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Arizona Administrative Register
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From the Publisher

ABOUT THIS PUBLICATION

The authenticated pdf of the *Administrative Register* (A.A.R.) posted on the Arizona Secretary of State's website is the official published version for rulemaking activity in the state of Arizona.

Rulemaking is defined in Arizona Revised Statutes known as the Arizona Administrative Procedure Act (APA), A.R.S. Title 41, Chapter 6, Articles 1 through 10.

The *Register* is cited by volume and page number. Volumes are published by calendar year with issues published weekly. Page numbering continues in each weekly issue.

In addition, the *Register* contains notices of rules terminated by the agency and rules that have expired.

ABOUT RULES

Rules can be: made (all new text); amended (rules on file, changing text); repealed (removing text); or renumbered (moving rules to a different Section number). Rulemaking activity published in the *Register* includes: proposed, final, emergency, expedited, and exempt rules as defined in the APA, and other state statutes.

New rules in this publication (whether proposed or made) are denoted with underlining; repealed text is stricken.

WHERE IS A "CLEAN" COPY OF THE FINAL OR EXEMPT RULE PUBLISHED IN THE *REGISTER*?

The *Arizona Administrative Code* (A.A.C) contains the codified text of rules. The A.A.C. contains rules promulgated and filed by state agencies that have been approved by the Attorney General or the Governor's Regulatory Review Council. The *Code* also contains rules exempt from the rulemaking process.

The authenticated pdf of *Code* Chapters posted on the Arizona Secretary of State's website are the official published version of rules in the A.A.C. The *Code* is posted online for free.

LEGAL CITATIONS AND FILING NUMBERS

On the cover: Each agency is assigned a Chapter in the *Arizona Administrative Code* under a specific Title. Titles represent broad subject areas. The Title number is listed first; with the acronym A.A.C., which stands for the *Arizona Administrative Code*; following the Chapter number and Agency name, then program name. For example, the Secretary of State has rules on rulemaking in Title 1, Chapter 1 of the *Arizona Administrative Code*. The citation for this Chapter is 1 A.A.C. 1, Secretary of State, Rules and Rulemaking. Every document filed in the office is assigned a file number. This number, enclosed in brackets, is located at the top right of the published documents in the *Register*. The original filed document is available for 10 cents a page.

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ADMINISTRATIVE REGISTER
This publication is available online for free at www.azsos.gov.

ADMINISTRATIVE CODE
The *Arizona Administrative Code* is available online at www.azsos.gov.

PUBLICATION DEADLINES
Publication dates are published in the back of the *Register.* These dates include file submittal dates with a three-week turnaround from filing to published document.

CONTACT US
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Participate in the Process

Look for the Agency Notice

Review (inspect) notices published in the *Arizona Administrative Register.* Many agencies maintain stakeholder lists and would be glad to inform you when they proposed changes to rules. Check an agency's website and its newsletters for news about notices and meetings.

Feel like a change should be made to a rule and an agency has not proposed changes? You can petition an agency to make, amend, or repeal a rule. The agency must respond to the petition. (See A.R.S. § 41-1033)

Attend a public hearing/meeting

Attend a public meeting that is being conducted by the agency on a Notice of Proposed Rulemaking. Public meetings may be listed in the Preamble of a Notice of Proposed Rulemaking or they may be published separately in the *Register*. Be prepared to speak, attend the meeting, and make an oral comment.

