharmacy permittee shall ensure compliance with the provisions in this subsection.
 - 1. All substances for compounding that are received, stored, or used by the pharmacy permittee:
 - a. No change
 - b. No change
 - c. Are obtained from a source that, in the professional ~~judgement~~ judgment of the pharmacist, is acceptable and reliable.
 - 2. No change
 - 3. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - 4. No change
- C. No change
 - 1. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - 2. No change
 - a. No change
 - b. No change
 - c. No change
 - i. No change
 - ii. No change
- D. No change
 - 1. No change
 - 2. No change
- E. No change
 - 1. No change
 - a. No change
 - b. No change
 - 2. No change
 - 3. No change
- F. No change
 - 1. No change
 - 2. No change
 - 3. No change
 - 4. No change
 - 5. No change
- G. A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, ~~and~~ implements, ~~and~~ complies with procedures to prevent cross-contamination when pharmaceutical products that require special precautions to prevent cross-contamination, such as penicillin, are used in a compounding procedure. The procedures shall include either the dedication of equipment or the meticulous cleaning of contaminated equipment before its use in compounding other pharmaceutical products.

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- H. A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, ~~and~~ implements, and complies with control procedures for components and pharmaceutical product containers and closures, either written or electronically stored with printable documentation, that conform with the standards in this subsection.
1. No change
 - a. No change
 - b. No change
 - c. No change
 2. No change
 3. No change
- I. A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, ~~and~~ implements, and complies with pharmaceutical product compounding controls that conform with the standards in this subsection.
1. No change
 - a. No change
 - i. No change
 - ii. No change
 - iii. No change
 - b. No change
 - i. No change
 - ii. No change
 - iii. No change
 2. No change
 - a. No change
 - b. No change
 3. No change
 4. No change
 - a. No change
 - b. No change
 5. No change
 6. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
- J. No change
1. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 2. No change
- K. A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, ~~and~~ implements, and complies with record-keeping procedures that comply with this subsection:
1. No change
 2. No change

ARTICLE 6. PERMITS AND DISTRIBUTION OF DRUGS

R4-23-670. Sterile Pharmaceutical Products

- A. In addition to the minimum area requirement of R4-23-609(A) and R4-23-655(B) and before compounding a sterile pharmaceutical product, a pharmacy permittee, limited-service pharmacy permittee, or applicant shall provide a minimum sterile pharmaceutical product compounding area that is not less than 60 100 square feet of contiguous floor area, except any pharmacy permit issued or pharmacy remodeled before November 1, 2006 may continue to use a sterile pharmaceutical product compounding area that is not less than 60 square feet of contiguous floor area, until a pharmacy ownership change occurs that requires issuance of a new permit or the pharmacy is remodeled. The pharmacy permittee or the pharmacist-in-charge shall ensure that the sterile pharmaceutical product compounding area:
1. Is dedicated to the purpose of preparing and compounding sterile pharmaceutical products;
 2. Is isolated from other pharmacy functions;
 3. Restricts entry or access;

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4. Is free from unnecessary disturbances in air flow; ~~and~~
 5. Is made of non-porous and cleanable floor, wall, and ceiling material; and
 6. Meets the minimum air cleanliness standards of an ISO Class 7 environment as defined in R4-23-110, except an ISO class 7 environment is not required if all sterile pharmaceutical product compounding occurs within an ISO class 5 environment isolator, such as a glove box, pharmaceutical isolator, barrier isolator, pharmacy isolator, or hospital pharmacy isolator.
- B.** In addition to the equipment requirements in R4-23-611 and R4-23-612 or R4-23-656 and before compounding a sterile pharmaceutical product, a pharmacy permittee, limited-service pharmacy permittee, or applicant shall ensure that a pharmacist who compounds a sterile pharmaceutical product has the following equipment:
1. Environmental control devices capable of maintaining a compounding area environment equivalent to a ~~“class 100 an~~ “ISO class 5 environment” as defined in R4-23-110. Devices capable of meeting these standards include: laminar air-flow hoods, hepa filtered zonal airflow devices, glove boxes, pharmaceutical isolators, barrier isolators, pharmacy isolators, hospital pharmacy isolators, and biological safety cabinets;
 2. Disposal containers designed for needles, syringes, and other material used in compounding sterile pharmaceutical products and if applicable, separate containers to dispose of cytotoxic, chemotherapeutic, and infectious waste products;
 3. Freezer storage units with thermostatic control and thermometer, if applicable;
 4. Packaging or delivery containers capable of maintaining official compendial drug storage conditions;
 5. Infusion devices and accessories, if applicable; and
 6. In addition to the reference library requirements of R4-23-612, a current reference pertinent to the preparation of sterile pharmaceutical products.
- C.** Before compounding a sterile pharmaceutical product, the pharmacy permittee, limited-service pharmacy permittee, or pharmacist-in-charge shall:
1. Prepare, ~~and~~ implement, and comply with policies and procedures for compounding and dispensing sterile pharmaceutical products,
 2. Review biennially and if necessary revise the policies and procedures required under subsection (C)(1),
 3. Document the review required under subsection (C)(2),
 4. Assemble the policies and procedures as a written manual or by another method approved by the Board or its designee, and
 5. Make the policies and procedures available in the pharmacy for employee reference and inspection by the Board or its designee.
- D.** The assembled policies and procedures shall include, where applicable, the following subjects:
1. Supervisory controls and verification procedures to ensure the quality and safety of sterile pharmaceutical products;
 2. Clinical services and drug monitoring procedures for:
 - a. Patient drug utilization reviews;
 - b. Inventory audits;
 - c. Patient outcome monitoring;
 - d. Drug information; and
 - e. Education of pharmacy and other health professionals;
 3. Controlled substances;
 4. Supervisory controls and verification procedures for:
 - a. Cytotoxics handling, storage, and disposal;
 - b. Disposal of unused supplies and pharmaceutical products; and
 - c. Handling and disposal of infectious wastes;
 5. Pharmaceutical product administration, including guidelines for the first dosing of a pharmaceutical product;
 6. Drug and component procurement;
 7. Pharmaceutical product compounding, dispensing, and storage;
 8. Duties and qualifications of professional and support staff;
 9. Equipment maintenance;
 10. Infusion devices and pharmaceutical product delivery systems;
 11. Investigational drugs and their protocols;
 12. Patient profiles;
 13. Patient education and safety;
 14. Quality management procedures for:
 - a. Adverse drug reactions;
 - b. Drug recalls;
 - c. Expired ~~and beyond use date~~ pharmaceutical products;
 - d. Beyond-use-dating for both standard-risk and substantial-risk sterile pharmaceutical products consistent with the requirements of R4-23-410(B)(3)(d);

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- ~~d-e.~~ Temperature and other environmental controls;
 - ~~e-f.~~ Documented process and product validation testing; and
 - ~~f-g.~~ Annual Semi-annual certification of the laminar air flow hood or other ISO class 400 5 environment, other equipment, and the ISO class 7 environment, including documentation of routine ~~hood~~ cleaning and maintenance for each laminar air flow hood or other ISO class 5 environment, other equipment, and the ISO class 7 environment; and
15. Sterile pharmaceutical product delivery requirements for:
- a. Shipment to the patient;
 - b. Security; and
 - c. Maintaining official compendial storage conditions.
- E.** Standard-risk sterile pharmaceutical product compounding. Before compounding a standard-risk sterile pharmaceutical product, a pharmacy permittee or pharmacist-in-charge shall ensure compliance with the following minimum standards:
- 1. Compounding occurs only in an ISO class 5 environment within an ISO class 7 environment, and the ISO class 7 environment may have a specified prep area inside the environment;
 - 2. Compounding sterile pharmaceutical products from sterile commercial drugs or sterile pharmaceutical otic or ophthalmic products from non-sterile ingredients occurs using procedures that involve only a few closed-system, basic, simple aseptic transfers and manipulations;
 - 3. Each person who compounds wears adequate personnel protective clothing for sterile preparation that includes gown, gloves, head cover, and booties. Each person who compounds is not required to wear personnel protective clothing when all sterile pharmaceutical compounding occurs within an ISO class 5 environment isolator, and the ISO Class 5 environment isolator is not inside an ISO Class 7 environment; and
 - 4. Each person who compounds completes an annual media-fill test to validate proper aseptic technique.
- F.** Substantial-risk sterile pharmaceutical product compounding. Before compounding a substantial-risk sterile pharmaceutical product, a pharmacy permittee or pharmacist-in-charge shall ensure compliance with the following minimum standards:
- 1. Compounding parenteral or injectable sterile pharmaceutical products from non-sterile ingredients occurs only in an ISO class 5 environment within an ISO class 7 environment and the ISO class 7 environment shall not have a prep area inside the environment;
 - 2. Each person who compounds wears adequate personnel protective clothing for sterile preparation that includes gown, gloves, head cover, and booties. Each person who compounds is not required to wear personnel protective clothing when all sterile pharmaceutical compounding occurs within an ISO class 5 environment isolator, and the ISO Class 5 environment isolator is not inside an ISO Class 7 environment; and
 - 3. Each person who compounds completes a semi-annual media-fill test that simulates the most challenging or stressful conditions for compounding using dry non-sterile media to validate proper aseptic technique.

NOTICE OF FINAL RULEMAKING

TITLE 7. EDUCATION

CHAPTER 6. SCHOOL FACILITIES BOARD

[R06-401]

PREAMBLE

- | | |
|--|--|
| <p>1. <u>Sections affected</u>
R7-6-302</p> <p>2. <u>The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):</u>
Authorizing Statute: A.R.S. § 15-2011(D) and A.R.S. § 41-1003
Implementing Statute: A.R.S. § 15-2041(D)</p> <p>3. <u>The effective date of the rules:</u>
December 4, 2006</p> <p>4. <u>A list of all previous notices in the Register addressing the final rule:</u>
Notice of Rulemaking Docket Opening: 12 A.A.R. 881, March 24, 2006
Notice of Proposed Rulemaking: 12 A.A.R. 1062, April 7, 2006</p> <p>5. <u>The name and address of agency personnel with whom persons may communicate regarding the rulemaking:</u>
Name: Monica Petersen, SFB Deputy Director for Finance</p> | <p><u>Rulemaking Action</u>
Amend</p> |
|--|--|

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Address: 1700 W. Washington, Suite 230
Phoenix, AZ 85007

Telephone: (602) 364-0283

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E-mail: mpetersen@azsfb.gov

6. An explanation of the rule, including the agency’s reasons for initiating the rule:

Currently, R7-6-302 requires the School Facilities Board (“SFB”) to help formulate a plan for growing school districts that are required to send high school students outside the district by as much as 45 miles to adjoining school districts. The proposed rulemaking changes to R7-6-302 would allow growing school districts to unify and apply to the School Facilities Board to provide funding for the necessary high school space based upon the projected growth in the school district’s geographic area, without the need for a locally funded bond issue. The following table identifies several school districts that are on the edge of current development areas projected to have significant growth in the next few years and that provided more than 100 high school students to adjoining districts in Fiscal Year 2005.

Average Daily Membership

CTD	District	FY 2003	FY 2004	FY 2005
020349000	Palominas Elementary District	366	427	444
100351000	Altar Valley Elementary District	346	360	354
110344000	J O Combs Elementary District	137	128	293
110302000	Oracle Elementary District	226	223	209
070381000	Nadaburg Elementary District	159	156	196
130326000	Beaver Creek Elementary District	95	87	106
100339000	Continental Elementary District	93	89	102
020323000	Naco Elementary District	102	107	101

The School Facilities Board is seeking to amend the rule defining the geographic factor exceptions that may allow a school district after unification to apply to the School Facilities Board for funding for needed high school space.

7. A reference to any study that the agency relied on in its evaluation of or justification for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of each study and other supporting material:

School districts contemplating new or replacement school construction request a “Capacity Review” from the School Facilities Board staff. These reviews compare the school district’s estimates of project student average daily membership (ADM) to those of the SFB to determine when any new or replacement school space may be needed. The SFB used reviews of the J O Combs School District as a partial basis for the subject rule amendment. These reviews may be obtained by request through the SFB Executive Director.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

This rule will not diminish a previous grant of authority of a political subdivision.

