NOTICES OF FINAL RULEMAKING

This section of the *Arizona Administrative Register* contains Notices of Final Rulemaking. Final rules have been through the regular rulemaking process as defined in the Administrative Procedures Act. These rules were either approved by the Governor's Regulatory Review Council or the Attorney General's Office. Certificates of Approval are on file with the Office.

The final published notice includes a preamble and text of the rules as filed by the agency. Economic Impact Statements are not published.

The Office of the Secretary of State is the filing office and publisher of these rules. Questions about the interpretation of the final rules should be addressed to the agency that promulgated them. Refer to Item #5 to contact the person charged with the rulemaking. The codified version of these rules will be published in the Arizona Administrative Code.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

[R17-200]

PREAMBLE

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

R9-22-712.60	Amend
R9-22-712.62	Amend
R9-22-712.63	Amend
R9-22-712.64	Amend
R9-22-712.65	Amend
R9-22-712.66	Amend
R9-22-712.68	Amend
R9-22-712.71	Amend
R9-22-712.72	Amend
R9-22-712.80	Amend
R9-22-712.81	Amend

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

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

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

3. The effective date of the rule:

January 1, 2018

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

Notice of Rulemaking Docket Opening: 23 A.A.R. 1811, July 7, 2017

Notice of Proposed Rulemaking: 23 A.A.R. 1791, July 7, 2017

Prior to the filing of this Notice of Final Rulemaking, GRRC approved amendments to R9-22-712.71 regarding incremental payments for hospitals that qualify for a value-based purchasing adjustment. The amendments became effective October 1, 2017. Additional information regarding the value-based purchasing amendment can be found via the following related notices published in the *Register*:

Notice of Rulemaking Docket Opening: 23 A.A.R. 1046, May 5, 2017

Notice of Proposed Rulemaking: 23 A.A.R. 1015, May 5, 2017

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

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

Notice of Final Rulemaking: 22 A.A.R. 2187, August 19, 2016

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

Name: Gina Relkin
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4232
Fax: (602) 253-9115
E-mail: AHCCCSrules@azahcccs.gov
Web site: www.azahcccs.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The Arizona Health Care Cost Containment System Administration is the single state agency responsible for administration of the Medicaid program in Arizona. The program is jointly funded by the State, counties, and the federal government. Federal law imposes a substantial number of conditions on the receipt of federal financial assistance reflected in federal statutes (42 U.S.C. § 1396 et seq.) and regulation (generally, 42 C.F.R. Parts 430 through 455). While States are provided substantial flexibility with respect to the payment methods for health care providers that agree to participate, federal law does require that States "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A). State law requires the agency to adopt a diagnosis-related group (DRG) based hospital reimbursement methodology consistent with Title XIX of the Social Security Act for inpatient dates of service on and after October 1, 2014. A.R.S. § 36-2903.01(G)(12).

A DRG based hospital reimbursement methodology pays a fixed amount on a "per discharge basis." Under this methodology each claim is assigned to a DRG based on the patient's diagnoses, surgical procedures performed, age, gender, birth weight, and discharge status. The goal of diagnosis related groups is to classify inpatient stays into categories based on similar clinical conditions and on similar levels of hospital resources required for treatment. These categories are identified using DRG codes each of which is assigned a relative weight appropriate for the relative amount of hospital resources expected to be used to treat the patient. An essential element of a DRG based hospital payment methodology is the selection of one of the several DRG classification systems. The DRG system was first implemented via rule published in 20 A.A.R. 1956, published September 6, 2014. As originally published, the Agency elected to use the All Patient Refined DRG (APR-DRG) system of codes and relative weights established and maintained by 3M Health Information Systems. At the time, the most current version of that system was version 31. More than three years have elapsed since initial implementation of APR-DRG. The original DRG reimbursement methodology was developed using Fiscal Year 2011 data from the Agency's tiered per diem system. Since that time, 3M Health Information Systems has issued version 34 of the system which is in use in the health care industry as the basis for payments by other payers. In addition, there have been updates to the national code sets used for diagnoses and procedures.

To meet its federal obligation to establish payment methodologies that are consistent with efficiency, economy, quality and access, the Agency contracted with Navigant Consulting to assess the impacts of these changes on reimbursement for inpatient hospital reimbursement (often referred to as "rebasing" the payment methodology). The current rebase will utilize updated claims and encounter data and incorporates related changes to policy and service adjustors in an effort to maintain cost effectiveness.

Hospitals may wish to take particular note of the proposed amendment to R9-22-712.72(B). The proposed amendment strikes an overly restrictive direction regarding the coding of claims when a member's enrollment changes during an inpatient stay, which direction may result in certain claims failing to qualify for the outlier payment add-on under R9-22-712.68 when such payment is appropriate. Providers should consult AHCCCS policy manuals that are incorporated by reference into the provider participation agreement for specific guidance on correct coding practices effective for claims with dates of discharge on and after January 1, 2018.

In addition, hospitals should note that the wage indices referenced in R9-22-712.62(B) include the "rural floor" such that the wage index for a hospital in any urban area cannot be less than the wage index received by rural hospitals in the same State. Use of the rural floor is required for the Medicare program under 42 C.F.R. 412.64, and the AHCCCS Administration has elected to adopt the rural floor as part of this rulemaking.

Pursuant to A.R.S. § 36-2903.01(G), the Agency promulgates rules that describe the payment methodology; however, per A.R.S. § 41-1005(A)(9), the Agency is not required to have rules that set forth the actual amounts of fee-for-service payments. As a condition of federal financial participation, the Agency is required to provide notice through its website and/or publication through the State administrative register. In addition, the State must provide an opportunity for public comment on significant proposed changes to methods and standards for payment rates. 42 U.S.C. § 1396a(a)(13) and 42 C.F.R. § 447.205. To accommodate future editions of the APR-DRG system, changes in the national code sets, and the corresponding changes to service and policy adjustors, the Agency is proposing to remove from the text of the rule references to specific dollar amounts and other numerical factors which, going forward, will be published to the Agency's website with advanced notice and public comment prior to implementation.

For ease of reference, the amounts intended for use as of January 1, 2018 (and historical values) appear below and will be published to the Agency's website:

Rule Section (R9-22)	Description of Value Moved to Web	Current Values	Updated Values
R9-22-712.60(C) R9-22-712.60(F)(1)	Reference to the version of the 3M APR-DRG classification system	Version 31	Version 34
R9-22-712.62(B)	The amount of the statewide standardized amount of the base payment.	$5,295.40	$5,168.06

R9-22-712.63	The amount of the alternative to the statewide standardized amount of the base payment for urban hospitals with high Medicare utilization and short-term hospitals.	$3,436.08	$3,359.24
R9-22-712.64(A)(2)	The amount of the DRG base payment for out of state hospitals.	$5,184.75	$5,157.58
R9-22-712.65(A)	The multiplier for high-utilization hospitals	1.055	1.110
R9-22-712.66	Multipliers for service policy adjustors.	Newborns: 1.55 Neonates: 1.10 Obstetrics: 1.55 Psychiatric: 1.65 Rehab: 1.65 Children - • Severity level 1 & 2: 1.25 • Severity levels 3 & 4 (2016): 1.60	Newborns: 1.55 Neonates: 1.10 Obstetrics: 1.55 Psychiatric: 1.65 Rehab: 1.65 Burns: 2.70 Children - • Severity level 1 & 2: 1.25 • Severity levels 3 & 4 (2016): 1.60 • Severity levels 3 & 4 (2017): 1.945 • Severity levels 3 & 4 (2018): 2.30 All other claims: 1.025
R9-22-712.68(D)	The fixed loss amount for CAHs and all other hospitals.	CAHs $5,000 All others $65,000	CAHs $5,000 All others $65,000
R9-22-712.68(E)	The DRG marginal cost percentages for burns and all other claims.	Burns 90% All others 80%	Burns 90% All others 80%

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

The Agency engaged the services of Navigant Consulting who modeled the estimated impact of the proposed amendments on payments to hospitals for inpatient services under the DRG payment methodology. Information regarding that model will be posted to the Agency's website, and will be located on the webpage "AHCCCS APR-DRG REBASE". https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGRebase.html.

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

This rulemaking does not diminish a previous grant of authority of a political subdivision.

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

Multiple factors may influence the actual economic impact of the amendments proposed by this rulemaking, including the nature and frequency of inpatient hospital services and where those services are received. Assuming no significant changes in utilization from prior years, the Agency anticipates that the aggregate increase in expenditures as a result of this rule will be $35.5 million in additional payments to hospitals annually. Through the Medicaid program, the federal government funds a substantial percentage of the Agency's expenditures for medical services which percentage varies by eligibility category. Based on estimates of the level of federal financial participation, the Agency estimates the proposed amendments increase State expenditures (General Fund and hospital assessment) by $8.3 million annually. The Agency does not anticipate that the rulemaking will have an effect on State revenues or materially impact political subdivisions of the State. According to hospital uniform accounting reports information filed with the Arizona Department of Health Services for 2015 (the most current information publicly available), 2 of the 104 hospitals listed reported fewer than one hundred full-time employees which qualifies those hospitals as "small businesses" under A.R.S. § 41-1001(21). The two hospitals, Arizona Orthopedic Surgical and Specialty Hospital and Arizona Spine & Joint Hospital are hospitals that are small businesses impacted by the DRG payment system. Estimates regarding the impact to those hospitals and all other hospitals participating in the AHCCCS program are posted to the Agency's website.

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

There have been no changes between the proposed rulemaking and the final rulemaking. The AHCCCS Administration may make minor grammatical and technical corrections, as needed.