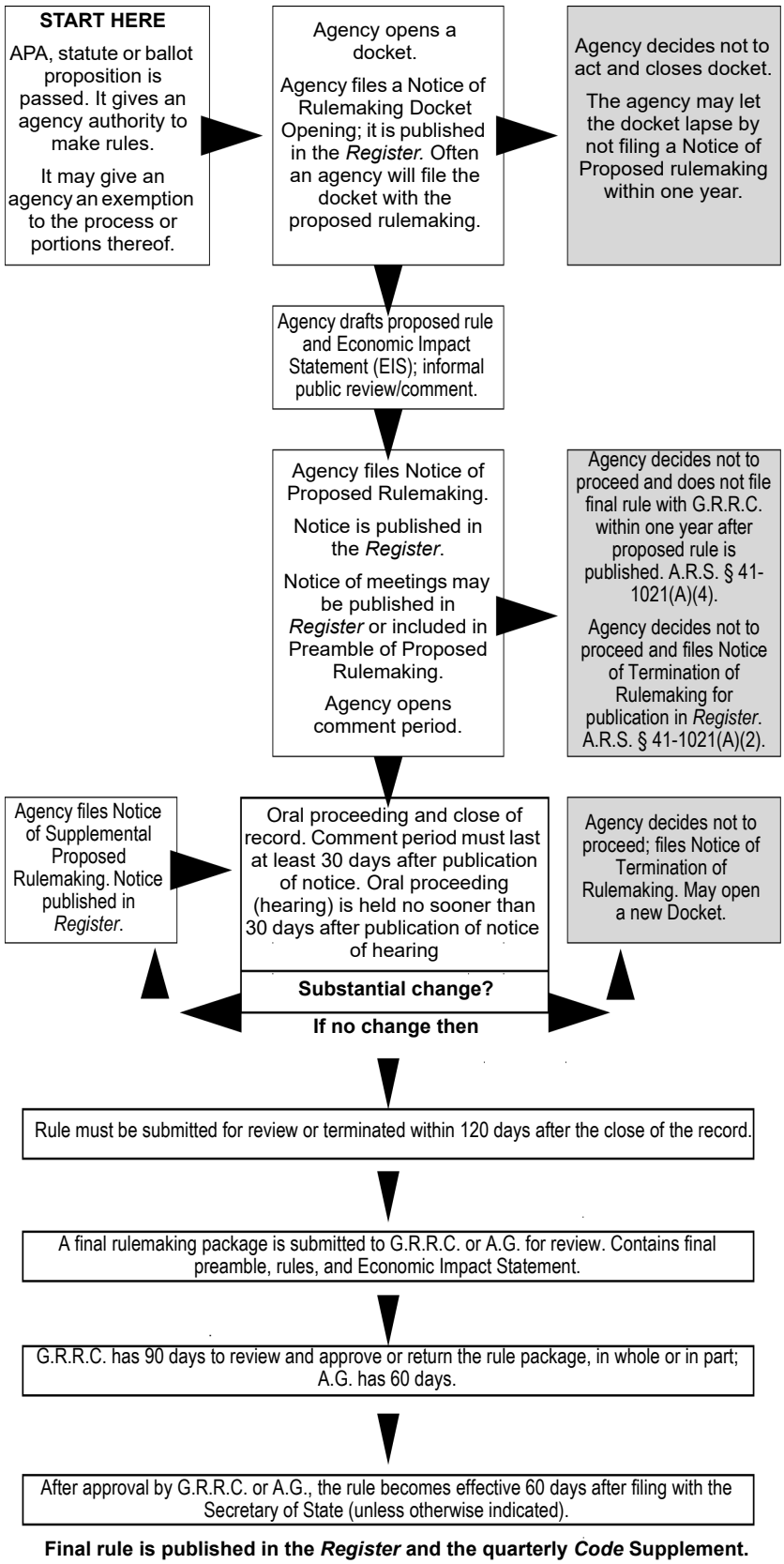
An agency may not have a public meeting scheduled on the Notice of Proposed Rulemaking. If not, you may request that the agency schedule a proceeding. This request must be put in writing within 30 days after the published Notice of Proposed Rulemaking.

Write the agency

Put your comments in writing to the agency. In order for the agency to consider your comments, the agency must receive them by the close of record. The comment must be received within the 30-day comment timeframe following the *Register* publication of the Notice of Proposed Rulemaking.

You can also submit to the Governor's Regulatory Review Council written comments that are relevant to the Council's power to review a given rule (A.R.S. § 41-1052). The Council reviews the rule at the end of the rulemaking process and before the rules are filed with the Secretary of State.

Arizona Regular Rulemaking Process



Final rule is published in the *Register* and the quarterly *Code* Supplement.