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

The number of school districts that may be eligible for unification and subsequent high school facility construction, and have the desire to do so are hard to predict. However, the impact of such construction on the local communities is two fold. The immediate impact is during the construction of the facility, which may yield certain short-term construction job opportunities. The long-term operations of the high schools present job opportunities ranging from educators, facility operations and maintenance, to increased need for local, small businesses that may be needed to supply products for the operation and maintenance of the high schools. The rural location of these school districts make such projections hard to quantify beyond projections of construction costs that are approximated to be just over \$10 million per high school under the current state allocation formula. The long-term cost of educators and support staff to operate the high schools is to be borne by the school districts. The cost for land is more flexible in that potential donations by landowners may significantly impact this component. Such high schools are anticipated to have initial student populations under 500.

The primary economic impact of this rule amendment is the choice of geographic location of high school facilities. To support the growing student population, the School Facilities Board will continue building high schools. The amended rule allows those facilities to be built in more convenient and cost-effective locations that the unified school districts determine to be most advantageous to the student communities they serve.

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10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

Minor technical changes were made at the suggestion of GRRRC staff.

11. A summary of the principal comments and the agency response to them:

No comments were received.

12. Any other matters prescribed by the statute that are applicable to the specific agency or to any specific rule or class or rules:

None

13. Incorporation by reference and their location in the rules:

None at this time

14. Was this rule previously made as an emergency rule?

No

15. The full text of the rules follows:

TITLE 7. EDUCATION

CHAPTER 6. SCHOOL FACILITIES BOARD

ARTICLE 3. SQUARE FOOTAGE CALCULATIONS

Section

R7-6-302. Modification of Square Footage for Geographic Factors

ARTICLE 3. SQUARE FOOTAGE CALCULATION

R7-6-302. Modification of Square Footage for Geographic Factors

A. In those school districts where students are transported one hour or more via the most reasonable and direct route or where students reside 45 miles or more from the closest school via the most reasonable and direct route, and where 100 or more students are affected by these conditions within the same region, the School Facilities Board shall provide additional school space to the district to accommodate the educational needs of the affected students. However, the educational space provided may be modified as the Board sees fit in making a conscientious effort to meet the Minimum Adequacy Guidelines without requiring extraordinary expenditures of public funds.

B. If an elementary school district that is not in a high school district unifies after June 30, 2005, the resulting unified school district may qualify for high school space under A.R.S. § 15-2041 if it meets the following criteria:

1. The elementary school district unifies after June 30, 2005; and
2. The resulting unified school district is projected to have more than 350 resident high school students being served in school districts other than the student's resident school district within three years following the current fiscal year; and
3. One of the following is true:
 - a. At least 350 of the high school students would travel 20 miles or more to the receiving school facility; or
 - b. The receiving school district is projected to need additional high school space within seven years. For purposes of this analysis, the projected average daily membership of the receiving district includes the high school students of both the receiving and sending districts.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

**CHAPTER 1. DEPARTMENT OF HEALTH SERVICES
ADMINISTRATION**

[R06-402]

PREAMBLE

1. Sections Affected

Article 5
R9-1-501

Rulemaking Action

New Article
New Section

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R9-1-502	New Section
R9-1-503	New Section
R9-1-504	New Section
R9-1-505	New Section
R9-1-506	New Section

2. The statutory authority for the rulemaking, including both the authorizing statutes (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 36-136(A)(7) and 36-136(F)

Implementing statutes: A.R.S. §§ 36-104(16), 36-2172(B), 36-2174(A), and 36-2907.06(D)

3. The effective date of the rules:

December 4, 2006

4. A list of all previous notices appearing in the Register addressing the final rules:

Notice of Rulemaking Docket Opening: 11 A.A.R. 2389, June 24, 2005

Notice of Proposed Rulemaking: 11 A.A.R. 5298, December 16, 2005

Notice of Supplemental Proposed Rulemaking 12 A.A.R. 1464, May 5, 2006

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Patricia Tarango, Office Chief

Address: Arizona Department of Health Services
Office of Health Systems Development
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6. An explanation of the rules, including the agency's reasons for initiating the rules:

The Department of Health Services (Department) placed the existing sliding-fee-schedule Article, 9 A.A.C. 2, Article 1, in the Chapter labeled "Tobacco Tax-funded Programs" because the sliding-fee-schedule rule, R9-2-101, applied to the A.R.S. § 36-2907.06 primary care program funded under former A.R.S. § 36-2921. Former A.R.S. § 36-2921 allocated tobacco tax funds, including allocations to the primary care program and other Department programs. Laws 2003, Chapter 265, § 30, retroactively effective to July 1, 2003, repealed all versions of A.R.S. § 36-2921. The state's general fund currently funds the programs.

In addition to the primary care program, Department programs, such as the primary care provider loan repayment program under A.R.S. § 36-2172 and 42 CFR Part 62¹, the rural private primary care provider loan repayment program under A.R.S. § 36-2174, and the J-1 visa waiver program and the national interest waiver program under A.R.S. § 36-104(16), need to reference the sliding-fee-schedule rules. Therefore, the Department determined to make updated sliding-fee-schedule rules and to place them in 9 A.A.C. 1, Administration, as new Article 5, Sliding Fee Schedules. The new Article includes R9-1-501, Definitions; R9-1-502, Family Member Determination; R9-1-503, Family Income Determination; R9-1-504, Sliding Fee Schedule Submission and Contents; R9-1-505, Sliding Fee Schedule Approval Time-frames; and R9-1-506, Fees Payable by Uninsured Individuals Under a Sliding Fee Schedule.

[¹ 42 CFR 62.55(c)(2) provides that a health professional who participates in a state loan repayment program receiving federal grants authorized by 42 USC 254q-1 shall "charge for his or her professional services at the usual and customary rate prevailing in the area in which such services are provided, except that if a person is unable to pay such charge, such person shall be charged at a reduced rate or not charged any fee."]

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In this rulemaking, the Department is providing stakeholders and the public with clear, concise, and understandable rules for sliding fee schedules used by health care providers who have a sliding-fee-schedule requirement (sliding-fee-schedule providers). Under the new sliding-fee-schedule rules:

- Hospital inpatient services or medical services at a correctional facility or detention facility are not subject to the discounts or single administrative fee contained in a sliding fee schedule.
- Sliding-fee-schedule providers can submit for the Department's approval a sliding fee schedule with fee percentages [defined in R9-1-501(17)], a sliding fee schedule with flat fees [defined in R9-1-501(19)], or both.
- A sliding fee schedule must contain at least three levels for individuals with family incomes above 100 percent of the current federal poverty guidelines up to and including 200 percent of the federal poverty guidelines, with each sliding-fee-schedule provider specifying the amount and spread of the fee percentages or flat fees.
- A sliding fee schedule must contain a 100 percent fee reduction or a \$0 flat fee for uninsured individuals with family incomes at or below the current federal poverty guidelines.
- Sliding-fee-schedule providers can charge uninsured individuals with family incomes at or below the current federal poverty guidelines a single administrative fee that does not exceed \$25.
- In lieu of the fee calculated according to their sliding fee schedules, sliding-fee-schedule providers can charge the single administrative fee that does not exceed \$25 to uninsured individuals with family incomes above 100 percent of the federal poverty guidelines up to and including 200 percent of the federal poverty guidelines.

In a separate rulemaking the Department is repealing the Article and Rule remaining in A.A.C. Title 9, Chapter 2, Tobacco Tax-funded Programs: Article 1, Sliding-fee Schedule; and R9-2-101, Approval of Sliding-fee Schedule. The Department established rulemaking schedules resulting in the same effective date for the new sliding-fee-schedule rules and repeal of the former rule.

7. A reference to any study relevant to the rules that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

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

8. A showing of good cause why the rules are necessary to promote a statewide interest if the rules will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

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

For fiscal year 2004, the Department determined that it supported the primary care of nearly 50,000 uninsured individuals with an appropriation of \$9,938,900. For fiscal year, 2005 the legislature appropriated \$10,412,300 for primary care program community health center grants to provide primary care services to 48,100 uninsured individuals. For fiscal year 2006, the legislature appropriated \$10,426,600 for the community health center grants.

The Department's primary care program and other Department programs that call for a sliding fee schedule increase access to health care resources for the medically underserved. These programs increase the health care system's capacity to deliver services. Under the new sliding-fee-schedule rules, sliding fee schedules will establish and limit the amount charged to uninsured individuals at or below 200 percent of the current federal poverty guidelines who receive services under the primary care program or from a provider serving the underserved through the primary care provider loan repayment program, the rural private primary care provider loan repayment program, the J-1 visa waiver program, the national interest waiver program, or possibly under other programs in the future.

For purposes of this economic impact summary, "minimal" means under \$1000, "moderate" means \$1000 to \$10,000, and "substantial" means more than \$10,000.

Low-income uninsured individuals receiving medical services from sliding-fee-schedule providers

Low-income uninsured individuals receiving services covered by a sliding fee schedule will benefit from no fee or reduced fees, charged according to the fee percentages or flat fees established by the schedule, or charged according to a single administrative fee of \$25 or less.

The Department determined that a charge applicable to uninsured individuals at or below the current federal poverty guidelines is appropriate. Some community health centers that are Department primary care program providers also receive federal grants to health centers under Section 330 of the Public Health Service Act, 42 USC 254b. Federal regulations² authorize these grant recipients to charge a nominal fee to individuals who receive services and who are at or below the poverty guidelines. New R9-1-506(E), allowing a sliding-fee-schedule provider to charge individual uninsured patients at or below the poverty guidelines a maximum \$25 administrative fee, is consistent with the federal grants program.

[² 42 CFR Part 51c contains the regulations on grants to community health centers. 42 CFR 51c.303(f) requires a community health center to have "a schedule of fees or payments . . . designed to cover its reasonable costs of operation" and a schedule of discounts with "a full discount" for those at or below the poverty guidelines. Subsection (f)

also provides that “nominal fees for services may be collected from individuals with annual incomes at or below such levels where imposition of such fees is consistent with project goals.”]

Based on a comment received after publication of the proposed rules, the Department determined R9-1-506(C) and (D) as originally proposed were difficult to understand. Therefore, the Department removed the phrases “balance remaining” and “that is not subject to payment under A.R.S. §§ 36-2906.05 or 36-2907.06” from the two subsections. In the preamble to the Notice of Supplemental Proposed Rulemaking, the Department stated that this change possibly could result in increased fees for uninsured individuals with family incomes more than 100 percent of the current federal poverty guidelines but not more than 200 percent of the current federal poverty guidelines. The preamble also stated that the Department believes any fee increase would be small. The Department did not receive any comments related to the possibility of increased fees resulting from the changes to R9-1-506(C) and (D).

Sliding-fee-schedule providers generally render services to low-income uninsured individuals at a low cost. The Department's primary care program providers generally charge \$75 dollars or less per visit to uninsured individuals with family incomes more than 100 percent of the current federal poverty guidelines but not more than 200 percent of the current federal poverty guidelines. The Department believes that an increase in charges to these individuals, if any, resulting from the changes to R9-1-506(C) and (D) would be less than \$5. The Department did not need to reduce the economic impact of the changes to R9-1-506(C) and (D).

For low-income uninsured individuals, the cost of any fee assessed according to a sliding fee schedule is offset by improved health status and quality of life for them and their families from the increased availability of health care. Increased availability of health care allows prevention or earlier diagnosis and treatment of medical conditions, decreasing the need for more costly treatments. Individuals who are responsible for a fee might place greater value on the services they receive. Additionally, individuals who share in paying for the services they receive might have enhanced self-esteem. Finally, a charge for services might reduce overuse of health care resources.

Sliding-fee-schedule providers

Under the new sliding-fee-schedule rules, sliding-fee-schedule providers will include medical practices, non-profit organizations, other business entities, or county health departments, and individuals who provide health care services at or through such entities under the Department's primary care provider loan repayment program, rural private primary care provider loan repayment program, J-1 visa waiver program, national interest waiver program, or possibly other programs in the future. Excluding hospital inpatient services and medical services at a correctional facility or a detention facility generally limits the applicability of a sliding fee schedule to outpatient settings.