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

The AHCCCS Administration appreciates the input of stakeholders to implement the modified DRG reimbursement methodol-

ogy. AHCCCS held a stakeholder's meeting on May 4, 2017 and presented the preliminary model to the stakeholders. In addition, AHCCCS presented a power point with information at the Tribal Consultation Meeting on April 20, 2017. The proposed rules were also posted on the AHCCCS website on June 16, 2017. The proposed rules were published in the Arizona Administrative Register on July 7, 2017. As part of the Arizona Administrative Procedures Act, AHCCCS allowed for public comment at the public hearing and during the comment process. The AHCCCS Administration has listed the public comments and AHCCCS response in the table below:

	COMMENT FROM COMMENTOR	AHCCCS RESPONSE:
1.	**Comment from Julia Strange** **Vice President, Community Benefit** **Tucson Medical Center (TMC):** Under R9-22-712.62 DRG Base Payment, AHCCCS suggests using the wage index values published August 22, 2016. Although these values were the proposed values published by CMS, final values were subsequently published in the tables of the October 5, 2016 Federal Register. Tucson Medical Center believes that using the final values as opposed to the proposed values would be more appropriate, given that it matches the wage index value in place today.	**AHCCCS RESPONSE:** The values published on August 22, 2016 are part of a final rule applicable to reimbursement for inpatient services under the Medicare program. On October 5, 2016, the federal government published a correction to the earlier rule. Federal law does not require the application of these same indices to the Medicaid program. AHCCCS believes that the August 22, 2016 indices more accurately reflect wage values in Arizona.
2.	**Comment from Julia Strange** **Vice President, Community Benefit** **Tucson Medical Center (TMC):** In regards to R9-22-712.66 DRG Service Policy Adjustor, while TMC is appreciative that AHCCCS has increased the policy adjustor for neonate cases when compared to the adjustors originally shared with the state hospitals, TMC remains concerned that it will have a detrimental impact on the newborn and obstetrics adjustors. While we understand the goal of infusing additional resources into pediatrics, we believe that that investment would be more appropriately spread across all of the service lines that are primary to AHCCCS' mission - and most notably, to support services for moms, babies, and children.	**AHCCCS RESPONSE:** Per 42 U.S.C. § 1396a(a)(30)(A), AHCCCS is required to establish rates that are consistent with efficiency, economy, quality of care, and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. In essence, the federal requirement is that AHCCCS pay neither too much nor too little to achieve the goal of access to appropriate care. Spreading an "investment" across all service lines is not necessarily consistent with the federal standard. In AHCCCS opinion, the Service Policy Adjustors reflect select adjustment to payments necessary to achieve adequate access to care.
3.	**Comment from Mary Lonon** **Senior Financial Analyst, Tucson Medical Center:** Was the proposed rule updated at any point? a. I originally had that the updated standardized payment rate for TMC would go from $5,295.40 to $5,142.36. Now when I pull up the proposed rule from the AHCCCS website, it shows that the new standard payment will be $5,168.06. b. If it has been revised and the $5,168.06 is correct, can you send me a copy of the original proposed rule? I want compare, so that I make and other necessary changes.	**AHCCCS RESPONSE:** The preamble to the proposed rule originally posted to the Agency website on July 16, 2017, included inaccurate values. On July 27, 2017, AHCCCS amended the information on the website. The values published on July 27, 2016 were the values that were included in the proposed rule published by the Arizona Secretary of State. In addition to this written response, AHCCCS provided technical assistance to the commenter.
4.	**Comment from Mary Lonon** **Senior Financial Analyst, Tucson Medical Center:** In the final model version that was posted this past week, the first section states that it is V31 ***without transition***. Is this referring to the transition from the base payments when AZ rebased payments based on going from a tiered per diem to a DRG payment formula? If not, what "transition" is it referring to?	**AHCCCS RESPONSE:** The contents of the final model posted to the AHCCCS website is not incorporated into the proposed rule and was provided as information to stakeholders about the anticipated impact of the rule. As originally implemented, the DRG methodology included a three year transition period. The statement "without transition" reflects that the transition period has concluded.
5.	**Comment from Mary Lonon** **Senior Financial Analyst, Tucson Medical Center:** TMC had a shift in its wage index in recent years. Can you verify the wage index for TMC that is being used to calculate each of the V31 and V34 payments?	**AHCCCS RESPONSE:** The wage indices applicable to TMC under the current rule and under the proposed rule are included in tables referenced in proposed R9-22-712.62.
6.	**Comment from Dave Yoder, Senior Director - Client Services** **Toyon Associates, Inc.:** At MIHS, we found the latest two published exhibits to be very helpful. Our calculations based on FY2016 data were close to the published estimates for MIHS. We believe that the APR-DRG rebase does not penalize MIHS from a rate perspective. However, changes in patient volumes, in particular burn volumes, may affect the net benefit received year over year. Otherwise, we had no questions at this time, and we were interested in hearing the questions and comments from other Arizona healthcare systems.	**AHCCCS RESPONSE:** Thank you for your positive feedback.
7.	**Comment from Jim Champlin, Phoenix Children's Hospital:** In the 2014 project PCH was listed under High Medicaid Utilization Providers, why the change?	**AHCCCS RESPONSE:** One of the criteria for that designation is: "Covered inpatient days subject to DRG reimbursement, determined using adjudicated claim and encounter data during the fiscal year beginning October 1, 2015, equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals." PCH falls below that threshold.

8.	**Comment from Matt Goss, Reimbursement Manager, Dignity Health and Brandi Brashear, Reimbursement Director, Dignity Health:** We've reviewed the proposed rule and noticed that there is a new requirement to receive the high-utilization multiplier. Would the qualification requiring hospitals to receive less than $2M in outlier payments exclude St. Joseph's from getting this adjustment factor? Please let us know. What was the logic behind this additional qualifier?	**AHCCCS RESPONSE:** The new qualifier does not exclude St Joseph's Hospital which will continue to receive the high-utilization policy adjustor following the rebase. **AHCCCS RESPONSE:** This additional qualifier is further refinement to ensure the described policy adjustor receives its intended application.
9.	**Comment from John McMullin CPA, MBA, FHFMA, Chief Financial Officer at RMCHCS:** I don't see any information for RMCHCS is Gallup, NM. Are you able to help me understand how it will impact our AZ Medicaid population?	**AHCCCS RESPONSE:** Based on our FY 2016 data, Rehoboth McKinley no longer meets the threshold for a "High Utilization Out of State Hospital." For that reason, beginning 01/01/2018 under the proposed rule, Rehoboth McKinley would be reimbursed by AHCCCS under proposed A.A.C. R9-22-712.64(A)(2). To gauge the practical effect of that, you can compare the current reimbursement values for Rehoboth McKinley (see the spreadsheet at this link, row 56: https://www.azahcccs.gov/PlansProviders/Downloads/FFSrates/APR/DRG_Provider_Table_FFY2017_20170101.xlsx) to the table below illustrating the rebased "All Other Out-of-State" reimbursement values under the proposed rule. **Parameter** / **Value** Hospital category: Out of State Statewide Average DRG Base Rate: $5,157.58 High Medicaid Volume Hold-Harmless Adjustor: 1.000 Out-of-state cost-to-charge ratio: 0.240 Cost Outlier Fixed Loss Threshold: $65,000
10.	**Comment from Mr. Robert Myers, Tenet Health:** Do you have a copy of the version 34 DRG table that you could send to us?	**AHCCCS RESPONSE:** Provided table to Mr. Myers.
11.	**Comment from Greg Vigdor, President and Chief Executive Officer, AzHHA:** The Preamble to the NOPR states that state expenditures will increase by approximately $8.3 million, some of which will come from the general fund, and some from the hospital assessment. In order for stakeholders to evaluate the impact of this proposal, we recommend the Administration provide an estimate of how this proposal would impact the assessment paid by each hospital. This is especially important because some hospitals are not paid within the APR-DRG system and would not receive any increased payments from this proposal. Moreover, the impact statement sent by the Administration to hospitals estimates that payments to thirteen hospitals and three health systems within the DRG system would be reduced under the rebase proposal. Payments to one hospital are estimated to be reduced by 4.1%—not an inconsequential amount. While one would expect a revenue-neutral rebasing initiative to result in estimated payment losses for some hospitals, the fact that the Administration's proposal includes additional funds, which are partially funded by the provider assessment, and the proposal includes a 1.025 policy adjustment "for all other claims" makes this proposal different. To be clear, we are not opposed to using the hospital assessment to fund a rate increase. In fact, AzHHA has previously supported the use of the assessment for this purpose. However, we feel very strongly that stakeholders should have the opportunity to understand the implications of this approach, particularly for providers who are reimbursed under different payment methodologies or who are estimated to experience reduced reimbursement under the proposal.	**AHCCCS RESPONSE:** The impacts of the changes reflected in this proposed rule have been incorporated into the State Fiscal Year 2018 assessment amounts for individual hospitals that have been posted to the Agency's website since May of this year. Any future amendments to the hospital assessment will require separate rule making by the Agency. As part of any future rule making regarding the assessment, the Agency will publish the projected impact to individual hospitals. Any future amendments will include public notice and an opportunity for comments at that time. Additionally, a hospital workgroup has been established to discuss any changes to the assessment for State Fiscal Year 2019. The first meeting of the workgroup has been scheduled for September 15, 2017.

12.	**Comment from Greg Vigdor, President and Chief Executive Officer, AzHHA:** However, the Administration has revised the methodology since its May meeting with stakeholders, and has not posted an updated model with the NOPR. While the Preamble states that information regarding the model would be posted to the agency's website with the publication of the NOPR, we have not been able to locate this information. We appreciate the Administration sending out hospital and health system impact information last week, but this does not provide enough information to fully evaluate the current model and its impact on access to care for Medicaid beneficiaries. We are particularly interested in understanding the rationale behind some of the policy adjusters and their corresponding weights. The APR-DRG system as a methodology takes into account high acuity cases that some providers may experience disproportionately, and the relative weights reflect the typical resources needed to care for a patient within a particular DRG category. AzHHA believes that any additional policy adjusters should be based on key Medicaid principles of enhancing access to care and/or improving quality and efficiency. Many of the policy adjusters that AHCCCS has put in place previously or that it proposes in the NOPR are typical of this approach. They target high cost service lines and/or those services on which Medicaid beneficiaries particularly rely, including pediatrics, obstetrics, and neonatology. Many other states use similar adjusters. The proposal to include a policy adjuster for burn services fits this approach as well. It is a very high cost, specialized service that is critical to maintain for Medicaid Beneficiaries. If the State were to lose burn services at the one burn center in Arizona, Medicaid beneficiaries would need to be transported out of state for appropriate care. For this reason, we support including an adjuster for burn services. While we support the inclusion of a policy adjuster for burn services, we seek clarity on how the Administration developed the specific weight for this service line adjustment, as well as the weights associated with the other policy adjusters. Specifically, what is the rationale for the *specific weights* proposed by the Administration for each policy adjuster?	**AHCCCS RESPONSE:** The Arizona Administrative Procedure Act does not require the posting of models that estimate the impact of proposed rules on individual hospitals. Nevertheless, for the information of stakeholders, an updated model was posted to the Agency's website on August 7, 2017, and the comment period was extended to August 14, 2017. At the request of the AzHHA, additional information regarding the estimated payment to cost ratios was added to the model contributing to the delay in posting. All of the policy adjusters reflected in the proposed rules are based on the Agency's evaluation of adjustments that are necessary for, and consistent with, federal requirements for establishing payment methodologies consistent with efficiency, economy, quality of care, and access to care. We appreciate your support for the policy adjuster for burns and other service categories. The Agency's justifications regarding specific adjusters are addressed in responses to other comments.
13.	**Comment from Greg Vigdor, President and Chief Executive Officer, AzHHA:** There is one adjuster for which we have not been able to ascertain a specific policy rationale—regardless of the weight proposed. The Administration proposes to retain a provider adjuster for "high Medicaid utilization hospitals," and in fact proposes to double the weight for this adjuster in the rebase proposal. According to information released last week, three hospitals would qualify as "high Medicaid utilization hospitals" under the revised definition. The definition does not necessarily target hospitals with the highest Medicaid payer mix in the State, although having a Medicaid inpatient utilization rate greater than 30% for FY 2016 is one of the criteria. Rather, in order to qualify for the adjustment, a hospital for all practical purposes must be one of the largest in the State—because the adjustment is also based on the hospital having at least 400% of the statewide average number of AHCCCS-covered inpatient days during FFY 2016. All three hospitals that qualify for this provider adjustment are located in the Phoenix metropolitan area. They are surrounded by many other hospitals that offer similar services to Medicaid beneficiaries. As such, we ask the Administration to describe the policy rationale for providing additional payments to these specific hospitals. For example, how does this adjustment enhance access to care for Medicaid beneficiaries? What inpatient services do these facilities provide that beneficiaries cannot receive elsewhere nearby? What hardships would beneficiaries encounter if they had to travel elsewhere to receive these services? If these hospitals provide specialty services that Medicaid beneficiaries cannot access elsewhere, why not provide an adjustment for those specific service lines rather than an across-the-board provider adjustment? It is vital for the integrity of the APR-DRG payment system and to promote fairness and transparency that stakeholders fully understand the policy rationale for each adjustment. This is especially true for this particular adjustment because (1) the adjustment was modified after the preliminary model was released, and there has been no public discussion on it since then; (2) other hospitals may be paying for this adjustment through an increase to their provider assessment; and (3) the qualifying providers will continue to receive the adjustment regardless of whether their Medicaid utilization or other factors shift from year to year—at least until the rule is next modified.	**AHCCCS RESPONSE:** While the published model identifies three "high utilizing hospitals," under section R9-22-712.65 and 712.68 of the proposed rule, AHCCCS estimates that only one high utilizing hospital would meet all criteria including the proposed outlier threshold. Without the adjustment, this one hospital is projected to have losses under the DRG reimbursement methodology. Establishing a methodology that permits the hospital to incur a projected loss would be inconsistent with AHCCCS' obligation under the federal requirements for the Medicaid program to ensure adequate access to care. The preliminary model was precisely that – a preliminary model. While AHCCCS values the input of stakeholders, to implement the modified DRG reimbursement methodology reflected in the proposed rule by January 1, 2018, AHCCCS solicited comments on the final model through the notice and comment process established as part of the Arizona Administrative Procedures Act.