Definitions

***Arizona Administrative Code* (A.A.C.):** Official rules codified and published by the Secretary of State's Office. Available online at www.azsos.gov.

***Arizona Administrative Register* (A.A.R.):** The official publication that includes filed documents pertaining to Arizona rulemaking. Available online at www.azsos.gov.

Administrative Procedure Act (APA): A.R.S. Title 41, Chapter 6, Articles 1 through 10. Available online at www.azleg.gov.

Arizona Revised Statutes (A.R.S.): The statutes are made by the Arizona State Legislature during a legislative session. They are complied by Legislative Council, with the official publication codified by Thomson West. Citations to statutes include Titles which represent broad subject areas. The Title number is followed by the Section number. For example, A.R.S. § 41-1001 is the definitions Section of Title 41 of the Arizona Administrative Procedures Act. The "§" symbol simply means "section." Available online at www.azleg.gov.

Chapter: A division in the codification of the *Code* designating a state agency or, for a large agency, a major program.

Close of Record: The close of the public record for a proposed rulemaking is the date an agency chooses as the last date it will accept public comments, either written or oral.

Code of Federal Regulations (CFR): The *Code of Federal Regulations* is a codification of the general and permanent rules published in the *Federal Register* by the executive departments and agencies of the federal government.

Docket: A public file for each rulemaking containing materials related to the proceedings of that rulemaking. The docket file is established and maintained by an agency from the time it begins to consider making a rule until the rulemaking is finished. The agency provides public notice of the docket by filing a Notice of Rulemaking Docket Opening with the Office for publication in the *Register*.

Economic, Small Business, and Consumer Impact Statement (EIS): The EIS identifies the impact of the rule on private and public employment, on small businesses, and on consumers. It includes an analysis of the probable costs and benefits of the rule. An agency includes a brief summary of the EIS in its preamble. The EIS is not published in the *Register* but is available from the agency promulgating the rule. The EIS is also filed with the rulemaking package.

Governor's Regulatory Review (G.R.R.C.): Reviews and approves rules to ensure that they are necessary and to avoid unnecessary duplication and adverse impact on the public. G.R.R.C. also assesses whether the rules are clear, concise, understandable, legal, consistent with legislative intent, and whether the benefits of a rule outweigh the cost.

Incorporated by Reference: An agency may incorporate by reference standards or other publications. These standards are available from the state agency with references on where to order the standard or review it online.

Federal Register (FR): The *Federal Register* is a legal newspaper published every business day by the National Archives and Records Administration (NARA). It contains federal agency regulations; proposed rules and notices; and executive orders, proclamations, and other presidential documents.

Session Laws or "Laws": When an agency references a law that has not yet been codified into the Arizona Revised Statutes, use the word "Laws" is followed by the year the law was passed by the Legislature, followed by the Chapter number using the abbreviation "Ch.", and the specific Section number using the Section symbol (§). For example, Laws 1995, Ch. 6, § 2. Session laws are available at www.azleg.gov.

United States Code (U.S.C.): The Code is a consolidation and codification by subject matter of the general and permanent laws of the United States. The Code does not include regulations issued by executive branch agencies, decisions of the federal courts, treaties, or laws enacted by state or local governments.

Acronyms

A.A.C. – *Arizona Administrative Code*

A.A.R. – *Arizona Administrative Register*

APA – Administrative Procedure Act

A.R.S. – Arizona Revised Statutes

CFR – *Code of Federal Regulations*

EIS – Economic, Small Business, and Consumer Impact Statement

FR – *Federal Register*

G.R.R.C. – Governor's Regulatory Review Council

U.S.C. – *United States Code*

About Preambles

The Preamble is the part of a rulemaking package that contains information about the rulemaking and provides agency justification and regulatory intent.

It includes reference to the specific statutes authorizing the agency to make the rule, an explanation of the rule, reasons for proposing the rule, and the preliminary Economic Impact Statement.

The information in the Preamble differs between rulemaking notices used and the stage of the rulemaking.