Under the new rules, sliding-fee-schedule providers generally will incur minimal staff-related costs for:

- Reviewing the annual update of the U.S. Department of Health and Human Services' Poverty Guidelines published in the Federal Register. The 2006 annual update is published at 71 FR 3848, January 24, 2006, and is available online at <http://aspe.os.dhhs.gov/poverty/06fedreg.htm>.
- Preparing annually a sliding fee schedule based on the updated Poverty Guidelines.
- Submitting the sliding fee schedule to the Department.
- Assessing and receiving payment according to the sliding fee schedule.

Under the new sliding-fee-schedule rules, a sliding-fee-schedule provider can charge low-income uninsured individuals at least a single administrative fee of \$25 or less. The changes from the originally proposed versions of R9-1-506(C) and R9-1-506(D) might result in some increase in the fees chargeable by a sliding-fee-schedule provider to uninsured individuals with incomes above 100 percent of the federal poverty guidelines up to and including 200 percent of the federal poverty guidelines. The administrative fees and the fees calculated according to a sliding fee schedule can supply an important source of revenue for sliding-fee-schedule providers. The revenue from uninsured individuals' fees might enable facilities and individual providers to expand services. Additionally, the changes to R9-1-506(C) and (D) make the new rules more understandable and make sliding fee schedules easier for providers to use.

The Department

The Notice of Proposed Rulemaking and the Notice of Supplemental Proposed Rulemaking stated the Department's sliding-fee-schedule related costs as moderate to substantial. The Department does not separate sliding-fee-schedules costs from other costs of the primary care program under A.R.S. § 36-2907.06; therefore, the Department did not have an exact determination of its sliding-fee-schedule costs. The Department now has determined that, under former sliding-fee-schedule rule, A.A.C. R9-2-101, it annually incurred minimal costs from personnel time spent on review and approval of sliding fee schedules submitted for the primary care program and on compliance activities related to the use of sliding-fee-schedules in the primary care program. Under the new sliding-fee-schedule rules, the Department also will be reviewing for approval sliding fee schedules used by providers under other Department programs. The Department believes that its costs will be minimal to moderate. These costs result from the requirements in state statutes, state administrative rules, or federal regulations for a system of reduced health care fees for low-income uninsured individuals.

The general public

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Arizonans in general benefit from sliding-fee-schedule providers' reduced fees for low-income uninsured individuals. Increased access to health care by the underserved, including low-income uninsured individuals, allows for earlier and less expensive treatment and helps to control the total bill for health care in the state.

The benefits from repealing former Article 1 and R9-2-101 from 9 A.A.C. 2 and making new sliding fee schedule rules at 9 A.A.C. 1, Article 5 outweigh the costs.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

As a result of public comments received after publication of the Notice of Proposed Rulemaking, the Department made some changes to the rules and published a Notice of Supplemental Proposed Rulemaking. In the supplemental proposed rules, the Department revised R9-1-506(C) and (D).

Subsections (C) and (D) as originally proposed stated:

C. If a provider uses a sliding fee schedule with fee percentages, an uninsured individual's fee for medical services shall not exceed the amount calculated by applying the fee percentage for the individual's family income to the balance remaining on the lowest contracted charge for each medical service provided that is not subject to payment under A.R.S. §§ 36-2907.05 or 36-2907.06.

D. If a provider uses a sliding fee schedule with flat fees, an uninsured individual's fee for medical services shall not exceed the balance remaining on the lowest contracted charge for each medical service provided that is not subject to payment under A.R.S. §§ 36-2907.05 or 36-2907.06.

In the supplemental proposed rules, subsections (C) and (D) stated:

C. If a provider uses a sliding fee schedule with fee percentages, an uninsured individual's fee for medical services shall not exceed the amount calculated by applying the fee percentage for the individual's family income to the lowest contracted charge for each medical service provided.

D. If a provider uses a sliding fee schedule with flat fees, an uninsured individual's fee for medical services shall not exceed the lowest contracted charge for each medical service provided.

In the supplemental proposed rules, the Department also made the following technical changes. The Department:

- Included the Department's rural private primary care provider loan repayment program within the sliding fee schedule requirement, as required in A.R.S. § 36-2174(A);
- Corrected the definition of "lowest contracted charge" by deleting the repetition of the word "service" in R9-1-501(26);
- Improved the definition of "provider" by changing R9-1-501(32)(b) from:

Participates in a program that is authorized under A.R.S. §§ 36-104(16), 36-2907.06, or 36-2172, and that requires participants to use a sliding fee schedule;

to:

Participates in a program that requires participants to use a sliding fee schedule, such as a program authorized under A.R.S. §§ 36-104(16), 36-2907.06, 36-2172, or 36-2174;

- Added the word "single" to R9-1-506(A)(2) so that the subsection states: May charge an individual described in subsection (A)(1) only the single administrative fee determined according to subsection (E); and
- Added the word "single" to R9-1-506(E)(1) so that the subsection states: Establish a single administrative fee that does not exceed \$25; and.

For the final rules, the Department is retaining the changes to the text of the rules made in the Notice of Supplemental Proposed Rulemaking. For the final rules, the Department:

- Deleted the word "income" at the end of R9-5-101(31)(b);
- Changed R9-1-501(43)(j) from:

A nonprofit hospital, medical, dental, and optometric service corporation, a nonprofit hospital service corporation, a nonprofit medical corporation, or a nonprofit medical and hospital service corporation, including Blue Cross Blue Shield of Arizona, under A.R.S. Title 20, Chapter 4, article 3, or organized under the laws of another state;

to:

A nonprofit hospital, medical, dental, or optometric service corporation as defined in A.R.S. § 20-822, including Blue Cross Blue Shield of Arizona, or organized under the laws of another state;

- Changed the phrase "over age 19" in R9-1-502(1)(b) to "at least age 19;"
- Changed the phrase "a Saturday, a Sunday, or a state service holiday" in R9-1-505(D) to "a Saturday, Sunday, or state service holiday;"

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- Changed “amount” or “amounts” to “dollar amount” or “dollar amounts” in R9-1-501(11), R9-1-501(11)(g), R9-1-501(15), R9-1-501(28), R9-1-501(37), R9-1-501(39), R9-1-501(41), R9-1-501(44), R9-1-503(B)(6), and R9-1-506(C); and
- Deleted the word “amounts” from R9-1-504(C)(2).

The Department made other technical changes at the suggestion of the staff of the Governor's Regulatory Review Council.

11. A summary of the comments made regarding the rules and the agency response to them:

After the Notice of Proposed Rulemaking was published the Department received three comments from the public. The comments and the Department's response to each comment are described in the following table.

Organization that Submitted the Comment	Comment Summary	Department Response
Maricopa Integrated Health System (MIHS)	<ol style="list-style-type: none"> 1. Can a provider have multiple administrative fees? 2. MIHS does not understand the meaning of the “balance remaining” language in R9-1-506. 3. Can a provider waive a flat fee for patients with incomes above 100 percent of the Federal Poverty Guidelines (FPG) and not more than 200 percent of the FPG? 	<ol style="list-style-type: none"> 1. The Department will allow only a single administrative fee. 2. The Department agrees that R9-1-506 (C) and (D) need clarification. 3. These rules address the sliding fee schedule requirements and do not address fee waiver by a provider.
Community Health Center of West Yavapai, Yavapai County	<ol style="list-style-type: none"> 1. Can a provider charge patients with incomes at or below 100 percent of the FPG the administrative fee not to exceed \$25? 2. Does a sliding fee schedule have to have at least three levels for patients with incomes above 100 percent of the FPG and not more than 200 percent of the FPG? 3. If so, then the commenter is okay with these rules. 	<ol style="list-style-type: none"> 1. Yes 2. Yes 3. The Department appreciates the commenter's support.
MIHS	For uniformity in all MIHS patient care programs, MIHS' draft sliding fee schedule policy contemplates two levels for patients with incomes above 100 percent of the FPG and not more than 200 percent of the FPG. R9-1-504 (B)(4) and (C)(4) require at least three levels.	During a follow-up communication, the commenter stated that MIHS agrees to use a sliding fee schedule with three levels for patients with incomes above 100 percent of the FPG and not more than 200 percent of the FPG if required by the payer. The Department is not making any change to R9-1-504.

After the Notice of Supplemental Proposed Rulemaking was published, the Department received one comment from the public.

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Organization that Submitted the Comment	Comment	Department Response
MIHS	“With the exception of the number of 'price breaks,' [levels for individuals with incomes above 100 percent of the FPG and not more than 200 percent of the FPG], the rules look good to me.”	The Department previously addressed the issue with MIHS, and MIHS agreed to use a sliding fee schedule with three levels if required by the payer. The Department appreciates the commenter's support.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

None

14. Were the rules previously made as emergency rules?

The Department did not previously make the rules as emergency rules.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 1. DEPARTMENT OF HEALTH SERVICES
ADMINISTRATION**

ARTICLE 5. SLIDING FEE SCHEDULES

Section

- R9-1-501. Definitions
- R9-1-502. Family Member Determination
- R9-1-503. Family Income Determination
- R9-1-504. Sliding Fee Schedule Submission and Contents
- R9-1-505. Sliding Fee Schedule Approval Time-frames
- R9-1-506. Fees Payable by Uninsured Individuals Under a Sliding Fee Schedule

ARTICLE 5. SLIDING FEE SCHEDULES

R9-1-501. Definitions

In this Article, unless otherwise specified:

1. “Administrative fee” means a fee payable by an uninsured individual that is established and charged according to R9-1-506(E).
2. “AHCCCS” means the Arizona Health Care Cost Containment System.
3. “Business day” means the same as in A.R.S. § 10-140.
4. “Calendar year” means January 1 through December 31.
5. “Child” means an individual under age 19.
6. “Consideration” means valuable compensation for something received or to be received.
7. “Correctional facility” means the same as in A.R.S. § 13-2501.
8. “Costs of producing rental income” means payments made by a rental-income recipient that are attributable to the premises or the portion of the premises generating the income, including payments for:
 - a. Property taxes.
 - b. Insurance premiums.
 - c. Mortgage principal and interest.
 - d. Utilities, and
 - e. Maintenance and repair.
9. “Costs of producing self-employment income” means payments made by a self-employment-income recipient that are attributable to generating the income, including payments for:
 - a. Equipment, machinery, and real estate;

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- b. Labor;
 - c. Inventory;
 - d. Raw materials;
 - e. Insurance premiums;
 - f. Rent; and
 - g. Utilities.
10. “Current federal poverty guidelines” means the most recent annual update of the U.S. Department of Health and Human Services' Poverty Guidelines published in the Federal Register.
11. “Deduction” means a dollar amount subtracted from a payment, before an individual receives the payment, for:
- a. Federal income tax.
 - b. Social Security tax.
 - c. Medicare tax.
 - d. State income tax.
 - e. Insurance other than OASDI.
 - f. Pension, or
 - g. Other dollar amounts required by law or authorized by the individual to be subtracted.
12. “Department” means the Department of Health Services.
13. “Detention facility” means a place of confinement, including:
- a. A juvenile facility under the jurisdiction of:
 - i. A county board of supervisors, or
 - ii. A county jail district authorized by A.R.S. Title 48, Chapter 25;
 - b. A juvenile secure care facility under the jurisdiction of the Department of Juvenile Corrections; or
 - c. A facility for individuals who are not United States citizens and who are in the custody of the U.S. Immigration and Customs Enforcement, Department of Homeland Security.
14. “Earned income” means work-related payments received by an individual, including:
- a. Wages.
 - b. Commissions and fees.
 - c. Salary.
 - d. Profit from self-employment.
 - e. Profit from rent received from an individual or entity, and
 - f. Any other work-related monetary payments received by an individual.
15. “Family income” means the dollar amount determined according to R9-1-503(B).
16. “Family member” means an individual, determined according to R9-1-502, whose income is included in family income.
17. “Fee percentage” means a part of a provider's usual charges for medical services that is:
- a. Expressed in hundredths, and
 - b. Established by a provider in a sliding fee schedule for medical services rendered to an uninsured individual.
18. “Fetus” means the same as in A.R.S. § 36-2152.
19. “Flat fee” means a dollar amount that is:
- a. Established by a provider in a sliding fee schedule for a medical service or group of medical services rendered to an uninsured individual, and
 - b. Less than the provider's usual charges for the medical service or group of medical services.
20. “Gift” means money, real property, personal property, a service, or anything of value other than unearned income for which the recipient does not provide consideration of equal or greater value.
21. “Hospital services” means the same as in A.A.C. R9-10-201.
22. “Income” means combined earned and unearned income.
23. “Inpatient services” means hospital services provided to an individual who will receive the services for 24 consecutive hours or more.
24. “Interrupted income” means income that stops for at least 30 continuous days during the current calendar year and then resumes.
25. “KidsCare” means the children's health insurance program, a federally funded program administered by AHCCCS under A.R.S. Title 36, Chapter 29, Article 4.
26. “Lowest contracted charge” means the smallest reimbursement a provider has agreed to accept for a medical service:
- a. Determined by the provider's review of all the contracts between the provider and third party payors as defined in A.R.S. § 36-125.07(C), that:
 - i. Cover the medical service, and
 - ii. Are in effect at the time the medical service is provided to an uninsured individual; and
 - b. Subject to limitations of federal or state laws, rules, or regulations.
27. “Medical services” means the same as in A.R.S. § 36-401.