14.	**Comment from Greg Vigdor, President and Chief Executive Officer, AzHHA:** In the NOPR, the Administration is also proposing to no longer set the APR-DRG base amounts and weights through the rulemaking process. We are opposed to this proposal. The rulemaking process requires a certain level of accountability for agencies–regardless of who is leading the agency at a particular time. While rulemakings can be cumbersome for state agencies, the public benefits from this accountability and transparency. If the Administration chooses to move ahead with eliminating the base payment amounts and weights from the Administration's rules and instead adjusting them periodically on the Administration's website, we strongly recommend that the proposed rules be modified to include a requirement that the Administration publish modeling information and hospital impact analyses, and hold meetings with stakeholders when changes are proposed to the payment methodology, including changes to base amounts, weights and policy adjusters.	**AHCCCS RESPONSE:** As stated in the preamble to the proposed rule, pursuant to A.R.S. § 36-2903.01(G), the Agency promulgates rules that describe the payment methodology; however, per A.R.S. § 41-1005(A)(9), the Agency is not required to have rules that set forth the actual amounts of fee-for-service payments. As a condition of federal financial participation, the Agency is required to provide notice through its website and/or publication through the State administrative register when proposing a change to the payment methodology. In addition, the State must provide an opportunity for public comment on significant proposed changes to methods and standards for payment rates. 42 U.S.C. § 1396a(a)(13) and 42 C.F.R. § 447.205. Going forward, references to specific dollar amounts and other numerical factors will be published to the Agency's website with advanced notice and public comment prior to implementation. This approach is necessary to accommodate future editions of the APR-DRG system, changes in the national code sets, and the corresponding changes to service and policy adjustors.
15.	**Comment from Greg Vigdor, President and Chief Executive Officer, AzHHA:** Finally, we would like to thank the Administration for the change it made to the original model regarding the wage index. We support the inclusion of the "rural floor," which is also used by the Medicare program. AzHHA appreciates the opportunity to provide comments on this rulemaking.	**AHCCCS RESPONSE:** The Agency appreciates your support with respect to the changes to the wage index.
16.	**Comment from Craig McKnight, Executive VP, Chief Financial Officer, Phoenix Children's Hospital:** The first relates to the qualifying calculation for High Medicaid Utilization Providers. One of the factors of the criteria for that designation is, "covered inpatient days subject to DRG reimbursement, determined using adjudicated claim and encounter data during the fiscal year beginning October 1, 2015, equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals." This calculation compares total AHCCCS days at each facility to the Statewide average. We would suggest that a more relevant measurement for High Medicaid Utilization providers would be a calculation that better represents the extent to which each hospital has dedicated its resources to Medicaid patient services. This calculation should include a factor for or be based on the comparison of AHCCCS days as compared to the total inpatient days of each facility. Utilizing AHCCCS payor mix would show that Phoenix Children's percentage of AHCCCS patient days is over 62%, among the very highest in Arizona. It is worth noting that the State data shows that the average AHCCCS inpatient payor mix is 27%. This shows that PCH is impacted to a much greater degree by AHCCCS APR-DRG reimbursement than most AZ Hospitals while being one of largest hospitals by AHCCCS days and should be considered a High Medicaid Usage facility.	**AHCCCS RESPONSE:** We agree that there are many different methods that could be used to identify high utilizing hospitals. We disagree that the method proposed by the commenter would materially improve the analysis compared to the methodology set forth in the rule. The current rule continues the methodology for identifying high utilizing hospitals that has been in place for the past several years. With the addition of the outlier criteria, the proposed methodology is consistent with the federal standard for establishing a reimbursement methodology that is consistent with efficiency, economy, quality of care, and access to care, and with the objective of not incurring expenditures for inpatient services above the level necessary to meet that standard.
17.	**Comment from Craig McKnight, Executive VP, Chief Financial Officer, Phoenix Children's Hospital:** The second area of concern for PCH is the data utilized in the study. PCH would have welcomed being involved in validating the data gathered for the study. As it is, the reported patient days for PCH are 19% below the level that PCH reports as AHCCCS patient days for that same time period and is below the level that we report annually on our Cost Report as Title XIX Days (excluding observation). Using corrected data would materially impact the representation of PCH. The costs as reported of $127,403,159 do not represent PCH's cost to provide care for AHCCCS patients. Total costs for that time period related to AHCCCS inpatients were $177,058,162. Subtracting this from the calculated reimbursement as reported of $190,302,017, produces a payment-to-cost ratio of 1.07, not the 1.49 reported.	**AHCCCS RESPONSE:** We disagree that the data from the AHCCCS claims and encounter system is invalid. That data is a representative and easily available source that AHCCCS employed for its analysis for the entire system. This is the same data source that is attested to by certified actuaries and accepted by the federal government as the basis for capitation payments to managed care organizations. To the extent the commenter is suggesting that every hospital should have the opportunity to validate data or that the analysis should rely on hospital-reported data, the suggestion is administratively impractical. In addition, given that identification of high utilizing hospital is determined relative to the utilization of all hospitals, it is uncertain at best that a different data source would result in any improvement to the analysis or the outcome of the analysis.
18.	**Comment from Craig McKnight, Executive VP, Chief Financial Officer, Phoenix Children's Hospital:** Lastly, Supplemental payments are a factor in the calculations included in the study report, the inclusion and degree of which can preclude facilities from receiving various policy adjusters. Phoenix Children's is in the process of transitioning away from the Safety Net Care Pool that has recently provided the majority of supplemental payments, including those in this survey. To the extent to which supplemental payments is a factor in these calculations, we would ask that decisions made regarding future reimbursement levels take into consideration that PCH will no longer be receiving SNCP once the current approved SNCP has been distributed.	**AHCCCS RESPONSE:** The commenter incorrectly assumes that supplemental payments affect the application of the adjusters included in the rule. Supplemental payments were not a factor considered in those determinations. At the request of stakeholders based upon input on the preliminary model, the final model includes data on supplemental payments for informational purposes.

19.	**Comment from Linda Hunt, Sr. Vice President of Operations & President/CEO, Arizona, Dignity Health** **Shirley Gunther, VP of External Affairs, Arizona** **Dignity Health, Arizona Service Area Office:** **R9-22-712.65 DRG Provider Policy Adjustor** The Proposed Rule takes into account the unique populations and the high level of acuity served in high-utilization acute care facilities. Hospitals that meet the criteria of a high-utilization provider should be adequately compensated to meet high acuity and frequency of such patients. SJHMC is one of Arizona's first intercity urban acute care hospitals that delivers world-class and as such is one of the State's largest high-utilizers for a subset of patients. **Therefore, we strongly support and urge the adoption of the provider adjustment as it addresses the inequities high-utilization hospitals incur.**	**AHCCCS RESPONSE:** AHCCCS appreciates the commenter's support.
20.	**Comment from Linda Hunt, Sr. Vice President of Operations & President/CEO, Arizona, Dignity Health** **Shirley Gunther, VP of External Affairs, Arizona** **Dignity Health, Arizona Service Area Office:** **R9-22-712.66. DRG Service Policy Adjustor** Dignity Health requests "neurology" services to be added to the policy adjustors under the Proposed Rule. Like the other services listed in R9-22-712.66, neurology patients are acutely ill patients with diseases of the brain, spinal cord and nervous system issues that often have associated medical problems complicating their care. The Barrow Neurological Institute at SJHMC is known throughout the U.S. and world as a leader in brain and spine patient care often taking the most complex cases other facilities can't or won't consider. The Barrow preforms more brain surgeries than any other hospital in the United States. It is our experience that claims/encounters data are disproportionately high for this service and the hospital resources required to treat the acuity and complex conditions of these patients justifies the need for neurology to be included the Service Policy Adjustor. **For those reasons, Dignity Health requests that the AHCCCS Administration consider including "neurology" to Service Policy Adjustors in this Proposed Rule.**	**AHCCCS RESPONSE:** While the Agency appreciates and values the skilled services provided by the Barrow Neurological Institute, the Agency has determined that the proposed reimbursement structure, including policy adjustors, is adequate to ensure access to quality care and comply with federal requirements to establish methodologies consistent with efficiency and economy.
21.	**Comment from Jason Bezozo** **Vice President, Government Relations, Banner Health:** Under the proposed rule, eligible hospitals for the high-utilization policy adjuster would also need to have less than $2 million in outlier payments in FFY 16. Banner would strongly urge AHCCCS to maintain the historical eligibility criteria and eliminate the proposed outlier test. The purpose of outlier payments is to reimburse providers for extraordinary costs that are not represented in the base APR-DRG reimbursement methodology. The inclusion of an outlier test for this adjuster unfairly penalizes high-Medicaid volume hospitals solely based on the provider's presentation of unusually high-cost Medicaid patients. Based on the DRG projections provided by AHCCCS, this proposed addition would preclude both Banner Desert Medical Center and Banner-University Medical Center Phoenix from being eligible for the high-utilization policy adjuster. Both of these facilities have very high Medicaid inpatient utilization compared to other hospitals across the state and should be included in this peer group—not excluded. As AHCCCS prepares to finalize the proposed rule changes to the APR-DRG payment system, we would strongly urge the AHCCCS Administration to establish a payment system that reimburses all high-Medicaid utilization hospitals equally. With AHCCCS covering over 1.9 million Arizonans, nearly 28% of the state population, AHCCCS has the ability to create distortions in the marketplace. That should not be the role of government which is why it is important to treat all providers and peer groups fairly and equally. Thank you	**AHCCCS RESPONSE:** We disagree that the outlier test unfairly penalizes high utilizing hospitals. Receipt of projected outlier payments in excess of $2 million results in the hospital receiving adequate reimbursement for extraordinary costs above the DRG. Thus, an additional adjuster for these hospitals is not necessary. Under sections R9-22-712.65 and 712.68 of the proposed rule, AHCCCS estimates that only one high utilizing hospital would meet all criteria including the proposed outlier threshold. Without the adjustment, this one hospital is projected to have losses under the DRG reimbursement methodology. In contrast, other high utilizing hospitals that do not meet the outlier threshold are not projected to have losses. Adoption of the commenter's suggestion would increase AHCCCS expenditures for inpatient hospital services without an anticipated commensurate increase in quality or access to care. This would be inconsistent with the federal standard for establishing a reimbursement methodology that is consistent with efficiency, economy, quality of care, and access to care.