NOTICES OF PROPOSED RULEMAKING

This section of the *Arizona Administrative Register* contains Notices of Proposed Rulemaking.

A proposed rulemaking is filed by an agency upon completion and submittal of a Notice of Rulemaking Docket Opening. Often these two documents are filed at the same time and published in the same *Register* issue.

When an agency files a Notice of Proposed Rulemaking under the Administrative Procedure Act (APA), the notice is published in the *Register* within three weeks of filing. See the publication schedule in the back of each issue of the *Register* for more information.

Under the APA, an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule (A.R.S. §§ 41-1013 and 41-1022).

The Office of the Secretary of State is the filing office and publisher of these rules. Questions about the interpretation of the proposed rules should be addressed to the agency that promulgated the rules. Refer to item #4 below to contact the person charged with the rulemaking and item #10 for the close of record and information related to public hearings and oral comments.

NOTICE OF PROPOSED RULEMAKING

TITLE 18. ENVIRONMENTAL QUALITY

CHAPTER 2. DEPARTMENT OF ENVIRONMENTAL QUALITY AIR POLLUTION CONTROL

[R25-208]

PREAMBLE

1. Permission to proceed with this proposed rulemaking was granted under A.R.S. § 41-1039 by the governor on:

May 1, 2024

2. Article, Part, or Section Affected (as applicable)	**Rulemaking Action**
R18-2-B1301	Amend
R18-2-B1301.01	Amend
R18-2-B1302	Amend
A14. Appendix 14	Amend

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

Authorizing statute: A.R.S. §§ 49-104(A)(1) and (A)(10), 49-404(A), and 49-406.

Implementing statute: A.R.S. § 49-425(A).

4. Citations to all related notices published in the *Register* that pertain to the current record of the proposed rule:

Notice of Rulemaking Docket Opening: 31 A.A.R. 2256; Issue Date: July 4, 2025; Issue Number: 27; File Number: R25-146.

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

Name:	Lexi Ahmad
Title:	Environmental Legal Specialist II
Division:	Air Quality Division
Address:	Arizona Department of Environmental Quality 1110 W. Washington St. Phoenix, AZ 85007
Telephone:	(602) 771-4149
Email:	airplanning@azdeq.gov
Website:	https://azdeq.gov/

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

Summary.

This Arizona Department of Environmental Quality (ADEQ) is proposing to amend Arizona Administrative Code (A.A.C.) Title 18, Chapter 2, Article 13, R18-2-B1301, R18-2-B1301.01, and R18-2-B1302 to incorporate the Title V permit terms for the Hayden Smelter that forms the basis for the controls at the facility for the lead (Pb) and sulfur dioxide (SO_2) National Ambient Air

Quality Standards (NAAQS). The current site-specific rules establishing limits on Pb and SO_2 emissions from the Hayden Smelter do not include key permit terms set forth in the revised permits. Codifying these permit conditions into state rule will facilitate EPA approval of both of the Pb and SO_2 state implementation plan (SIP) revisions.

Background.

In September 2014, EPA redesignated the Hayden Pb area from "unclassifiable" to "nonattainment" for the 2008 primary NAAQS (79 FR 52205 (Sept. 3, 2014)). On March 3, 2017 ADEQ submitted a SIP revision to demonstrate attainment of the 2008 Lead NAAQS by the statutory attainment date of October 3, 2019. EPA approved the plan and associated control measures in 2018. On January 31, 2022, EPA published a finding of failure to attain the 2008 Pb NAAQS by the October 3, 2019 attainment date (83 FR 7614 (February 22, 2018), 83 FR 56734 (November 14, 2018), and 83 FR 56736 (November 14, 2018)). ADEQ subsequently submitted a Pb nonattainment SIP revision in September, 2024.

In 2017, ADEQ submitted the Final SIP Revision: 2017 Hayden Sulfur Dioxide Nonattainment Area for the 2010 SO_2 NAAQS.