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28. “Medicare tax” means the dollar amount subtracted from a payment for the health care insurance program for the aged and disabled under Title XVIII of the Social Security Act, 42 USC 1395 et seq.
29. “New income” means income that begins at least 30 days after the start of the current calendar year.
30. “OASDI” means old age, survivors, and disability insurance.
31. “Profit” means the remainder after subtracting:
 - a. The costs of producing rental income from the rent received from an individual or entity, or
 - b. The costs of producing self-employment income from the self-employment.
32. “Provider” means an individual or entity that:
 - a. Provides medical services;
 - b. Participates in a program that requires participants to use a sliding fee schedule, such as a program authorized under A.R.S. §§ 36-104(16), 36-2907.06, 36-2172, or 36-2174;
 - c. Includes:
 - i. A dentist licensed under A.R.S. Title 32, Chapter 11;
 - ii. A physician licensed under A.R.S. Title 32, Chapter 13 or Chapter 17;
 - iii. A registered nurse practitioner defined in A.R.S. § 32-1601 and licensed under A.R.S. Title 32, Chapter 15;
 - iv. A physician assistant licensed under A.R.S. Title 32, Chapter 25 and practicing according to A.R.S. § 32-2531;
 - v. A health care institution licensed under A.R.S. Title 36, Chapter 4; or
 - vi. An office or facility that is exempt from licensing under A.R.S. § 36-402(A)(3); and
 - d. Excludes an individual or entity when the individual or entity provides:
 - i. Inpatient services,
 - ii. Medical services at a correctional facility, or
 - iii. Medical services at a detention facility.
33. “Secure care” means the same as in A.R.S. § 41-2801.
34. “Self employment” means earning income from one's own business, trade, or profession rather than receiving a salary or wages from an employer.
35. “Sliding fee” means flat fee or fee percentage that increases or decreases based on one or more factors.
36. “Sliding fee schedule” means a document containing a provider's flat fees or fee percentages based on:
 - a. Family members determined according to R9-1-502, and
 - b. Family income determined according to R9-1-503.
37. “Social Security tax” means the dollar amount subtracted from a payment for OASDI under Title II of the Social Security Act, 42 USC 401 et seq.
38. “State health benefits risk pool” means:
 - a. A state-established organization qualifying under 26 USC 501(c)(26);
 - b. A state-established qualified high risk pool described in Section 2744(c)(2) of the Public Health Service Act, 42 USC 300gg-44(c)(2); or
 - c. A state-sponsored arrangement, for which the state specifies the membership, primarily established and maintained to provide health insurance coverage for state residents with a medical condition or a history of a medical condition that:
 - i. Prevents them from obtaining coverage for the condition through insurance or from a health maintenance organization, or
 - ii. Enables them to obtain coverage for the condition only at a rate substantially more than the rate available through the state-sponsored arrangement.
39. “Support payment” means a dollar amount, received at regular intervals by an individual, for food, shelter, furniture, clothing, and medical expenses.
40. “Terminated income” means income received during the current calendar year that stops and will not resume.
41. “Training stipend” means a dollar amount, received at regular intervals by an individual, during a course or program for the development of the individual's skills.
42. “Unearned income” means payments received by an individual that are not gifts and not earned income, including:
 - a. Unemployment insurance;
 - b. Workers' compensation;
 - c. Disability payments;
 - d. Social Security payments;
 - e. Public assistance payments, excluding food stamps;
 - f. Periodic insurance or annuity payments;
 - g. Retirement or pension payments;
 - h. Strike benefits from union funds;
 - i. Training stipends;
 - j. Child support payments;

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- k. Alimony payments;
 - l. Military family allotments or other support payments from a relative or other individual not residing with the recipient;
 - m. Investment income;
 - n. Royalty payments;
 - o. Periodic payments from estates or trusts; and
 - p. Any other monetary payments received by an individual that are not gifts, earned income, capital gains, lump-sum inheritance or insurance payments, or payments made to compensate for personal injury.
43. “Uninsured individual” means an individual who does not have health care coverage under any of the following:
- a. A group health plan as defined in Section 2792(a)(1) of the Public Health Service Act, 42 USC 300gg-91(a)(1), including a small employer's group health plan under A.R.S. Title 20, Chapter 13 or under the laws of another state;
 - b. A church plan as defined in section 3(33) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 USC 1002(33);
 - c. Medicare, the health insurance program for the aged and disabled under Title XVIII of the Social Security Act, 42 USC 1395 et seq.;
 - d. Medicaid, the program that pays for medical assistance for certain individuals and families with low incomes and resources, through AHCCCS or another state's Medicaid agency, under Title XIX of the Social Security Act, 42 USC 1396 et seq., excluding a state program for distribution of pediatric vaccines under 42 USC 1396s;
 - e. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or Tricare, the medical and dental care programs for members of the armed forces, certain former members, and their dependents under 10 USC 1071 et seq. and 32 CFR 199;
 - f. A medical care program of the Indian Health Service or of a tribal organization;
 - g. The Federal Employees Health Benefits Program for U.S. government employees, certain former employees, and their family members under 5 USC 8901 et seq. and 5 CFR 890 and 891;
 - h. Peace Corps plans under Section 5(e) of the Peace Corps Act, 22 USC 2504(e), including:
 - i. Medical and dental care for Peace Corps applicants, Peace Corps volunteers, and minor children living with Peace Corps volunteers under 32 CFR 728.59;
 - ii. Form PC-127C authorization for payment for evaluation of the Peace Corps related conditions of former Peace Corps volunteers;
 - iii. Treatment of the Peace Corps related conditions of former Peace Corps volunteers under 32 CFR 728.53; and
 - iv. CorpsCare coverage for the non-Peace Corps related conditions of former Peace Corps volunteers and their dependents.
 - i. A state health benefits risk pool;
 - j. An individual policy or contract issued by:
 - i. An insurer for medical expenses, including a preferred provider arrangement;
 - ii. A health care services organization under A.R.S. Title 20, Chapter 4, Article 9 or a health maintenance organization as defined in Section 2792(b)(3) of the Public Health Service Act, 42 USC 300gg-91(b)(3); or
 - iii. A nonprofit hospital, medical, dental, or optometric service corporation as defined in A.R.S. § 20-822, including Blue Cross Blue Shield of Arizona, or organized under the laws of another state;
 - k. An individual policy or contract made available through the Healthcare Group of Arizona administered by AHCCCS under A.R.S. §§ 36-2912, 36-2912.01, and 36-2912.02;
 - l. A health insurance plan of a state or of a political subdivision as defined in A.R.S. § 35-511 or determined under the laws of another state;
 - m. A policy or contract issued to a member of a bona fide association as defined in section 2791(d)(3) of the Public Health Service Act, 42 USC 300gg-91(d)(3); or
 - n. KidsCare or another state's children's health insurance program under Title XXI of the Social Security Act, 42 USC 1397aa et seq.
44. “Variable income” means income in a dollar amount that changes from payment to payment.

R9-1-502. Family Member Determination

A provider shall determine the family members of an uninsured individual seeking medical services.

- 1. A family with one member consists of:
 - a. A non-pregnant child who does not live with:
 - i. A parent;
 - ii. A spouse;
 - iii. An individual with whom the child has a common biological or adopted child;
 - iv. A biological or adopted child; or
 - v. A biological or adopted child of an individual with whom the child has a common biological or adopted

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R9-1-505. Sliding Fee Schedule Approval Time-frames

- A.** The overall time-frame described in A.R.S. § 41-1072(2) for a request for sliding fee schedule approval is 32 days.
1. A provider and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame.
 2. An extension of the substantive review time-frame and the overall time-frame shall not exceed eight days.
- B.** The administrative completeness review time-frame described in A.R.S. § 41-1072(1) for a request for sliding fee schedule approval is 11 days, beginning on the day the Department receives the request.
1. Except as provided in subsections (B)(3) and (B)(4), the Department shall mail to a provider a written notice of administrative completeness when the provider's request for sliding fee schedule approval is complete.
 2. If a request for sliding fee schedule approval is incomplete, the Department shall mail to the provider a written notice of administrative deficiencies that:
 - a. Lists the missing documents or incomplete information, and
 - b. Suspends the administrative completeness review time-frame and the overall time-frame from the date on the notice of administrative deficiencies:
 - i. Until the date the Department receives a complete request for sliding fee schedule approval; or
 - ii. For 60 days, whichever comes first.
 3. If the Department does not receive all the additional documents or information required under subsection (B)(1) within 60 days after the date on the notice of administrative deficiencies, the Department deems the request for sliding fee schedule approval withdrawn.
 4. If the Department approves a sliding fee schedule during the administrative completeness review time-frame, the Department does not issue a separate written notice of administrative completeness.
- C.** The substantive review time-frame described in A.R.S. § 41-1072(3) for a request for sliding fee schedule approval is 21 days, beginning on the date on the Department's notice of administrative completeness under subsection (B)(1).
1. The Department shall mail to a provider a written notice granting or denying approval according to A.R.S. § 41-1076 by the last day of the substantive review time-frame and the overall time-frame.
 2. If the Department issues to a provider a written request for additional information according to A.R.S. § 41-1075(A), the request for additional information suspends the substantive review time-frame and the overall time-frame from the date on the request for additional information:
 - a. Until the date the Department receives all the information requested; or
 - b. For 60 days, whichever comes first.
 3. If the Department does not receive all the information requested under subsection (C)(2) within 60 days after the postmark date of the request for additional information, the Department shall deny sliding fee schedule approval.
- D.** If a time-frame's last day falls on a Saturday, Sunday, or state service holiday listed in A.A.C. R2-5-402, the Department considers the next business day the time-frame's last day.

R9-1-506. Fees Payable by Uninsured Individuals Under a Sliding Fee Schedule

- A.** A provider:
1. Shall not charge an uninsured individual with a family income equal to or less than 100 percent of the current federal poverty guidelines the fee determined according to subsection (C) or subsection (D), and
 2. May charge an individual described in subsection (A)(1) only the single administrative fee determined according to subsection (E).
- B.** A provider may charge an uninsured individual with a family income more than 100 percent of the current federal poverty guidelines but not more than 200 percent of the current federal poverty guidelines the fee determined according to subsection (C), subsection (D), or subsection (E).
- C.** If a provider uses a sliding fee schedule with fee percentages, an uninsured individual's fee for medical services shall not exceed the dollar amount calculated by applying the fee percentage for the individual's family income to the lowest contracted charge for each medical service provided.
- D.** If a provider uses a sliding fee schedule with flat fees, an uninsured individual's fee for medical services shall not exceed the lowest contracted charge for each medical service provided.
- E.** A provider may:
1. Establish a single administrative fee that does not exceed \$25; and
 2. Charge the administrative fee to:
 - a. Uninsured individuals with a family income equal to or less than 100 percent of the current federal poverty guidelines; and
 - b. Uninsured individuals with family incomes more than 100 percent of the current federal poverty guidelines but not more than 200 percent of the current federal poverty guidelines only in lieu of the fee calculated under subsection (C) or subsection (D).