12. Other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules.

There are no other matters prescribed by statute applicable to rulemaking specific to this agency, to this specific rule, or to this class of rules.

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

The rule does not require the provider to obtain a permit or a general permit.

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

The rule is not more stringent than federal law.

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

No such analysis was submitted.

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

R9-22-712.62(B) references the labor share for the Medicare inpatient prospective payment system published in Volume 81 of the Federal Register at page 57312 and the wage index tables referenced in Volume 81 of the Federal Register at page 57311 for the fiscal year beginning October 1, 2016.

R9-22-712.71(4)(b) references 42 C.F.R. § 495.22.

R9-22-712.81 references 42 C.F.R. § 447.205.

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

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

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-712.60. Diagnosis Related Group Payments
R9-22-712.62. DRG Base Payment
R9-22-712.63. DRG Base Payments Not Based on the Statewide Standardized Amount
R9-22-712.64. DRG Base Payments and Outlier CCR for Out-of-State Hospitals
R9-22-712.65. DRG Provider Policy Adjustor
R9-22-712.66. DRG Service Policy Adjustor
R9-22-712.68. DRG Reimbursement: Unadjusted Outlier Add-on Payment
R9-22-712.71. Final DRG Payment
R9-22-712.72. DRG Reimbursement: Enrollment Changes During an Inpatient Stay
R9-22-712.80. DRG Reimbursement: New Hospitals
R9-22-712.81. DRG Reimbursement: Updates

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-712.60. Diagnosis Related Group Payments

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

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

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

D. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to quick pay discounts and slow pay penalties under A.R.S. 36-2904.

E. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to the Urban Hospital Reimbursement Program under R9-22-718.

F. For purposes of this section and sections R9-22-712.61 through R9-22-712.81:

1. "DRG National Average length of stay" means the national arithmetic mean length of stay published in ~~version 31 of~~ the All Patient Refined Diagnosis Related Group (APR-DRG) classification established by 3M Health Information Systems.
2. "Length of stay" means the total number of calendar days of an inpatient stay beginning with the date of admission through discharge, but not including the date of discharge (including the date of a discharge to another hospital, i.e., a transfer) unless the member expires.
3. "Medicare" means Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq*.

4. "Medicare labor share" means a hospital's labor costs as a percentage of its total costs as determined by CMS for purposes of the Medicare Inpatient Prospective Payment System.

R9-22-712.62. DRG Base Payment

A. The initial DRG base payment is the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code assigned to the claim, and any applicable provider and service policy adjustors.

B. The DRG base rate for each hospital is the statewide standardized amount of which the hospital's labor-related share of that amount is adjusted by the hospital's wage index~~,~~ ~~where the standardized amount is $5,295.40, and the~~ The hospital's labor share is determined based on the labor share for the Medicare inpatient prospective payment system published in Volume 81 of the Federal Register at page 57312 published August 22, 2016. ~~and the~~ The hospital's wage index ~~are those used in the Medicare inpatient prospective payment system for the fiscal year beginning October 1, 2013~~ is determined based on the wage index tables reference in Volume 81 of the Federal Register at page 57311 published August 22, 2016. The statewide standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.

C. Claims shall be assigned both a DRG code derived from all diagnosis and surgical procedure codes included on the claim (the "pre-HCAC" DRG code) and a DRG code derived excluding diagnosis and surgical procedure codes associated with the health care acquired conditions that were not present on admission or any other provider-preventable conditions (the "post-HCAC" DRG code). The DRG code with the lower relative weight shall be used to process claims using the DRG methodology.

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

A. Notwithstanding section R9-22-712.62, ~~the amount of $3,436.08~~ a select specialty hospital standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) to calculate the DRG base rate for the following hospitals:

1. Hospitals located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2011 Medicare Cost Report are reimbursed by Medicare.
2. Hospitals designated as type: hospital, subtype: short-term that has a license number beginning "SH" in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year.

B. The select specialty hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.

R9-22-712.64. DRG Base Payments and Outlier CCR for Out-of-State Hospitals

A. DRG Base payment:

1. For high volume out-of-state hospitals defined in subsection (C), the wage adjusted DRG base payment is determined as described in R9-22-712.62.
2. Notwithstanding subsection R9-22-712.62 the wage adjusted DRG base rate for out-of-state hospitals that are not high volume hospitals shall be ~~$5,184.75~~ included in the AHCCCS capped fee schedule available on the agency's website.

B. Outlier CCR:

1. Notwithstanding subsection R9-22-712.68, the CCR used for the outlier calculation for out-of-state hospitals that are not high volume hospitals shall be the sum of the statewide urban default operating cost-to-charge ratio and the statewide capital CCR in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
2. The CCR used for the outlier calculation for high volume out-of-state hospitals is the same as in-state hospitals as described in R9-22-712.68.

C. A high volume out-of-state hospital is a hospital not otherwise excluded under R9-22-712.61, that is located in a county that borders the State of Arizona and had 500 or more AHCCCS covered inpatient days for the fiscal year beginning October 1, ~~2010~~ 2015.

D. Other than as required by this section, DRG reimbursement for out-of-state hospitals is determined under R9-22-712.60 through R9-22-712.81.

R9-22-712.65. DRG Provider Policy Adjustor

A. After calculating the DRG base payment as required in sections R9-22-712.62, R9-22-712.63, or R9-22-712.64, for claims from a high-utilization hospital, the product of the DRG base rate and the DRG relative weight for the post-HCAC DRG code shall be multiplied by a provider policy adjustor ~~of 1.055~~ that is included in the AHCCCS capped fee schedule available on the agency's website.

B. A hospital is a high-utilization hospital if the hospital had:

1. ~~At least 46,112 AHCCCS-covered~~ Covered inpatient days subject to DRG reimbursement, determined using adjudicated claim and encounter data during the fiscal year beginning October 1, ~~2010~~ 2015, ~~which is~~ equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals ~~of 11,528 days~~; ~~and,~~
2. A Medicaid inpatient utilization rate greater than 30% calculated as the ratio of AHCCCS-covered inpatient days to total inpatient days as reported in the hospital's Medicare Cost Report for the fiscal year ending ~~2011~~ 2016; and,
3. Received less than $2 million in add-on payment for outliers under R9-22-712.68, based on adjudicated claims and encounters for fiscal year beginning October 1, 2015.

R9-22-712.66. DRG Service Policy Adjustor

In addition to subsection R9-22-712.65, for claims with DRG codes in the following categories, the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code, and the DRG provider policy adjustor shall be multiplied by the service policy adjustor listed in the AHCCCS capped fee schedule, available on the agency's website, corresponding to the following DRG codes ~~following service policy adjustors~~:

1. Normal newborn DRG codes~~: 1.55.~~
2. Neonates DRG codes~~: 1.10.~~
3. Obstetrics DRG codes~~: 1.55.~~
4. Psychiatric DRG codes~~: 1.65.~~

5. Rehabilitation DRG codes~~: 1.65.~~
6. Burn DRG codes.
~~6~~7. Claims for members under age 19 assigned DRG codes other than listed above:
   a. ~~1.25 for~~ For dates of discharge occurring on or after October 1, 2014 and ending no later than December 31, 2015 regardless of severity of illness level,
   b. ~~1.25 for~~ For dates of discharge on or after January 1, 2016, for severity of illness levels 1 and 2,
   c. ~~1.60 for~~ For dates of discharge on or after January 1, 2016 and before January 1, 2017, for severity of illness levels 3 and 4.
   d. For dates of discharge on or after January 1, 2017, and before January 1, 2018 for severity of illness levels 3 and 4.
   e. For dates of discharge on or after January 1, 2018, for severity of illness levels 3 and 4.
8. Claims for members assigned DRG codes other than listed above.

R9-22-712.68. DRG Reimbursement: Unadjusted Outlier Add-on Payment

A. Claims for inpatient hospital services qualify for an outlier add-on payment if the claim cost exceeds the outlier cost threshold.

B. The claim cost is determined by multiplying covered charges by an outlier CCR as described by the following subsections:
1. For hospitals designated as type: hospital, subtype: children's in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year. The outlier CCR will be calculated by dividing the hospital total costs by the total charges using the most recent Medicare Cost Report available as of September 1 of that year.
2. For Critical Access Hospitals the outlier CCR will be the sum of the statewide rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
3. For all other hospitals the outlier CCR will be the sum of the operating cost-to-charge ratio and the capital cost-to-charge ratio established for each hospital in the impact file established as part of the Medicare Inpatient Prospective Payment System by CMS.

C. AHCCCS shall update the CCRs described in subsection (B) to conform to the most recent CCRs established by CMS as of September 1 of each year, and the CCRs so updated shall be used ~~For~~ for claims with dates of discharge on or after October 1 of that year.

D. The outlier threshold is equal to the sum of the unadjusted DRG base payment plus the fixed loss amount. The fixed loss amount ~~is~~ ~~$5,000~~ for critical access hospitals and ~~$65,000~~ for all other hospitals are included in the AHCCCS capped fee schedule available on the agency's website.