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 2. DEPARTMENT OF HEALTH SERVICES
TOBACCO TAX-FUNDED PROGRAMS

[R06-403]

PREAMBLE

- 1. Sections Affected**

Article 1	<u>Rulemaking Action</u>
R9-2-101	Repeal
	Repeal
- 2. The statutory authority for the rulemaking, including both the authorizing statutes (general) and the statutes the rules are implementing (specific):**

Authorizing statutes: A.R.S. §§ 36-136(A)(7) and 36-136(F)
Implementing statute: A.R.S. § 36-2907.06(D)
- 3. The effective date of the rule:**

December 4, 2006
- 4. A list of all previous notices appearing in the Register addressing the final rule:**

Notice of Rulemaking Docket Opening: 12 A.A.R. 2515, July 14, 2006
Notice of Proposed Rulemaking: 12 A.A.R. 2458, July 14, 2006
- 5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name:	Patricia Tarango, Office Chief
Address:	Arizona Department of Health Services Office of Health Systems Development 1740 W. Adams, Room 410 Phoenix, AZ 85007
Telephone:	(602) 542-1219
Fax:	(602) 542-2011
E-mail:	tarangp@azdhs.gov
Or	
Name:	Kathleen Phillips, Rules Administrator
Address:	Arizona Department of Health Services Office of Administrative Rules 1740 W. Adams, Suite 202 Phoenix, AZ 85007
Telephone:	(602) 542-1264
Fax:	(602) 364-1150
E-mail:	phillik@azdhs.gov
- 6. An explanation of the rule, including the agency's reasons for initiating the rule:**

The Department placed the existing sliding fee schedule Article, 9 A.A.C. 2, Article 1, in the Chapter labeled "Tobacco Tax-funded Programs" because sliding fee schedules applied to the A.R.S. § 36-2907.06 primary care program Part B, funded under former A.R.S. § 36-2921. Laws 2003, Chapter 265, § 30, retroactively effective to July 1, 2003, repealed all versions of A.R.S. § 36-2921, which allocated tobacco tax funds. The state's general fund currently funds the Department's primary care program Part B.

Other Department programs, such as the primary care provider loan repayment program under A.R.S. § 36-2172 and 42 CFR Part 62¹ and the J-1 visa waiver program and the national interest waiver program under A.R.S. § 36-104(16), also need to reference the sliding fee schedule rules. Therefore, the Department decided to repeal the Article and Section remaining in 9 A.A.C. 2: Article 1, Sliding-fee Schedule; and R9-2-101, Approval of Sliding-fee Schedule. In a separate rulemaking the Department is making new sliding fee schedule rules in 9 A.A.C. 1, Article 5.

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[¹ 42 CFR 62.55(c)(2) provides that a health professional participating in a state loan repayment program that receives federal grants authorized by 42 USC 254q-1 shall “charge for his or her professional services at the usual and customary rate prevailing in the area in which such services are provided, except that if a person is unable to pay such charge, such person shall be charged at a reduced rate or not charged any fee.”]

- 7. **A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**
The Department did not review, rely on, or not rely on, any study for this rulemaking.
- 8. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable
- 9. **The summary of the economic, small business, and consumer impact:**
Under A.R.S. § 41-1055(D)(3) this rulemaking is exempt from the economic, small business, and consumer impact statement requirement. Repealing the Article and Section remaining in 9 A.A.C. 2 imposes no costs on stakeholders or the general public. The Department is making new sliding fee schedule rules at 9 A.A.C. 1, Article 5.
- 10. **A description of the changes between the proposed rule, including supplemental notices, and final rule (if applicable):**
The Department did not make any changes from the proposed rule.
- 11. **A summary of the comments made regarding the rule and the agency response to them:**
The Department did not receive any oral or written comments regarding the rule.
- 12. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
Not applicable
- 13. **Incorporations by reference and their location in the rules:**
None
- 14. **Were the rules previously made as emergency rules?**
The Department did not previously make the rules as emergency rules.
- 15. **The full text of the rules follows:**

TITLE 9. HEALTH SERVICES

CHAPTER 2. DEPARTMENT OF HEALTH SERVICES
TOBACCO TAX-FUNDED PROGRAMS

~~ARTICLE 1. SLIDING FEE SCHEDULE REPEALED~~

Section

R9-2-101. ~~Approval of Sliding-fee Schedule Repealed~~

~~ARTICLE 1. SLIDING FEE SCHEDULE REPEALED~~

~~R9-2-101. Approval of Sliding-fee Schedule Repealed~~

- ~~A. For purposes of this Section, “sliding-fee schedule” means a document that sets forth the relationship between an individual’s income and family size and states the percentage of the charges for health care services provided pursuant to A.R.S. § 36-2907.06 for which the individual will be responsible.~~
- ~~B. At least 30 calendar days before implementation of the sliding-fee schedule, a qualifying community health center shall submit an application for approval of the schedule to the Department of Health Services. Submission occurs at the time the Department receives a correctly completed application. The application shall contain:
 - 1. The qualifying community health center’s name and street address including city, state, and zip code;
 - 2. The qualifying community health center’s telephone number; and
 - 3. The name of the qualifying community health center’s administrator.~~
- ~~C. The Department of Health Services shall notify the qualifying community health center in writing of approval or disapproval within 20 calendar days of submission of application. A sliding-fee schedule shall not be implemented without approval. If an application is disapproved, the Department shall set forth the reasons for the disapproval in the written notice. Within 15 calendar days of receiving a written disapproval, a qualifying community health center may file a written request for a hearing with the Department to appeal the disapproval.~~
- ~~D. The sliding-fee schedule shall cover income levels from 0 to at least 200% of the federal poverty level.~~

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- ~~E.~~ A qualifying community health center shall not deny health care services to an individual eligible for health care services pursuant to A.R.S. § 36-2097.06 because the individual is unable to pay for the health care services.
- ~~F.~~ A qualifying community health center shall apply a 100% discount for an eligible individual with an income at or below 100% of the federal poverty level. A qualifying community health center may establish a minimum fee for administrative processing costs for all eligible individuals without regard to income level. A qualifying community health center shall charge the greater of either the administrative fee or the amount of the charges for services for which an eligible individual is determined to be responsible according to the sliding fee schedule.
- ~~G.~~ An individual covered by a sliding fee schedule shall not be responsible for an amount greater than the amount determined by applying the sliding fee schedule to the lowest contracted charge for each service received. The lowest contracted charge for a service is determined by reference to contracts covering that service, in effect at the time that the service is rendered, between the qualifying community health center and any payor, subject to limitations of federal and state laws and regulations.
- ~~H.~~ The qualifying community health center shall post a notice at or near the main entrance and in each waiting room. The notice shall be in both English and Spanish and shall contain the following information:
 - ~~1.~~ The qualifying community health center provides primary care services to uninsured Arizona residents with family incomes of 200% or less of the federal poverty guidelines and who meet the eligibility requirements of the Tobacco Tax Primary Care Program, A.R.S. § 36-2907.06.
 - ~~2.~~ The name of the individual or unit within the qualifying community health center that interested persons may contact to have an eligibility determination interview for the Tobacco Tax Primary Care program.
 - ~~3.~~ The qualifying community health center's use of an Arizona Department of Health Services approved sliding fee schedule to determine the payment responsibility or eligible persons.
 - ~~4.~~ The name and phone number of the qualifying community health center's staff member responsible for receiving and hearing any complaints from eligible persons regarding their payment responsibility for Tobacco Tax Primary Care program services.
- ~~I.~~ The qualifying community health center shall keep a log and file of all complaints dealing with payment responsibility under the sliding fee schedule. The log and file shall indicate the name and address of the eligible person, the nature of the complaint, the date the complaint was received, the date the decision was rendered, and the date the decision letter was sent to the eligible person. The qualifying community health center shall retain the log and file for 12 months after the decision letter is sent.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

**CHAPTER 10. DEPARTMENT OF HEALTH SERVICES
HEALTH CARE INSTITUTIONS: LICENSING**

R06-404]

PREAMBLE

- 1. Sections Affected**
R9-10-203
- Rulemaking Action**
Amend
- 2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rule is implementing (specific):**
Authorizing statute: A.R.S. §§ 36-132(A) and 36-136(F)
Implementing statute: A.R.S. § 36-405
- 3. The effective date of the rule:**
December 5, 2006
- 4. A list of all previous notices appearing in the Register addressing the final rule:**
Notice of Rulemaking Docket Opening: 12 A.A.R. 16, page 1343, published April 21, 2006
Notice of Proposed Rulemaking: 12 A.A.R. 26, page 2285, published June 30, 2006
- 5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
Name: Kathy McCanna, Program Manager
Address: Arizona Department of Health Services
Medical Facilities Licensing
150 N. 18th Ave., Suite 450
Phoenix, AZ 85007-3233

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Telephone: (602) 364-3030
Fax: (602) 364-4764
E-mail: mccannk@azdhs.gov
Or
Name: Kathleen Phillips, Rules Administrator
Address: Arizona Department of Health Services
Office of Administrative Rules
1740 W. Adams St., Suite 202
Phoenix, AZ 85007-3233
Telephone: (602) 542-1264
Fax: (602) 364-1150
E-mail: phillik@azdhs.gov

6. An explanation of the rule, including the agency's reasons for initiating the rule:

The purpose of this rulemaking is to amend minimum qualifications for a hospital administrator.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Department did not review or rely on any study related to this rulemaking package.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

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

Annual costs/revenues changes are designated as minimal when less than \$1,000, moderate when between \$1,000 and \$10,000, and substantial when \$10,000 or greater in additional costs or revenue.

Cost bearers

There are no cost bearers.

Beneficiaries

Hospitals will experience a minimal to moderate benefit by an increase in the number of individuals who are qualified to be a hospital administrator.

An individual who was not previously qualified to be a hospital administrator may now be qualified and would experience a minimal to moderate benefit if the individual accepted a position as a hospital administrator.

10. A description of the changes between the proposed rule, including supplemental notices, and final rule (if applicable):

Minor grammatical formatting or clarifying changes were made at the request of GRRC staff.

11. A summary of the comments made regarding the rule and the agency response to them:

There was one oral comment at the oral proceeding in support of the rule.