E. For those inpatient hospital claims that qualify for an outlier add-on payment, the payment is calculated by subtracting the outlier threshold from the claim cost and multiplying the result by the DRG marginal cost percentage. The DRG marginal cost percentage ~~is~~ ~~90%~~ for claims assigned DRG codes associated with the treatment of burns and ~~80%~~ for all other claims are included in the AHCCCS capped fee schedule available on the agency's website.

R9-22-712.71. Final DRG Payment

The final DRG payment is the sum of the final DRG base payment, the final DRG outlier add-on payment, and the Inpatient Value Based Purchasing (VBP) Differential Adjusted Payment.
1. For claims with dates of discharge prior to January 1, 2018, ~~The~~ the final DRG base payment is an amount equal to the product of the covered day adjusted DRG base payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition. For claims with dates of discharge on and after January 1, 2018, no adjustment will be made to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology or to account for improvements in documentation and coding.
2. For claims with dates of discharge prior to January 1, 2018, ~~The~~ the final DRG outlier add-on payment is an amount equal to the product of the covered day adjusted DRG outlier add-on payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition. For claims with dates of discharge on and after January 1, 2018, no adjustment will be made to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology or to account for improvements in documentation and coding.
3. The factor for each hospital and for ~~each federal fiscal year~~ claims with dates of discharge prior to January 1, 2018 is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS administration's website and is on file for public inspection at the AHCCCS administration located at 701 E. Jefferson Street, Phoenix, Arizona.
4. For inpatient services with a date of discharge from October 1, 2017 through September 30, 2018, the Inpatient VBP Differential Adjusted Payment is the sum of the final DRG base payment and the final DRG outlier add-on payment multiplied by a percentage published on the Administration's public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2017. To qualify for the Inpatient VBP Differential Adjusted Payment, a hospital providing inpatient hospital services must by May 15, 2017, have executed an agreement with a qualifying health information exchange organization and electronically submitted laboratory, radiology, transcription, and medication information, plus admission, discharge, and transfer information (including data from the hospital emergency department), to a qualifying health information exchange organization.

R9-22-712.72. DRG Reimbursement: Enrollment Changes During an Inpatient Stay

A. If a member's enrollment changes during an inpatient stay, including changing enrollment from fee-for-service to a contractor, or vice versa, or changing from one contractor to another contractor, the contractor with whom the member is enrolled on the date of discharge shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in sections R9-22-712.60 through R9-22-712.81. If the member is eligible but not enrolled with a contractor on the date of discharge, then the AHCCCS

administration shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in sections R9-22-712.60 through R9-22-712.81.

B. When a member's enrollment changes during an inpatient stay, the hospital shall use the date of enrollment with the payer responsible on the date of discharge as the "from" date of service on the claim regardless of the date of admission. ~~The claim may include all surgical procedures performed during the entire inpatient stay, but the hospital shall only include revenue codes, service units, and charges for services performed on or after the date of enrollment~~.

C. Interim claims submitted to a payer other than the payer responsible on the day of discharge shall be processed in the same manner as other interim claims as described in R9-22-712.76.

R9-22-712.80. DRG Reimbursement: New Hospitals

A. DRG base payment for new hospitals. For any hospital that does not have a labor share or wage index published by CMS as described in section R9-22-712.62(B) because the hospital was not in operation, the DRG base rate described in section R9-22-712.62(B) shall be calculated as the statewide standardized amount ~~of $5,295.40~~ after adjusting that amount for the labor-related share and the wage index published by CMS as described in section R9-22-712.62(B) that is appropriate to the location of the hospital published by CMS as described in section R9-22-712.62(B).

B. Outlier calculations for new hospitals. For any hospital that does not have an operating cost-to-charge ratio listed in the impact file described in section R9-22-712.68(B) because the hospital was not in operation prior to the publication of the impact file, the statewide urban or rural default operating cost-to-charge ratio appropriate to the location of the hospital and the statewide capital cost-to-charge ratio shall be used to determine the unadjusted outlier add-on payment. The statewide urban or rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio shall be based on the ratios published by CMS and updated by the Administration as described in section R9-22-712.68(C).

C. In addition to the requirement of this section, DRG reimbursement for new hospitals is determined under R9-22-712.60 through R9-22-712.79.

R9-22-712.81. DRG Reimbursement: Updates

In addition to the other updates provided for in sections R9-22-712.60 through R9-22-712.80, the Administration may update the version of the APR-DRG classification system established by 3M Health Information Systems, adjust the statewide standardized amount in section R9-22-712.62, the base payments in sections R9-22-712.63 and R9-22-712.64, the provider policy adjustor in section R9-22-712.65, service policy adjustors section R9-22-712.66, and the fixed loss amounts and marginal cost percentages used to calculate the outlier threshold in section R9-22-712.68 to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. The Administration shall publish any proposed classification system on the agency's website at least 30 days prior to the effective date, to ensure a sufficient period for public comment, as required by 42 C.F.R. § 447.205. In addition, the public notice shall be available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. The requirements of 42 C.F.R. § 447.205 as of November 2, 2015 are incorporated by reference and do not include any later amendments.

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

[R17-201]

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

Article 12	Amend
R20-5-1201	Amend
R20-5-1202	Amend
R20-5-1205	Amend
R20-5-1206	Amend
R20-5-1208	Amend
R20-5-1209	Amend
R20-5-1210	Amend
R20-5-1211	Amend
R20-5-1213	Amend
R20-5-1218	Amend

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

Authorizing statutes: A.R.S. §§ 23-364,23-376

Implementing statutes: A.R.S. Title 23, Chapter 2, Articles 8 and 8.1

3. The effective date of the rule:

October 3, 2017.

The Industrial Commission of Arizona (the "Commission") requests an immediate effective date under A.R.S. § 41-1032(A)(1) ("[t]o preserve the public peace, health or safety") and (A)(3) ("[t]o comply with deadlines in amendments to an agency's governing statute . . ., if the need for an immediate effective date is not created due to the agency's delay or inaction").

The Commission requests an immediate effective date under A.R.S. § 41-1032(A)(1) ("[t]o preserve the public peace, health or safety") and (A)(3) ("[t]o comply with deadlines in amendments to an agency's governing statute . . ., if the need

for an immediate effective date is not created due to the agency's delay or inaction").Arizona voters approved Proposition 206, the Fair Wages and Healthy Families Act (the "Act"), in November 2016, and the Act's minimum wage and earned paid sick time provisions went into effect on January 1 and July 1, 2017, respectively. In title and substance, the Act concerns the health of Arizona citizens. The Commission anticipates that the proposed rulemaking will facilitate broader employer compliance with the Act, thereby promoting public health. In addition, the Act fundamentally alters the Commission's governing statutes by tasking it with enforcement of the Act's earned paid sick time provisions, effective July 1, 2017. The Commission has worked diligently and transparently to craft rules that add clarity to the Act, ease the burdens of compliance for Arizona employers, and preserve the rights granted to employees by the Act. To assist the Commission in complying with its statutory enforcement obligations and to promote the health of Arizona citizens, the Commission requests an immediate effective date.

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

Notice of Rulemaking Docket Opening: 23 A.A.R. 1047, May 5, 2017

Notice of Proposed Rulemaking: 23 A.A.R. 1019, May 5, 2017

Notice of Supplemental Proposed Rulemaking: 23 A.A.R. 1799, July 7, 2017

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

Name:	Steven Welker
Address:	Industrial Commission of Arizona Labor Department 800 W. Washington St., Suite 303 Phoenix, AZ 85007
Telephone:	(602) 542-4515
Fax:	(602) 542-8097
E-mail:	PublicComments@azica.gov (include "Article 12 Notice of Final Rulemaking" in the subject line)

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

Arizona voters approved the Act in November 2016. The Act established a new state minimum wage effective January 1, 2017, and granted employees earned paid sick time rights effective July 1, 2017. The Act authorizes the Commission to "enforce and implement" both the minimum wage and earned paid sick time provisions and promulgate regulations consistent with the articles. *See* A.R.S. § 23-364(A); A.R.S. Title 23, Chapter 2, Articles 8 and 8.1. In the earned paid sick time context, the Act provides that "[t]he commission shall be authorized to coordinate implementation and enforcement of [Article 8.1, Earned Paid Sick Time] and shall promulgate appropriate guidelines or regulations for such purposes." A.R.S. § 23-376.

Currently, the rules in Article 12—implemented in 2007 after the referendum that created the Arizona Minimum Wage Act—address only those procedures related to the enforcement and implementation of minimum wage law. Because the Commission is now statutorily tasked with implementing, enforcing, and regulating the Act's earned paid sick time provisions, the Commission is proposing to amend existing rules in Article 12 to address matters related to earned paid sick time. *See infra* § 10.

In addition to amendments related to the Act's earned paid sick time provisions, the proposed rulemaking conforms the independent contractor analysis to factors outlined in A.R.S. §§ 23- 902(D) and 23-1601(B); defines "small employer" and exempts "small employers" from the Act's posting requirements; amends R20-5-1209 to conform to current technologies, and includes various non-substantive amendments.

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

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

Not applicable

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

The proposed rulemaking is primarily responsive to the Act, and, as such, creates minimal economic, small business, or consumer impact beyond that already created by the Act. To the extent that the proposed rulemaking creates any impact beyond the Act, the Commission anticipates that the proposed amendments will reduce regulatory burden on employers by aligning Article 12 with current Arizona statutes and providing clarifications that reduce uncertainty for Arizona employers and employees. Among its provisions, the proposed rulemaking includes: (1) definitions (including "employee's regular paycheck," "health care professional," and "smallest increment that the employer's payroll system uses to account for absences or use of other time") that offer clarity for employers and employees and reduce burden; (2) methods for calculating hourly rates of pay for various employee types, reducing the likelihood of disputes between employers and employees; and (3) allowance of front- loading options that exceed the accrual and carry-over requirements in the Act without burdening employers with recordkeeping requirements that provide no benefit to employees. In addition, the proposed rulemaking reduces the regulatory burden on "small employers" by waiving posting requirements pursuant to A.R.S. § 23-364(D) (*see* proposed amendment to R20-5-1208). The proposed amendments will reduce regulatory burden while achieving the Commission's regulatory objectives as prescribed by the Act.

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

The Commission made significant substantive changes to the proposed rulemaking in its Notice of Supplemental Proposed Rulemaking. These changes were primarily prompted by public comments received after the Commission published its May 5, 2017 Notice of Proposed Rulemaking. The Notice of Supplemental Proposed Rulemaking included the following substantive changes:

Generally

- Where necessary, included "equivalent paid time off" when referencing earned paid sick time.