The Department did not receive any written comments.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rule:

Not applicable

14. The full text of the rule follows:

Notices of Final Rulemaking

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES
HEALTH CARE INSTITUTIONS: LICENSING

ARTICLE 2. HOSPITALS

Section

R9-10-203. Administration

ARTICLE 2. HOSPITALS

R9-10-203. Administration

A. No change

1. No change
2. No change
3. Appoint an administrator in writing who ~~has~~:
 - a. ~~A~~ Has a baccalaureate degree or a post-baccalaureate degree in a health care-related field; ~~and~~
 - b. ~~At~~ Has at least three years of experience in health care administration; or
 - c. On December 5, 2006, was currently employed as an administrator in a licensed hospital;
4. No change
5. No change
6. No change
7. No change
8. No change
9. No change
10. No change
11. No change
12. No change
13. No change

B. No change

1. No change
2. No change
3. No change
4. No change

C. No change

1. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - i. No change
 - ii. No change
 - iii. No change
 - iv. No change
 - e. No change
 - f. No change
 - i. No change
 - ii. No change
 - iii. No change
 - iv. No change
 - g. No change
 - h. No change
 - i. No change
 - j. No change
 - k. No change
 - l. No change
 - m. No change
2. No change

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- a. No change
- b. No change
- c. No change
- d. No change
- e. No change
- f. No change
- g. No change
- h. No change
- i. No change
- ii. No change
- i. No change
- j. No change
- 3. No change
- 4. No change
- 5. No change
- a. No change
- b. No change
- 6. No change
- a. No change
- b. No change
- c. No change
- d. No change
- e. No change
- f. No change
- i. No change
- ii. No change
- iii. No change
- iv. No change
- D. No change
- 1. No change
- 2. No change

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

**CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ARIZONA LONG-TERM CARE SYSTEM**

[R06-405]

PREAMBLE

- | | |
|------------------------------------|---------------------------------|
| <u>1. Sections Affected</u> | <u>Rulemaking Action</u> |
| R9-28-301 | Amend |
| R9-28-303 | Amend |
| R9-28-304 | Amend |
| R9-28-307 | Amend |
- 2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
Authorizing statute: A.R.S. § 36-2936
Implementing statute: A.R.S. §§ 36-2936, 36-559, 36-2901, 36-2933(B)
- 3. The effective date of the rules:**
October 5, 2006
The rules are effective on filing with the Office of the Secretary of State as allowed under A.R.S. § 41-1032(A)(4). The rules provide a public benefit by clarifying, revising, and updating the regulations related to the preadmission screening (PAS) process for the Elderly and Physically Disabled (EPD) population and incorporating other recommendations of the AHCCCS Administration. There is no penalty associated with a violation of the rules.
- 4. A list of all previous notices appearing in the Register addressing the final rule:**

Notices of Final Rulemaking

Notice of Rulemaking Docket Opening: 12 A.A.R. 1423, April 28, 2006

Notice of Proposed Rulemaking: 12 A.A.R. 2367, July 7, 2006

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Linda Barry
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4484
Fax: (602) 253-9115
E-mail: Linda.Barry@azahcccs.gov

6. An explanation of the rule, including the agency's reasons for initiating the rule:

In 9 A.A.C. 28, Article 3, the preadmission screening process (PAS) is used by the AHCCCS Administration to determine the individual's medical eligibility for receiving Arizona Long-term Care System (ALTCS) services. The revised EPD PAS instrument is designed to update and refine the assessment process for ALTCS customers, by incorporating components of state-of-the-art instruments used in other states and the recommendations of senior ALTCS clinicians. The rules have been reviewed and amended to update the EPD PAS assessment process and other recommendations of the AHCCCS Administration. The rule language was amended for clarity, conciseness, and understandability.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The consulting firm of EP & P Consulting and its subcontractor the Pacific Health Policy Group were retained by the AHCCCS Administration to revise the current EPD PAS instrument. The consultants under the direction and in collaboration with the AHCCCS Administration began in early 2005 and completed the project in April of 2006. The report describes in detail the steps to revise the EPD PAS and scoring methodology used for the determination of eligibility.

The public may obtain a copy of the "Development of a Revised Pre-Admission Screen for the Elderly and Physically Disabled, Final Report" through the AHCCCS Administration.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

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

The economic impact of the following provisions is minimal. The revised PAS instrument is designed to update and refine the assessment process for ALTCS customers. The criteria for eligibility did not change with the new PAS. It is anticipated that the revised scoring algorithm should have no net effect on the number or type of persons found eligible for ALTCS. Moreover, the need for physician reviews is expected to be reduced.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

Location	A description of the changes between the proposed rule and final rule.
General	The Administration made the rules clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.
General	Technical and grammatical changes were made at the suggestion of GRRC staff.

11. A summary of the comments made regarding the rule and the agency response to them:

No comments were received by the agency.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

13. Incorporations by reference and their location in the rules:

None

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ARIZONA LONG-TERM CARE SYSTEM**

ARTICLE 3. PREADMISSION SCREENING (PAS)

Section

R9-28-301. Definitions

R9-28-303. Preadmission Screening (PAS) Process

R9-28-304. Preadmission Screening Criteria for an Applicant or Member who is Elderly and Physically Disabled (EPD)

R9-28-307. The ALTCS Transitional Program for a Member who is Elderly and Physically Disabled (EPD) or Developmentally Disabled (DD)

ARTICLE 3. PREADMISSION SCREENING (PAS)

R9-28-301. Definitions

A. Common definitions. In addition to definitions contained in A.R.S. Title 36, Chapter 29, and 9 A.A.C. 28, Article 1, the words and phrases in this ~~Chapter~~ Article have the following meanings for an individual who is elderly or physically disabled (EPD) or developmentally disabled (DD) unless the context explicitly requires another meaning:

~~“Acute” means an active medical condition having a sudden onset, lasting a short time, and requiring immediate medical intervention.~~

“Applicant” is defined in A.A.C. R9-22-101.

“Assessor” means a social worker as defined in this subsection or a licensed registered nurse (RN) who:

Is employed by the Administration to conduct PAS assessments,

Completes a minimum of 30 hours of classroom training in both EPD and DD ~~preadmission screening (PAS)~~ PAS for a total of 60 hours, and

Receives intensive oversight and monitoring by the Administration during the first 30 days of employment ~~with~~ and ongoing oversight by the Administration during all periods of employment.

~~“Chronic” means a medical condition that is always present, occurs periodically, or is marked by a long duration.~~

~~“Constant or constantly” means at least once a day.~~

“Current” means belonging to the present time.

“Disruptive behavior” means inappropriate behavior by the applicant or member including urinating or defecating in inappropriate places, sexual behavior inappropriate to time, place, or person or excessive whining, crying, or screaming that interferes with an applicant's or member's normal activities or the activities of others and requires intervention to stop or interrupt the behavior.

~~“Frequent or Frequently” means weekly to every other day.~~

“Frequency” means the number of times a specific behavior occurs within a specified interval.

“Functional assessment” means an evaluation of information about an applicant's or member's ability to perform activities related to:

Developmental milestones;

Activities of daily living;

Communication; and

Behavior.

~~“History” means a medical condition that occurred in the past that may not have required treatment and is not now active.~~

“Immediate risk of institutionalization” means the status of an applicant or member under A.R.S. § 36-2934(A)(5) and as specified in A.R.S. § 36-2936 and in the Administration's Section 1115 Waiver with CMS Centers for Medicare and Medicaid Services (CMS).

“Intervention” means therapeutic treatment, including the use of medication, behavior modification, and physical restraints to control behavior. Intervention may be formal or informal and includes actions taken by friends or family to control the behavior.

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“Limited or occasional” means a small portion of an entire task or assistance for the task if the assistance is required less than daily.

“Medical assessment” means an evaluation of an applicant's or member's medical condition and the applicant's or member's need for medical services.

“Medical or nursing services and treatments” or “services and treatments” ~~in this Article~~ means specific, ongoing medical, psychiatric, or nursing intervention used actively to resolve or prevent deterioration of a medical condition. Durable medical equipment and activities of daily living assistive devices are not treatment unless the equipment or device is used specifically and actively to resolve the existing medical condition.

~~“Occasional or occasionally” means from time to time such as less than once per week during the assessment period.~~

“Physical participation” means ~~the~~ an applicant's or member's active participation.

“Physically lift” means actively bearing some part of an applicant's or member's weight during movement or activity and excludes bracing or guiding activity.

“Physician consultant” means a physician who contracts with the Administration.

“Social worker” means an individual with two years of case management-related experience or a baccalaureate or master's degree in:

- Social work,
- Rehabilitation,
- Counseling,
- Education,
- Sociology,
- Psychology, or
- Other closely related field.

“Special diet” means a diet planned by a dietitian, nutritionist, or nurse that includes high fiber, low sodium, or pureed food.

“Toileting” means the process involved in an applicant's or member's managing of the elimination of urine and feces in an appropriate place.

“Vision” means the ability to perceive objects with the eyes.

B. EPD. In addition to definitions contained in subsection (A), the following also ~~applies~~ apply to an applicant or member who is EPD:

“Aggression” means physically attacking another, including:

- Throwing an object,
- Punching,
- Biting,
- Pushing,
- Pinching,
- Pulling hair,
- Scratching, and
- Physically threatening behavior.

“Bathing” means the process of washing, rinsing, and drying all parts of the body, including an applicant's or member's ability to transfer to a tub or shower and to obtain bath water and equipment.

“Continence” means the applicant's or member's ability to control the discharge of body waste from bladder ~~or~~ and bowel.

“Dressing” means the physical process of choosing, putting on, securing fasteners, and removing clothing and footwear. Dressing includes choosing a weather-appropriate article of clothing but excludes aesthetic concerns. Dressing includes the applicant's or member's ability to put on artificial limbs, braces, and other appliances that are needed daily.

“Eating” means the process of putting food and fluids by any means into the digestive system.

“Elderly” means an applicant or member who is age 65 or older.

“Emotional and cognitive functioning” means an applicant's or member's orientation and mental state, as evidenced by ~~overt behavior~~ aggressive, self-injurious, wandering, disruptive, and resistive behaviors.

“EPD” means an applicant or member who is elderly and physically disabled.

“Grooming” means ~~the~~ an applicant's or member's process of tending to appearance. Grooming includes: combing or brushing hair; washing face and hands; shaving; ~~performing routine nail care~~; oral hygiene (including denture care); and menstrual care. Grooming does not include aesthetics such as styling hair, skin care, nail care, and applying cosmetics.

“Mobility” means the extent of an applicant's or member's purposeful movement within a residential environment.

“Orientation” means an applicant's or member's awareness of self in relation to person, place, and time.

“Physically disabled” means an applicant or member who is determined physically impaired by the Administration through the PAS assessment as allowed under the Administration's Section 1115 Waiver with CMS.

“Resistiveness” means inappropriately obstinate and uncooperative behaviors, including passive or active obstinate behaviors, or refusing to participate in self-care or to take necessary medications. Resistiveness does not include difficul-

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ties with auditory processing or reasonable expressions of self-advocacy.

“Self-injurious behavior” means repeated self-induced, abusive behavior that is directed toward infliction of immediate physical harm to the body.

“Sensory” means of or relating to the senses.

~~“Suicidal behavior” means an act or intent to take one's life voluntarily.~~

“Transferring” means an applicant's or member's ability to move horizontally or vertically between two surfaces within a residential environment, excluding transfer for toileting or bathing.

“Wandering” means an applicant's or member's moving about with no rational purpose and with a tendency to go beyond the physical parameter of the residential environment.

C. DD. In addition to definitions contained in subsection (A), the following also ~~applies~~ apply to an applicant or member who is DD:

“Acute” means an active medical condition having a sudden onset, lasting a short time, and requiring immediate medical intervention.

“Aggression” means physically attacking another, including:

- Throwing objects,
- Punching,
- Biting,
- Pushing,
- Pinching,
- Pulling hair, and
- Scratching.

“Ambulation” means the ability to walk and includes quality of the walking and the degree of independence in walking.

“Associating time with an event and an action” means an applicant's or member's ability to associate a regular event with a specific time-frame.

“Bathing or showering” means an applicant's or member's ability to complete the bathing process including drawing the bath water, washing, rinsing, and drying all parts of the body, and washing the hair.

~~“Caregiver training” means a direct care staff person or caregiver trained in special health care procedures normally performed or monitored by a licensed professional, such as a registered nurse.~~ means training received by a direct-care staff person or caregiver for special health care procedures that are normally performed or monitored by a licensed professional, such as a registered nurse. These procedures may include ostomy care, positioning for medical necessity, use of an adaptive device, or respiratory services such as suctioning or a small volume nebulizer treatment.

“Chronic” means a medical condition that is always present, occurs periodically, or is marked by a long duration.

“Clarity of communication” means an ability to speak in recognizable language or use a formal symbolic substitution, such as American-Sign Language.

“Climbing stairs or a ramp” means an applicant's or member's ability to move up and down stairs or a ramp.

“Community mobility” means the applicant's or member's ability to move about a neighborhood or community independently, by any mode of transportation.

“Crawling and standing” means an applicant's or member's ability to crawl and stand with or without support.

“DD” means developmentally disabled.

“Developmental milestone” means a measure of an applicant's or member's functional abilities, including:

- Fine and gross motor skills,
- Expressive and receptive language,
- Social skills,
- Self-help skills, and
- Emotional or affective development.

“Dressing” means the ability to put on and remove an article of clothing, ~~and Dressing does not include the ability to put on or remove~~ braces nor does it reflect an applicant's or member's ability to match colors or choose clothing appropriate for the weather.

“Eating or drinking” means the process of putting food and fluid by any means into the digestive system.

“Expressive verbal communication” means an applicant's or member's ability to communicate thoughts with words or sounds.