R20-5-1202

- Amended the rule to apply definitions found in the Act to Article 12 and apply the definitions in Article 12 to the Act.
- Added the following definitions:
  - "Amount of earned paid sick time available to the employee";
  - "Amount of earned paid sick time taken by the employee to date in the year";
  - "Amount of pay the employee has received as earned paid sick time";
  - "Employee's regular paycheck";
  - "Equivalent paid time off";
  - "Heath care professional"; and
  - "Smallest increment that the employer's payroll system uses to account for absences or use of other time"
- Amended and reorganized the definition of "same hourly rate," as follows: (1) modified the methods for determining "same hourly rate" to result in hourly rates, not lump sums; (2) added a reference to minimum wage in each method of determining "same hourly rate"; (3) amended the method for determining "same hourly rate" for salaried employees; (4) modified and added an option for determining "same hourly rate" for commission, piece-rate, or fee-for-service employees; and (5) added language to subsection 25(f)(ii) referencing subsection 25(e).

R20-5-1206

- Changed Section title to reference the ability to "front load" earned paid sick time.
- Added subsections (F, G, and H) to address procedures for "front loading" earned paid sick time and the effect of "front loading" on accrual and carry over.
- Amended prior proposed subsection (H) (now subsection [I]) to address: (1) an employer's carry over obligations; (2) an employer's ability to permit greater carry over than that required by the Act: and (3) the impact of carry over on accrual, usage rights, and usage limits.

R20-5-1210

- Added reference in subsection (B) to the collective bargaining agreement exception found in A.R.S. § 23-381.
- Deleted subsections (B)(13) and (B)(14) and replaced with subsections (B)(13) through (B)(16), which: (1) make earned paid sick time recordkeeping requirements consistent with A.R.S. § 23-375's notice requirements; (2) add a requirement to maintain records concerning employees' earned paid sick time balances; and (3) define the phrase "[t]he employee's earned paid sick time balance."
- Amended subsection (C)(1) to reference the changes to subsection (B).

R20-5-1218

- Changed Section title to reference earned paid sick time and equivalent paid time off.

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

The Commission received numerous public and stakeholder comments in response to its May 5, 2017 Notice of Proposed Rulemaking. Based on these comments, the Commission made significant substantive changes to the proposed rules via its July 7, 2017 Notice of Supplemental Proposed Rulemaking. The Notice of Supplemental Rulemaking addressed the majority of the previously-submitted comments and rendered other comments moot. During the public comment period following publication of the Notice of Supplemental Proposed Rulemaking, the Commission received additional comments, only one of which reiterated a comment raised during the initial comment period. The Commission will therefore address those comments submitted after publication of the Notice of Supplemental Proposed Rulemaking.

COMMENT 1: The proposed rules should include language permitting an employer to seek review from the Commission or the Superior Court.

A.A.C. R20-5-1214, R20-5-1215, and R20-5-1216, as currently written, provide Commission and Superior Court review rights. Additional rule changes concerning review rights is unnecessary.

COMMENT 2: Employers should not be required to report the information required by A.R.S. § 23-375(C) on an employee's regular paycheck.

Comment 2 is not responsive to the proposed rulemaking, as it takes issue with the Act's notice requirements. Nevertheless, in an attempt to alleviate employer burden without diminishing employee rights under the Act, the proposed rules define the term "employer's regular paycheck" to include electronic payroll records.

COMMENT 3: The proposed rules should address the intersection of the Act's earned paid sick time provisions and federal laws (including the ADA and the FMLA) and other state laws that extend other protections to employees (including Arizona's workers' compensation laws).
The Act addresses potential conflicts between the Act and federal law in A.R.S. § 23-379, which provides that "[n]othing in this article shall be interpreted or applied so as to create a conflict with federal law." Section 23-379 also provides that the Act's earned paid sick time provisions "shall not be construed to preempt, limit, or otherwise affect the applicability of any other law . . . that extends other protections to employees." The Commission believes these statutory provisions adequately address the intersection of the Act's earned paid sick time provisions and related federal/state law. Although the Commission does not intend to promulgate rules addressing these issues, the Commission may provide additional guidance pursuant to A.R.S. § 23-376.

COMMENT 4: Proposed rule 1206(F) burdens employers by requiring that they track exempt employees' hours worked.
For over a decade, Arizona's administrative rules have required employers to track exempt employees' hours. Pursuant to A.A.C. R20-5-1210(C), employers are required to keep a "record of the hours upon which payment of [an exempt employee's] salary is based." Proposed rule 1206(F) is consistent with existing rules and adds no additional burden. In addition, eliminating this requirement would interfere with the Commission's statutorily- mandated duty to determine whether Arizona employers are complying with minimum wage and earned paid sick time requirements.

COMMENT 5: The proposed rules should require that employers use the higher of a base rate or minimum wage when determining a commissioned employee's hourly rate for earned paid sick time purposes.
The Act provides that earned paid sick time shall be "compensated at the same hourly rate . .
. as the employee normally earns during hours worked." A.R.S. § 23-371. This language is somewhat incongruent in the context of commissioned employees, where employers may not
have already established hourly rates for commissioned employees. To adequately address the treatment of commissioned employees, the proposed rules offer five methods for determining a commissioned employee's hourly rate (which are to be followed in priority order). *See* proposed rule 1202(25)(d). The first method is to use an agreed-upon hourly rate, which can be no less than minimum wage. Per the Commission's guidance, the Commission "will consider an employee-acknowledged policy concerning the hourly rate of pay adequate evidence of an agreement between employee and employer." *See* FREQUENTLY ASKED QUESTIONS (FAQS) ABOUT MINIMUM WAGE AND EARNED PAID SICK TIME (Rev. July 3,
2017) *at* https://www.azica.gov/sites/default/files/media/070317%20FREQUENTLY%_20ASKED%20QUESTIONS_Masterw-TOC%20FINAL.pdf. Where an employer establishes an agreed-upon hourly rate that equals or exceeds minimum wage, and the employer pays the employee this rate for earned paid sick time, the employer will be in compliance with the Act. The proposed rules also provide flexibility in the event that an employer has not established an hourly base rate for commissioned employees. In such cases, the employer may determine a commissioned employee's hourly rate by utilizing the following (in priority order): (1) an hourly rate based on the amount the employee would have earned during the period earned paid sick time is used, if known; (2) an hourly rate based on the employer's reasonable estimation of the amount the employee would have earned during the period of earned paid sick time used; (3) an hourly rate based on the employee's earning over the previous 90 days, if the employee worked regularly during previous 90 days; and (4) an hourly rate based upon the employee's earnings over the previous year. The Commission believes the options outlined in proposed rule 1202(25) will assist employers in determining an accurate rate of pay for commissioned employees who use earned paid sick time, while still permitting employers to establish an hourly rate in the manner the commenter recommended.

COMMENT 6: The proposed rules' earned paid sick time calculation should not include shift differentials and premiums meant to compensate an employee for work performed under differing conditions (such as hazard pay or a shift differential for working at night) because it places undue burdens on employers by requiring different PTO rates and incentivizes the use of earned paid sick time during shifts that are subject to shift differentials or hazard pay.
The Act provides that earned paid sick time shall be "compensated at the same hourly rate . . . as the employee normally earns during hours worked." A.R.S. § 23-371. The Commission considers the inclusion of shift differentials and hazard pay necessary to accurately reflect an employee's hourly rate for earned sick time purposes. While the Commission recognizes that the inclusion of shift differentials and hazard pay may prevent an employer from using a singular hourly rate in the earned paid sick time context, the same burden exists when employers determine rates of pay for hours worked during overtime periods or holidays. The Commission's Notice of Supplemental Proposed Rulemaking qualifies the inclusion of differing condition pay by specifying that it need only be included "if the employee would have been entitled to the shift differential or premium for the period of time in which earned paid sick time or equivalent paid time off is used."

COMMENT 7: The rules should provide that union employers may establish a bank of accumulated earned paid sick time that short-term or itinerant union employees can take from union employer to union employer.
The Act does not contemplate the issue raised in Comment 7 and the proposed concept exceeds the scope of the Commission's authorizing and implementing statutes. The Act specifies that employees hired after July 1, 2017, are not entitled to use accrued earned paid sick time until the ninetieth calendar day after commencing employment (unless the employer permits otherwise). *See* A.R.S. § 23-372. Therefore, the Act already contemplates short-term or itinerant-worker employment and denies these employees access to accrued earned paid sick time before their ninetieth day of employment (unless the employer permits otherwise). Promulgating a rule that obviates this statutory provision by allowing employees to use earned paid sick time within the first 90 days of employment exceeds the Commission's authority. On the other hand, because A.R.S. § 23-381 provides employers subject to a collective bargaining agreement a method for opting out of the Act's earned paid sick time provisions, these employers could elect to opt out and instead adopt an earned paid sick time banking system, consistent with the commenter's requirements.

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

None

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

The amended rules do not require issuance of a regulatory permit or license.

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

Although federal law establishes a baseline for minimum wage, it does not preclude states from adopting a higher minimum wage. Nor does federal law address earned paid sick time. The proposed rule amendments implement Arizona's minimum wage and earned paid sick time provisions and do not implicate federal law.

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

No analysis was submitted.

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

None

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

Not applicable

15. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

ARTICLE 12. ARIZONA MINIMUM WAGE ~~ACT~~ AND EARNED PAID SICK TIME PRACTICE AND PROCEDURE

Section

ARTICLE 12. ARIZONA MINIMUM WAGE ~~ACT~~ AND EARNED PAID SICK TIME PRACTICE AND PROCEDURE

R20-5-1201. Notice of Rules

A. This Article applies to all actions and proceedings before the Industrial Commission of Arizona arising under ~~the Raise the Arizona Minimum Wage for Working Arizonans Act, as added by 2006 Proposition 202, § 2~~ A.R.S. Title 23, Articles 8 and 8.1.

B. The Industrial Commission of Arizona shall provide a copy of this Article upon request to any person free of charge.

R20-5-1202. Definitions

In this Article, the definitions of A.R.S. §§ 23-362 (version two), 23-371, and 23-364 apply. In addition, unless the context otherwise requires, the following definitions shall apply to both the Act and this Article:

1. "Act" means ~~the Raise the Arizona Minimum Wage for Working Arizonans Act, as added by 2006 Proposition 202, § 2~~ A.R.S. Title 23, Chapter 2, Articles 8 and 8.1.
2. "Affected employee" means an employee or employees on whose behalf a complaint may be filed alleging a violation under the Act.
3. "Amount of earned paid sick time available to the employee" means the amount of earned paid sick time or equivalent paid time off that is available to the employee for use in the current year.
4. "Amount of earned paid sick time taken by the employee to date in the year" means the amount of earned paid sick time or equivalent paid time off taken by the employee to date in the current year. Where an employee has used available equivalent paid time off for either the purposes enumerated in A.R.S. § 23-373 or other purposes, the employer may count that usage towards the "amount of earned paid sick time taken by the employee to date in the year."
5. "Amount of pay the employee has received as earned paid sick time" means the amount of pay the employee has received as earned paid sick time or equivalent paid time off to date in the current year. Where an employee has received pay for equivalent

paid time off for the purposes enumerated in A.R.S. § 23-373 or other purposes, the employer may count that pay towards the "amount of pay the employee has received as earned paid sick time."