“Food preparation” means the ability to prepare a simple meal including a sandwich, cereal, or a frozen meal.

“Hand use” means the applicant's or member's ability to use ~~the~~ both hands, or one hand if an applicant or member has only one hand; or has the use of only one hand.

“History” means a medical condition that occurred in the past, regardless of whether the medical condition required treatment in the past, and is not now active.

~~“Limited or occasional” means a small portion of an entire task or assistance for the task required less than daily.~~

“Personal hygiene” means the process of tending to one's appearance. Personal hygiene may include: combing or brushing hair, washing face and hands, shaving, performing routine nail care, oral hygiene including denture care, and

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menstrual care. This does not include aesthetics such as styling hair, skin care, and applying cosmetics.

“Physical interruption” means immediate hands-on interaction to stop a behavior.

“Remembering an instruction and demonstration” means an applicant's or member's ability to recall an instruction or demonstration on how to complete a specific task.

“Resistiveness or rebelliousness” means an applicant's or member's inappropriate, stubborn, or uncooperative behavior. Resistiveness or rebelliousness does not include an applicant's or member's difficulty with processing information or reasonable expression of self-advocacy that includes an applicant's or member's expression of wants and needs.

“Rolling and sitting” means an applicant's or member's ability to roll and sit independently or with the physical support of another person or with a device such as a pillow or specially-designed chair.

“Running or wandering away” means an applicant or member leaving a physical environment without notifying or receiving permission from the appropriate individuals.

“Self-injurious behavior” means an applicant's or member's repeated behavior that causes injury to the applicant or member.

“Verbal or physical threatening” means any behavior in which an applicant or member uses words, sounds, or action to threaten harm to self, others, or an object.

“Wheelchair mobility” means an applicant's or member's mobility using a wheelchair and does not include the ability to transfer to the wheelchair.

R9-28-303. Preadmission Screening (PAS) Process

~~A.~~ An assessor shall complete the PAS instrument as part of the initial assessment or reassessment for:

- ~~1. An applicant or member who is DD or EPD;~~
- ~~2. A hospitalized applicant, or~~
- ~~3. An applicant or member who is ventilator dependent.~~

~~B.A.~~ The assessor shall use the PAS instrument to determine ~~to assess~~ whether the following applicants or members are at immediate risk of institutionalization:

1. The assessor shall use the PAS instrument prescribed in R9-28-304 to assess an applicant or member who is EPD except as specified in subsection (A)(2) for a physically disabled applicant or member who is less than 6 six years old. After assessing a physically disabled child age six years to less than 12 years, the assessor shall refer the child for physician consultant review under R9-28-303.
2. The assessor shall use the age-specific PAS instrument prescribed in R9-28-305 ~~for to assess~~ an applicant or member who is physically disabled ~~or and~~ less than 6 six years old. After assessing the child, ~~in subsection (1),~~ the assessor shall refer the child for physician consultant review under ~~R9-28-303; this Section.~~
3. The assessor shall use the PAS instrument prescribed in R9-28-305 to assess an applicant or member who is DD, except as specified in subsection (A)(4) for an applicant or member who is: DD and residing in a NF. After assessing a child who is DD and less than six months of age, the assessor shall refer the child for physician consultant review under subsections (G) through (H).
 - a. ~~DD and residing in a NF. The assessor shall use the PAS instrument prescribed in R9-28-304; or~~
 - b. ~~DD or physically disabled and less than 6 months of age. The assessor shall use the PAS instrument prescribed in R9-28-305. After assessing the child, the assessor shall refer the child for physician consultant review under R9-28-303.~~
4. The assessor shall use the PAS instrument prescribed in R9-28-304 for an applicant or a member who is DD and residing in a NF.
5. The assessor shall use the PAS instrument prescribed in R9-28-304 or R9-28-305, whichever is applicable, to assess an applicant or member who is classified as ventilator-dependent, under Section 1902(e)(9) of the Social Security Act.

~~C.~~ For an applicant or member who is ventilator dependent, a registered nurse assessor shall complete the PAS instrument, and determine an applicant or member at immediate risk of institutionalization when the applicant or member is classified as ventilator dependent, under Section 1902(e)(9) of the Social Security Act, January 1, 1995, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

~~D.B.~~ For an initial assessment of an applicant who is in a hospital or other acute care setting:

1. A registered nurse assessor shall complete the PAS ~~instrument~~ assessment, or
2. In the event that a registered nurse assessor is not available, a social worker assessor shall complete the PAS assessment; and
3. The assessor shall conduct the PAS assessment and determine medical eligibility when discharge is scheduled within seven days.

~~E.C.~~ An assessor shall conduct a face-to-face PAS assessment with an applicant or member, except as provided in subsection ~~(HE)~~. The assessor shall make reasonable efforts to obtain the applicant's or member's available medical records. The assessor may also obtain information for the PAS assessment from face-to-face interviews with the:

1. Applicant or member,

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2. Parent,
3. Guardian,
4. Caregiver, or
5. Any person familiar with the applicant's or member's functional or medical condition.

~~F.D.~~ Using the information described in subsection ~~(E.C.)~~, an assessor shall complete the PAS instrument assessment based on the assessor's education, experience, professional judgment, and training, ~~as described in R9-28-301(A).~~

~~G.E.~~ After the assessor completes the PAS instrument assessment, the assessor shall calculate a PAS score. The assessor shall compare the PAS score to an established threshold score. The scoring methodology and threshold scores are specified in R9-28-304 and R9-28-305. Except as determined by physician consultant review as provided in subsections ~~(H.G.)~~ and ~~through~~ (J), the threshold score is the point at which an applicant or member is determined to be at immediate risk of institutionalization.

~~H.F.~~ Upon request from a person acting on behalf of the applicant, the Administration shall conduct a PAS assessment to determine whether a deceased applicant who was residing in a NF or who received services in an ICF-MR any time during the months covered the time period covered by the application would have been eligible to receive ALTCS benefits for those months.

~~I.G.~~ In the following circumstances, ~~The the~~ Administration shall request that an AHCCCS physician consultant review the PAS instrument assessment, the available medical records, and use professional judgement ~~judgment when to make the determination that an applicant or member has a developmental disability or has a nonpsychiatric medical condition that, by itself or in combination with a medical condition, places an applicant or member at immediate risk of institutionalization:~~

1. The PAS score of an applicant or member who is EPD is less than the threshold specified in R9-28-304, but is at least 56;
2. The PAS score of an applicant or member who is DD is less than the threshold specified in R9-28-305, but is at least 38;
3. An applicant or member scores below the threshold specified in R9-28-304, but the Administration has reasonable cause to believe that the applicant's or member's unique functional abilities or medical condition ~~places~~ may place the applicant or member at immediate risk of institutionalization;
4. An applicant or member scores below the threshold specified in R9-28-304 and has a documented diagnosis of autism, autistic-like behavior, or pervasive developmental disorder; ~~or~~
5. An applicant or member who is seriously mentally ill as defined in A.R.S. § 36-550 and who achieves a score scores at or above the threshold specified in R9-28-304, but does may not meet the requirements of A.R.S. § 36-2936. ~~Despite~~ When an applicant or member who is seriously mentally ill scores a score at or above the threshold, the physician consultant ~~exercises~~ shall exercise professional judgement judgment to determine whether and determines if the applicant or member meets the requirements of A.R.S. § 36-2936.
6. An applicant is an AHCCCS acute care member and scores at or above the threshold specified in R9-28-304 but the Administration has reasonable cause to believe that the applicant's condition is convalescent and requires less than 90 days of institutional care;
7. An applicant or member is a physically disabled child who is at least six but less than 12 years of age;
8. An applicant or member is a physically disabled child under six years of age; and
9. An applicant is under six months of age.

~~J.H.~~ The physician conducting the review shall use the information contained in the PAS instrument, available medical records, and professional judgement to determine whether an applicant or member is DD or has a nonpsychiatric medical condition that, by itself or in combination with a medical condition, places an applicant or member at immediate risk of institutionalization.

At a minimum, the ~~The~~ physician consultant shall consider the following:

1. ~~ADL~~ Activities of daily living dependence;
2. Delay in development;
3. Contenance;
4. Orientation;
5. Behavior;
6. Any medical condition, including stability and prognosis of the condition;
7. Any medical nursing treatment provided to the applicant or member including skilled monitoring, medication, and therapeutic regimens;
8. ~~Supervision requirements~~ The degree to which the applicant or member must be supervised;
9. ~~Caregiver skill and training requirements~~ The skill and training required of the applicant or member's caregiver; and
10. Any other factor of significance to the individual case.

~~K.~~ The physician shall state the reasons for the recommended decision in the comment section of the PAS instrument.

~~L.~~ If the physician consultant is unable to make the determination from the PAS assessment and the available medical records, the physician consultant may conduct a face-to-face review with the applicant or member or contact others famil-

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iar with the applicant's or member's needs, including a primary care physician or other caregiver, to make the determination.

- ~~L.~~ If the physician is unable to determine eligibility from the PAS instrument and available medical records, the physician may conduct a face-to-face review with the applicant or member or contact others familiar with the applicant's or member's needs, including primary care physician or other caregiver.
- ~~J.~~ The physician consultant shall state the reasons for the determination in the physician review comment section of the PAS instrument.

R9-28-304. Preadmission Screening Criteria for an Applicant or Member who is Elderly and Physically Disabled (EPD)

- A. The PAS instrument for an applicant or member who is EPD includes ~~four major~~ the following categories:
 - 1. Intake information category. The assessor solicits intake information category information on an applicant's or member's demographic background. The components of the intake information category are not included in the calculated PAS score.
 - 2. Functional assessment category. The assessor solicits functional assessment category information on an applicant's or member's:
 - a. Need for assistance with activities of daily living, including:
 - i. Bathing,
 - ii. Dressing,
 - iii. Grooming,
 - iv. Eating,
 - v. Mobility,
 - vi. Transferring, and
 - vii. Toileting in the residential environment or other routine setting;
 - b. Communication and sensory skills, including hearing, expressive communication, and vision; and
 - c. Continence, including bowel and bladder functioning.
 - 3. Emotional and cognitive functioning category. The assessor solicits emotional and cognitive functioning category information on an applicant's or member's:
 - a. Orientation to person, place, and time. In soliciting this information, the assessor shall also take into account the caregiver's judgment; and
 - b. Behavior, including:
 - i. Wandering,
 - ii. Self-injurious behavior,
 - iii. Aggression,
 - iv. ~~Suicidal behavior~~ Resistiveness, and
 - v. Disruptive behavior.
 - 4. Medical assessment category. The assessor solicits medical assessment category information on an applicant's or member's:
 - a. ~~Medical condition~~ conditions that have an and the medical condition's impact on the applicant's or member's functional ability in relation to perform independently activities of daily living, continence, and vision;
 - b. Medical condition that requires medical or nursing service and treatment;
 - c. Medication, treatment, and allergies;
 - d. Specific services and treatments that the applicant or member is currently receiving ~~receives or needs and the frequency of the services and treatments;~~ and
 - e. Physical measurements, hospitalization history, and ventilator dependency.
- B. The assessor shall use the PAS instrument to assess an applicant or member who is EPD as specified in this Section. A copy of the PAS instrument is available from the Administration. The Administration uses the assessor's PAS ~~instrument responses assessment~~ to calculate three scores: a functional score, a medical score, and a total score.
 - 1. Functional score.
 - a. The Administration calculates the functional score from responses to scored items in the functional assessment and emotional and cognitive functioning categories. For each response to a scored item, a number of points is assigned, which is multiplied by a weighted numerical value. The result is a weighted score for each response.
 - b. ~~Designated items in the categories are scored according to subsection (C), under the following assessment matrices~~
 - i. ~~Sensory skills;~~
 - ii. ~~Medical conditions; and~~
 - iii. ~~Medical or nursing service and treatment.~~
 - e.b. All items in the following categories are scored, according to subsection (C), under the Functional Assessment matrix In the functional assessment matrix, all items in the following categories are scored according to subsection (C):

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- i. Activities of daily living;₂
- ii. Continence;₂
- iii. ~~Orientation~~ Sensory;₂
- iv. Orientation;₂ and
- v. Behavior.