~~3.~~ 6. "Authorized representative" means a person prescribed by law to act on behalf of a party who files with the Department a written instrument advising of the person's authority to act on behalf of the party.

~~4.~~ 7. "Casual Basis," when applied to babysitting services, means employment which is irregular or intermittent.

~~5.~~ 8. "Commission" means monetary compensation based on:

a. A percentage of total sales,

b. A percentage of sales in excess of a specified amount,

c. A fixed allowance per unit, or

d. Some other formula the employer and employee agree to as a measure of accomplishment.

9. "Communicable disease" has the meaning prescribed by A.R.S. § 36-661.

~~6.~~ 10. "Complainant" means a person or organization filing an administrative complaint under the Act.

~~7.~~ 11. "Department" means the Labor Department of the Industrial Commission of Arizona or other authorized division of the Industrial Commission as designated bythe Industrial Commission.

12. "Earned sick time" under A.R.S. § 23-364(G) means earned paid sick time.

13. "Employee's regular paycheck" means a regular payroll record that is readily available to employees and contains the information required by A.R.S. § 23-375(C), including physical or electronic paychecks or paystubs.

14. "Equivalent paid time off" means paid time off provided under a paid leave policy, such as a paid time off policy, that makes available an amount of paid leave sufficient to meet the accrual requirements of the Act that may be used for the same purposes and under the same conditions as earned paid sick time.

~~8.~~ 15. "Filing" means receipt of a report, document, instrument, videotape, audiotape, or other written matter at an office of the Department.

16. The term "heath care professional" in A.R.S. § 23-373(G) has the same meaning as "health care professional," as defined in this Section.

17. "Health care professional" means any of the following:

a. A "physician" as defined by A.R.S. § 36-2351;

b. A "physician assistant" as defined by A.R.S. § 32-2501;

c. A "registered nurse practitioner" as defined by A.R.S. § 32- 1601.

d. A certified nurse midwife who is a registered nurse practitioner approved by the Arizona State Board of Nursing to provide primary care services during pregnancy, childbirth, and the postpartum period;

e. A dentist licensed under A.R.S. Title 32, Chapter 11, Article 2; or

f. A behavioral health provider practicing as:

i. A psychologist licensed under A.R.S. Title 32, Chapter 19.1;

ii. A clinical social worker licensed under A.R.S. § 32- 3293;

iii. A marriage and family therapist licensed under A.R.S. § 32-3311; or

iv. A professional counselor licensed under A.R.S. § 32- 3301.

18. "Health care provider" has the meaning prescribed by A.R.S. § 36-661.

~~9.~~ 19. "Hours worked" means all hours for which an employee covered under the Act is employed and required to give to the employer, including all time during which an employee is on duty or at a prescribed work place and all time the employee is suffered or permitted to work.

~~10.~~ 20. "Minimum wage" means the lowest rate of monetary compensation required under the Act.

~~11.~~ 21. "Monetary compensation" means cash or its equivalent due to an employee by reason of employment.

~~12.~~ 22. "On duty" means time spent working or waiting that the employer controls and that the employee is not permitted to use for the employee's own purpose.

23. "Public benefits" has the same meaning as "state or local public benefit," as prescribed by A.R.S. § 1-502(I).

24. "Public health emergency" means a state of emergency declared by the governor in which there is an occurrence or imminent threat of an illness or health condition caused by bioterrorism, an epidemic or pandemic disease or a highly fatal infectious agent or biological toxin and that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability.

25. "Same hourly rate" means the following:

a. For employees paid on the basis of a single hourly rate, "same hourly rate" shall be the hourly rate the employee would have earned for the period of time in which earned paid sick time or equivalent paid time off is used, but shall in no case be less than minimum wage.

b. For employees who are paid multiple hourly rates of pay, "same hourly rate" shall be determined in the following order of priority, but shall in no case be less than minimum wage:

i. The hourly rate the employee would have earned, if known, for each hour of earned paid sick time or equivalent paid time off used.

ii. The weighted average of all hourly rates of pay during the previous pay period.

c. For employees who are paid a salary, no additional pay is due when the employee's use of earned paid sick time or equivalent paid time off results in no reduction in the employee's regular salary during the pay period in which the earned paid sick time or equivalent paid time off is used. "Same hourly rate" for salaried employees shall be determined in the following order of priority, but shall in no case be less than minimum wage:

i. The wages an employee earns during each pay period covered by the salary divided by the number of hours agreed to be worked during each pay period, if the number of hours to be worked during each pay period was previously established.

ii. The wages an employee earns during each workweek covered by the salary in the current year divided by 40 hours.

d. For employees paid on a commission, piece-rate, or fee-for-service basis, "same hourly rate" shall be determined in the following order of priority, but shall in no case be less than minimum wage:

i. The hourly rate of pay previously agreed upon by the employer and the employee as: (1) a minimum hourly rate for work performed; or (2) an hourly rate for payment of earned paid sick time or equivalent paid time off.

ii. The wages that the employee would have been paid, if known, for the period of time in which earned paid sick time or equivalent paid time off is used, divided by the number of hours of earned paid sick time or equivalent paid time off used.

iii. A reasonable estimation of the commission, piece-rate, or fee-for-service compensation that the employee would have been paid for the period of time in which the earned paid sick time or equivalent paid time off is used, divided by the number of hours of earned paid sick time or equivalent paid time off used.

iv. The hourly average of all commission, piece- rate, or fee-for-service compensation that the employee earned during the previous 90 days, if the employee worked regularly during the previous 90-day period, based on: (1) hours that the employee actually worked; or (2) a 40-hour workweek.

v. The hourly average of all commission, piece- rate, or fee-for-service compensation that the employee earned during the previous 365 days, based on: (1) hours that the employee actually worked; or (2) a 40-hour workweek.

e. "Same hourly rate" includes shift differentials and premiums meant to compensate an employee for work performed under differing conditions (such as hazard pay or a shift differential for working at night) if the employee would have been entitled to the shift differential or premium for the period of time in which earned paid sick time or equivalent paid time off is used.

f. "Same hourly rate" does not include:

i. Additions to an employee's base rate for overtime or holiday pay;

ii. Subject to subsection (e), bonuses or other types of incentive pay; and

iii. Tips or gifts.

26. "Smallest increment that the employer's payroll system uses to account for absences or use of other time" means the smallest increment of time that an employer utilizes, by policy or practice, to account for absences or use of other paid time off.

~~13.~~27. "Tip" means a sum that a customer presents as a gift in recognition of some service performed, and includes gratuities. The sum may be in the form of cash, amounts paid by bank check or other negotiable instrument payable at par, or amounts the employer transfers to the employee under directions from a credit customer who designates an amount to be added to a bill as a tip. Gifts in forms other than cash or its equivalent as described in this definition, ~~including theater~~ such as event tickets, passes, or merchandise, are not tips.

~~14.~~28. "Violation" means a transgression of any statute or rule, or any part of a statute or rule, including both acts and omissions.

~~15.~~29. "Willfully" means acting with actual knowledge of therequirements of the Act or this Article, or acting with reckless disregard of the requirements of the Act or this Article.

~~16.~~30. "Workday" means any fixed period of 24 consecutive hours.

~~17.~~31. "Workweek" means any fixed and regularly recurring period of seven consecutive workdays.

R20-5-1205. Determination of Employment Relationship

A. Determination of an employment relationship under the Act, which includes whether an individual is an independent contractor, shall be based upon the economic realities of the relationship. Consideration of whether an individual is economically dependent on the employer for which the individual performs work shall be determined by factors showing dependence, which non-exclusive factors shall include~~:~~ those factors identified in A.R.S. §§ 23-902(D) and 23-1601(B).

~~1. The degree of control the alleged employer exercises over the individual,~~

~~2. The individual's opportunity for profit or loss and the individual's investment in the business,~~

~~3. The degree of skill required to perform the work,~~

~~4. The permanence of the working relationship, and~~

~~5. The extent to which the work performed is an integral part of the alleged employer's business.~~

B. An individual ~~that~~ who works for another person without any express or implied compensation agreement is not an employee under the Act. This may include an individual that volunteers to work for civic, charitable, or humanitarian reasons that are offered freely and without direct or implied pressure or coercion from an employer, provided that the volunteer is not otherwise employed by the employer to perform the same type of services as those which the individual proposes to volunteer.

C. An individual ~~that~~ who works for another individual as a babysitter on a casual basis and whose vocation is not babysitting, is not an employee under the Act even if the individual performs other household work not related to caring for the children, provided the household work does not exceed 20% of the total hours worked on the particular babysitting assignment.

R20-5-1206. Payment of Minimum Wage; Commissions; Tips; Front Loading Earned Paid Sick Time; Limitation on Carry Over of Unused Earned Paid Sick Time

A. Subject to the requirements of the Act and this Article, no less than the minimum wage shall be paid for all hours worked, regardless of the frequency of payment and regardless of whether the wage is paid on an hourly, salaried, commissioned, piece rate, or any other basis.

B. If the combined wages of an employee are less than the applicable minimum wage for a work week, the employer shall pay monetary compensation already earned, and no less than the difference between the amounts earned and the minimum wage as required under the Act.

C. The workweek is the basis for determining an employee's hourly wage. Upon hire, an employer shall advise the employee of the employee's designated workweek. Once established, an employer shall not change or manipulate an employee's workweek to evade the requirements of the Act.

D. In computing the minimum wage, an employer shall consider only monetary compensation and shall count tips and commissions in the workweek in which the tip or commission is earned.

E. An employer is allowed to:

1. Require or permit employees to pool, share, or split tips; and
2. Require an employee to report tips to the employer in order to meet reporting requirements of this Article and federal law.

F. An employer who hires an employee after the beginning of the employer's year is not required to provide additional earned paid sick time or equivalent paid time off during that year if the employer provides the employee for immediate use on the employee's ninetieth calendar day after commencing employment an amount of earned paid sick time or equivalent paid time off that meets or exceeds the employer's reasonable projection of the amount of earned paid sick time or equivalent paid time off that the employee would have accrued from the date of hire through the end of the employer's year at a rate of one hour for every 30 hours worked. If the amount of earned paid sick time or equivalent paid time off provided is less than the employee would have accrued based on hours actually worked during the employer's year, the employer shall immediately provide an amount of earned paid sick time or equivalent paid time off that reflects the difference between the employer's projection and the amount of earned paid sick time or equivalent paid time off that the employee would have accrued for hours actually worked in the year.