~~d-c.~~ The sum of the weighted scores equals the functional score. The weighted score per item can range from 0 to 15. The maximum functional score attainable by an applicant or member is ~~141~~166. ~~No minimum functional score is required except as prescribed in subsections (B)(3)(e) and (B)(3)(d).~~

2. Medical score.

a. The EPD population is divided into two groups for purposes of calculating the medical score. The primary distinction between the two groups is the difference in medical need as follows:

- i. Group 1 includes an applicant or member diagnosed with paralysis, head trauma, multiple sclerosis, amyotrophic lateral sclerosis, or Parkinson's disease that either impacts the applicant's or member's ability to perform activities of daily living independently or requires the applicant or member to receive nursing services or treatments.
- ii. Group 2 includes an applicant or member diagnosed with Alzheimer's disease, dementia, or an organic brain syndrome that either impacts the applicant's or member's ability to perform activities of daily living independently or requires medical or nursing services and treatments. If an applicant or member does not meet one of the criteria for Group 2, the applicant or member is considered to be in Group 1.

b. Scoring methodology: Group 1 individuals.

- i. The Administration calculates the medical score is from responses to scored items in the medical conditions and the services and treatments sections of the PAS instrument.
- ii. Each response to a scored item in the medical assessment category is assigned a certain number of points, ranging from 0 to 4 points per item.
- iii. The sum of the points equals the medical score, with a maximum score of 63. No minimum medical score is required, except as prescribed in subsection (B)(3)(e).

e. Scoring Methodology: Group 2 individuals.

- i. The Administration calculates the medical score from responses to scored items in the services and treatments section of the PAS instrument.
- ii. Each response to a scored item in the medical assessment category is assigned a number of points, ranging from 0 to 16 points per item.
- iii. The sum of the points equals the medical score, with a maximum score of 42. No minimum medical score is required, except as prescribed in subsection (B)(3)(d).

a. In the medical assessment matrix, all items in the following categories are scored according to:

- i. Medical conditions as specified in subsection (C), and
- ii. Medical or nursing services and treatments in subsection (C).

b. The Administration calculates the medical score based on the applicant's or member's

- i. Diagnosis of Alzheimer's, dementia, or organic brain syndrome (OBS);
- ii. Diagnosis of paralysis, and
- iii. Current use of oxygen.

c. The maximum medical score attainable by an applicant or member is 31.5.

3. Total score.

a. The sum of an applicant's or member's functional and medical scores equals the total score.

b. The total score is compared to ~~an~~ the established threshold score ~~in R9-28-304~~ as calculated under ~~R9-31-304~~ this Section. ~~Regardless of whether an applicant or member is in Group 1 or in Group 2, the threshold score is 60. The threshold score is 60.~~

c. ~~Except as~~ As defined in R9-28-303, an applicant or member is determined at immediate risk of institutionalization if ~~one of the following is met: the total score is equal to or greater than 60.~~

- i. ~~The applicant or member has a total score equal to or greater than 60;~~
- ii. ~~The applicant or member in Group 1 has a total score less than 60, a functional score equal to or greater than 30, and a medical score equal to or greater than 13;~~
- iii. ~~The applicant or member in Group 2 has a total score less than 60 and a functional score equal to or greater than 30, and a weighted score from the orientation section equal to or greater than 5; or~~
- iv. ~~The applicant or member in Group 2 has a total score equal to or greater than 30 and is assigned at least two points for any one item in the behavior section.~~

C. The following matrices represent the number of points available and the respective weight for each scored item.

- 1. Functional assessment points. The lowest value in the range of points available per item in the functional assessment category, zero, indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.
- 2. Medical assessment points. The lowest value in the range of points available per item in the medical assessment cate-

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gory, 0 zero, indicates that the applicant or member:

- a. Does not have ~~a the scored~~ medical condition,
- b. Does not need ~~the scored~~ medical or nursing services, or
- c. Does not receive ~~any the scored~~ medical or nursing services.

FUNCTIONAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score per Item (P)x(W)
Activities of Daily Living Section			
Bathing, Dressing, Grooming, Mobility, Toileting	0-5	3	0-15
Eating	0-6	2.5	0-15
Transfer	0-4	3.75	0-15
Continence Section			
Bowel	0-2	0	0
	3	.167	.5
Bladder	0-4	0.5	0-2
Sensory Section			
	0-1	0	0
Vision	2	1.75	3.5
	3	1.167	3.5
Orientation Section			
Person, Place, Time	0-3	1	0-3
Emotional or Cognitive Behavior Section			
Aggression, Self-injurious, Suicidal, Wandering	0-3	1	0-3
Disruptive	0-3	3	0-9

<u>FUNCTIONAL ASSESSMENT</u>	<u># of Points Available Per Item (P)</u>	<u>Weight (W)</u>	<u>Range of Possible Weighted Score per Item (P)x(W)</u>
<u>Activities of Daily Living Section</u>			
<u>Mobility</u>	<u>0-3</u>	<u>5</u>	<u>0-15</u>
<u>Transfer</u>	<u>0-3</u>	<u>5</u>	<u>0-15</u>
<u>Bathing</u>	<u>0-3</u>	<u>5</u>	<u>0-15</u>
<u>Dressing</u>	<u>0-3</u>	<u>5</u>	<u>0-15</u>
<u>Grooming</u>	<u>0-3</u>	<u>5</u>	<u>0-15</u>
<u>Eating</u>	<u>0-3</u>	<u>5</u>	<u>0-15</u>
<u>Toileting</u>	<u>0-3</u>	<u>5</u>	<u>0-15</u>
<u>Continence Section</u>			
<u>Bowel</u>	<u>0-3</u>	<u>1</u>	<u>0-3</u>
<u>Bladder</u>	<u>0-3</u>	<u>1</u>	<u>0-3</u>

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<u>Sensory Section</u>			
<u>Vision</u>	<u>0-3</u>	<u>2</u>	<u>0-6</u>
<u>Orientation Section</u>			
<u>Place</u>	<u>0-4</u>	<u>.5</u>	<u>0-2</u>
<u>Time</u>	<u>0-4</u>	<u>.5</u>	<u>0-2</u>
<u>Emotional or Cognitive Behavior Section</u>			
<u>Aggression-Frequency</u>	<u>0-3</u>	<u>1.5</u>	<u>0-4.5</u>
<u>Aggression-Intervention</u>	<u>0-3</u>	<u>1.5</u>	<u>0-4.5</u>
<u>Self-injurious-Frequency</u>	<u>0-3</u>	<u>1.5</u>	<u>0-4.5</u>
<u>Self-injurious-Intervention</u>	<u>0-3</u>	<u>1.5</u>	<u>0-4.5</u>
<u>Wandering- Frequency</u>	<u>0-3</u>	<u>1.5</u>	<u>0-4.5</u>
<u>Wandering- Intervention</u>	<u>0-3</u>	<u>1.5</u>	<u>0-4.5</u>
<u>Resistiveness-Frequency</u>	<u>0-3</u>	<u>1.5</u>	<u>0-4.5</u>
<u>Resistiveness-Intervention</u>	<u>0-3</u>	<u>1.5</u>	<u>0-4.5</u>
<u>Disruptive-Frequency</u>	<u>0-3</u>	<u>1.5</u>	<u>0-4.5</u>
<u>Disruptive-Intervention</u>	<u>0-3</u>	<u>1.5</u>	<u>0-4.5</u>

MEDICAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P)x(W)
GROUP 1			
Medical Conditions Section			
<u>Paralysis or Sclerosis</u>	<u>0-1</u>	<u>3</u>	<u>0-3</u>
<u>Alzheimer's, or OBS, or Dementia</u>	<u>0-1</u>	<u>3.5</u>	<u>0-3.5</u>
Services and Treatments Section			
<u>Physical Therapy, Occupational Therapy, Speech Therapy</u>	<u>0-1</u>	<u>0.5</u>	<u>0-.5</u>
<u>Suctioning, Oxygen, Small Volume Nebulizer, Tracheostomy Care, Postural Drainage, Respiratory Therapy</u>	<u>0-1</u>	<u>1.5</u>	<u>0 or 1.5</u>
<u>Drug Regulation</u>	<u>0-1</u>	<u>2</u>	<u>0 or 2</u>
<u>Decubitus Care, Wound Care, Ostomy Care, Feedings Tube or Parenteral, Catheter Care, Other Ostomy Care, Dialysis, Fluid Intake or Output</u>	<u>0-1</u>	<u>3</u>	<u>0 or 3</u>
<u>Teaching or Training Program, Bowel or Bladder Program, Range of Motion, Other Rehabilitative Nursing, Restraints</u>	<u>0-1</u>	<u>4</u>	<u>0 or 4</u>

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MEDICAL ASSESSMENT	# of Points Available per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item
GROUP 2			
Drug Regulation	0-1	2	0 or 2
Teaching or Training Program, Bowel or Bladder Program, Range of Motion, Other Rehabilitative Nursing	0-1	6	0 or 6
Restraints (Physical or Chemical)	0-1	16	0 or 16

<u>MEDICAL ASSESSMENT</u>	<u># of Points Available Per Item (P)</u>	<u>Weight (W)</u>	<u>Range of Possible Weighted Score Per Item (P)x(W)</u>
Medical Conditions Section			
Paralysis	0-1	6.5	0 or 6.5
Alzheimer's, OBS, or Dementia	0-1	20	0 or 20
Services and Treatments Section			
Oxygen	0-1	5	0 or 5

R9-28-307. The ALTCS Transitional Program for a Member who is Elderly and Physically Disabled (EPD) or Developmentally Disabled (DD)

- A. The ALTCS transitional program serves members enrolled in the ALTCS program who, at the time of reassessment as described in R9-28-306, no longer meet the threshold specified in R9-28-304 for EPD or in R9-28-305 for DD; ~~but do~~ The member must meet all other ALTCS eligibility criteria. ~~The~~ Administration shall compare the member's PAS assessment ~~will be compared to a second~~ scoring methodology for eligibility in the ALTCS transitional program as defined in subsections (B) and (C).
- B. The Administration shall transfer a member who is DD from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment, the total PAS score is less than the threshold described in R9-28-305 but is at least 30, or the member is diagnosed with moderate, severe, or profound mental retardation.
- C. The Administration shall transfer a member who is EPD from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment, the PAS score is less than the threshold described in R9-28-304 but ~~the member meets one or more of the following criteria:~~ is at least 40.
 - 1. ~~Has a score of two or more on three of the following activities for daily living:~~
 - a. ~~Eating,~~
 - b. ~~Dressing,~~
 - c. ~~Bathing,~~
 - d. ~~Toileting, and~~
 - e. ~~Transferring;~~
 - 2. ~~Has a diagnosis of:~~
 - a. ~~Alzheimer's disease,~~
 - b. ~~Organic brain syndrome,~~
 - c. ~~Dementia,~~
 - d. ~~Parkinson's disease, or~~
 - e. ~~Head trauma that impacts activities of daily living; and~~
 - 3. ~~Has a score of two or more on any of the items in the emotional and cognitive functioning category.~~
- ~~D.~~ An assessor shall conduct a reassessment annually of a member qualifying for the transitional program to determine if the member continues to meet the criteria specified in subsections (B) and (C).
- ~~E.~~ D. ~~For a member residing in a NF or ICF-MR, the program contractor or the Administration shall ensure that the member is moved to an approved home- and community-based setting within has up to 90 continuous days from the enrollment date of the member's eligibility for the ALTCS transitional program to move the member to an approved home- and community-based setting.~~

Notices of Final Rulemaking

- F.E.** A member in the ALTCS transitional program shall continue to receive all medically necessary covered services as specified in Article 2.
- G.F.** ~~The~~ A member in the ALTCS transitional program is eligible to receive up to 90 continuous days per NF or ICF-MR admission when the member's condition worsens to the extent that an admission is medically necessary.
- H.G.** For a member requiring medically necessary NF or ICF-MR services for longer than 90 days, the program contractor shall request the Administration to conduct a reassessment under R9-28-306.