G. Subject to subsection (F), an employer with 15 or more employees that provides its employees for immediate use at the beginning of each year 40 or more hours of earned paid sick time or 40 or more hours of equivalent paid time off is not required to provide carryover or additional accrual.

H. Subject to subsection (F), an employer with fewer than 15 employees that provides its employees for immediate use at the beginning of each year 24 or more hours of earned paid sick time or 24 or more hours of equivalent paid time off is not required to provide carryover or additional accrual.

I. Unless an employer: (1) elects to pay an employee for unused earned paid sick time or equivalent paid time off at the end of a year pursuant to A.R.S. § 23-372(D)(4); or (2) meets the requirements of subsections (G) or (H), unused earned paid sick time and equivalent paid time off may be carried over to the next year, as follows:

1. Subject to an employer's entitlement to permit greater carry over, an employee of an employer with 15 or more employees may carry over to the following year up to 40 hours of unused earned paid sick time or equivalent paid time off.
2. Subject to an employer's entitlement to permit greater carry over, an employee of an employer with fewer than 15 employees may carryover to the following year up to 24 hours of unused earned paid sick time or equivalent paid time off.
3. Carry over shall not affect accrual, usage rights, or usage limits under the Act.

R20-5-1208. Posting Requirements; Small Employer Exemption

A. ~~Every~~With the exception of small employers, every employer subject to the Act shall place ~~a poster~~ the posters prescribed by the Department informing employees of their rights under the Act in a conspicuous place in every establishment where employees are employed and where notices to employees are customarily placed. The employer shall ensure that the ~~notice is~~ notices are not removed, altered, defaced, or covered by other material.

B. In this Section, unless context otherwise requires, "small employer" means a corporation, proprietorship, partnership, joint venture, limited liability company, trust, or association that has less than $500,000 in gross annual revenue.

R20-5-1209. Records Availability

A. Each employer shall keep the records required under the Act and this Article safe and accessible at the place or places of employment, or at one or more established central recordkeeping offices where the records are customarily maintained. When the employer maintains the records at a central recordkeeping office other than in the place or places of employment, the employer shall make the records available to the Department within 72 hours following notice from the Department.

B. Employers ~~who use microfilm or another method for recordkeeping purposes~~ shall make available to the Department any equipment or technology that is necessary to facilitate inspection and copying of the records.

C. Each employer required to maintain records under the Act shall make enlargement, recomputation, or transcription of the records and shall submit to the Department the records or reports in a readable format upon the Department's written request.

R20-5-1210. General Recordkeeping Requirements

A. Payroll records required to be kept under the Act include:

1. All time and earning cards or sheets on which are entered the daily starting and stopping time of individual employees, or of separate work forces, or the amounts of work accomplished by individual employees on a daily, weekly, or pay period basis (for example, units produced) when those amounts determine in whole or in part; (1) those employees' ~~the~~ pay period wages; and (2) those employees' earned paid sick time or equivalent paid time off ~~of those employees~~;
2. From their last effective date, all wage-rate tables or schedules of the employer that provide the piece rates or other rates used in computing wages; and
3. Records of additions to or deductions from wages paid and records that support or corroborate the additions or deductions.

B. Subject to A.R.S. § 23-381 and ~~Except~~ except as otherwise provided in this Section, every employer shall maintain and preserve payroll or other records containing the following information and data with respect to each employee to whom the Act applies:
1. Name in full, and on the same record, the employee's identifying symbol or number if it is used in place of the employee's name on any time, work, or payroll record;
2. Home address, including zip code;
3. Date of birth, if under 19;
4. Occupation in which employed;
5. Time of day and day of week on which the employee's workweek begins. If the employee is part of a workforce or employed in or by an establishment all of whose workers have a workweek beginning at the same time on the same day, then a single notation of the time of the day and beginning day of the workweek for the whole workforce or establishment is permitted;
6. Regular hourly rate of pay for any workweek and an explanation of the basis of pay by indicating the monetary amount paid on a per hour, per day, per week, per piece, commission on sales, or other basis, including the amount and nature of each payment;
7. Hours worked each workday and total hours worked each workweek;
8. Total daily or weekly straight-time wages due for hours worked during the workday or workweek, exclusive of premium overtime compensation;
9. Total premium pay for overtime hours and an explanation of how the premium pay was calculated exclusive of straight-time wages for overtime hours recorded under subsection (B)(8) of this Section;
10. Total additions to or deductions from wages paid each pay period including employee purchase orders or wage assignments, including, for individual employee records, the dates, amounts, and nature of the items that make up the total additions and deductions;
11. Total wages paid each pay period; ~~and~~
12. Date of payment and the pay period covered by payment.;
13. The amount of earned paid sick time available to the employee;
14. The amount of earned paid sick time taken by the employee to date in the year;
15. The amount of pay the employee has received as earned paid sick time; and
16. The employee's earned paid sick time balance. "The employee's earned paid sick time balance" means the sum of earned paid sick time or equivalent paid time off that is: (1) carried over to the current year; (2) accrued to date in the current year; and (3) provided to date in the current year pursuant to A.R.S. § 23-372(D)(4) or A.A.C. R20-5-1206(F), (G), or (H).

C. For an employee who is compensated on a salary basis at a rate that exceeds the minimum wage required under the Act and who, under 29 CFR 541, is an exempt bona fide executive, administrative, or professional employee, including an employee employed in the capacity of academic administrative personnel or teachers in elementary or secondary schools, or in outside sales, an employer shall maintain and preserve:
1. Records containing the information and data required under subsections (B)(1) through (B)(5), ~~(B)(11)~~ and (B)(11) through (B)(~~12~~16) of this Section; and
2. Records containing the basis on which wages are paid in sufficient detail to permit a determination or calculation of whether the salary received exceeds the minimum wage required under the Act, including a record of the hours upon which payment of the salary is based, whether full time or part time.

D. With respect to employees working on fixed schedules, an employer may maintain records showing instead of the hours worked each day and each workweek as required under this Section, the schedule of daily and weekly hours the employee normally works, provided:
1. In weeks in which an employee adheres to this schedule, the employer indicates by check mark, statement, or other method, that the employee actually worked the hours; and
2. In weeks in which more or fewer than the scheduled hours are worked, the employer records the number of hours actually worked each day and each week.

E. With respect to an employee who customarily and regularly receives tips, the employer shall ensure that the records required under this Article include the following information:
1. A symbol, letter, or other notation placed on the pay records identifying each employee whose wage is determined in part by tips;
2. Amount of tips the employee reports to the employer;
3. The hourly wage of each tipped employee after taking into consideration the employee's tips;
4. Hours worked each workday in any occupation in which the employee does not receive tips, and total daily or week straight-time payment made by the employer for the hours;
5. Hours worked each workday in occupations in which the employee receives tips and total daily or weekly straight-time wages for the hours; and
6. Copy of the notice required under R20-5-1207(C).

F. An employer who makes retroactive payment of wages, voluntarily or involuntarily, shall record on the pay records, the amount of the payment to each employee, the period covered by the payment, and the date of payment.

R20-5-1211. Administrative Complaints

A. A person or organization alleging a minimum wage, earned paid sick time, or equivalent paid time off violation shall file a complaint with the Labor Department within one year from the date the wages, earned paid sick time, or equivalent paid time off were due.

B. A person or organization alleging retaliation, discrimination, or a violation of A.R.S. § 23-377 shall file a complaint with the Labor Department within one year from the date the alleged violation occurred or when the employee knew or should have known of the alleged violation.
C. The person or organization filing a complaint with the Labor Department shall sign the complaint.
D. Any person or organization other than an affected employee who files a complaint shall include the names of affected employees.
E. ~~For good cause, and upon~~ Upon its own complaint, the Department may investigate violations under the Act.

R20-5-1213. Findings and Order Issued by the Department

A. Except as provided in R20-5-1219, after receipt of a complaint alleging a violation of the ~~minimum wage requirement of the Act, or alleging retaliation under the~~ Act, the Department shall issue a Findings and Order of its determination. The Department shall send its Findings and Order to both the employer and the complainant at their last known addresses served personally or by regular first class mail. If the complaint named affected employees, the Department may send a copy of its Findings and Order to the affected employees.
B. If the Department determines that an employer has violated the minimum wage, earned paid sick time, or equivalent paid time off ~~payment requirement~~ requirements, the Department shall order the employer to pay the employee, and if applicable, affected employees, the balance of the wages, earned paid sick time, or equivalent paid time off owed, including interest at the legal rate and an additional amount equal to twice the underpaid wages, earned paid sick time, or equivalent paid time off owed.
C. If the Department determines that a retaliation, discrimination, confidentiality, or nondisclosure violation has occurred, the Department shall direct the employer or other person to cease and desist from the violation and may take action necessary to remedy the violation, including:
1. Rehiring or reinstatement,
2. Reimbursement of lost wages and interest,
3. Payment of penalty to employees or affected employees as provided for in the Act and this Article, and
4. Posting of notices to employees.

D. If the Department determines that no ~~retaliation~~ violation of the Act has occurred the Department shall notify the parties and shall dismiss the complaint without prejudice. After notification of the Department's determination, the complainant may bring a civil action under A.R.S. § 23- 364(E).
E. The Department may assess civil penalties for recordkeeping, posting, and other violations under the Act and this Article as part of a Findings and Order issued under subsection (A) or the civil penalties and other violations may be assessed as a separate Findings and Order. If issued as a separate Findings and Order, the Department shall serve, personally or by regular first class mail, the Findings and Order on the employer and, if a complaint has been filed, the complainant.
F. The Director of the Department shall sign the written Findings and Order issued by the Department.
G. If an employer does not comply with a Findings and Order issued by the Department within 10 days following finality of the Findings and Order, the Department may refer the matter to a law enforcement officer.

R20-5-1218. Collection of Wages, Earned Paid Sick Time, Equivalent Paid Time Off, or Penalty Payments Owed

A. Upon determination that wages, earned paid sick time, equivalent paid time off, or penalty payments are due and unpaid to any employee, the employee may, or the Department may on behalf of an employee, obtain judgment and execution, garnishment, attachment, or other available remedies for collection of unpaid wages and penalty payments established by a final Findings and Order of the Department.
B. If payment cannot be made to the employee, the Department shall receive monetary compensation or penalty payments on behalf of the employee and transmit monies it receives as payment in a special state fund as provided in A.R.S. § 23-356(C).
C. The Department may amend a Findings and Order to conform to the legal name of the business or the person who is the defendant employer to a complaint under the Act, provided service of the Findings and Order was made on the defendant or the defendant's agent. If a judgment has been entered on the order, the Department may apply to the clerk of the superior court to amend a judgment that has been issued under a final order, provided service was made on the defendant or the defendant's agent.