In 2020, EPA issued both a limited approval/limited disapproval (85 FR 70483 (Nov. 5, 2020)) and a partial approval/partial disapproval (85 FR 71547 (Nov. 10, 2020)) of the 2017 SIP revision. These actions triggered an 18-month sanctions clock for the area for the imposition of 2:1 emissions offset sanction for SO_2 (imposed May 2022); 6 months later (November 2022), EPA imposed highway funding sanctions that apply to the approval by the Secretary of Transportation of any projects or the awarding by the Secretary of any grants, under Title 23, U.S. Code. *See* CAA § 179. In January 2022, EPA found that the Hayden SO_2 nonattainment area failed to attain the 2010 1-hour SO_2 primary NAAQS by the applicable attainment date of October 4, 2018 (87 FR 4805 (Jan. 31, 2022)). ADEQ subsequently submitted the Final SIP Revision: 2023 Hayden Sulfur Dioxide Nonattainment Area for the 1971 and 2010 SO_2 NAAQS in October, 2023.

ADEQ is committed to securing EPA's approval of both the Pb and SO_2 SIP revisions in order to protect human health and the environment, and to also lift sanctions on the Hayden SO_2 nonattainment area. Previously, ADEQ relied on interpretation of A.A.C. R18-2-306.01 to allow permitted facilities to adopt voluntary limits in order to ensure compliance with a NAAQS, regional haze program, or other purpose under the Clean Air Act (CAA). Subsequently, ADEQ incorporated these voluntary limits as enforceable permit conditions for Pb and SO_2 and submitted the permits to the EPA for inclusion into the Arizona SIP. However, based on the specific language of A.A.C. R18-2-306.01, EPA recently informed ADEQ that it would no longer be accepting ADEQ's interpretation of the rule. Therefore, ADEQ commenced a rulemaking (30 A.A.R. 3365 (Nov. 15, 2024)) to address EPA's concern with the voluntary limits. ADEQ does not anticipate this rulemaking will be complete, and approved by EPA, within the timeframe necessary to obtain approval of both the Hayden Pb and SO_2 SIP revisions. Therefore, ADEQ is incorporating ASARCO's current permit conditions into the A.A.C. to bolster the approvability of the subsequent Pb and SO_2 SIP revisions.

The Hayden Smelter, located in Hayden, AZ, which is owned and operated by ASARCO, is the only facility impacted by the permitting conditions being codified into state rule. ASARCO was involved throughout the development of such permit conditions and is already required to comply with them. Through discussions with both ADEQ and EPA, ASARCO became aware that codification of the permitting conditions would likely become necessary. Codification is only intended to address the EPA's concerns about ADEQ's current authority to issue voluntary permit conditions outside of the plain language of A.A.C. R18-2-306.01 so that the relevant SIP revisions will be approved. This rulemaking will not place any additional burden on ASARCO or the regulated community in general, as it incorporates already binding permit conditions.

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:

Not Applicable.

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

Not Applicable.

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

The following discussion addresses each of the elements required for an Economic, Small Business, and Consumer Impact Statement (EIS) under A.R.S. § 41-1055.

An identification of the rulemaking: 18 A.A.C. 2, Article 13, R18-2-B1301, R18-2-1301.01, and R18-2-B1302

ADEQ is proposing to amend Arizona Administrative Code (A.A.C.) Title 18, Chapter 2, Article 13, R18-2-B1301, R18-2-B1301.01, R18-2-B1302 to incorporate the Title V permit terms for the Hayden Smelter that forms the basis for the controls at the facility for the lead (Pb) and sulfur dioxide (SO_2) National Ambient Air Quality Standards (NAAQS) into state rule. The current

site-specific rules establishing limits on Pb and SO2 emissions from the Hayden Smelter do not include key permit terms set forth in the revised permits. Codifying these permit conditions into state rule will facilitate EPA approval of both of the Pb and SO_2 SIP revisions.

Further, the Hayden Smelter, located in Hayden, AZ, and owned/operated by ASARCO, is the only facility impacted by the relevant permitting conditions. ASARCO was involved in the development of the permit conditions and is required to comply with them. Through discussions with both ADEQ and EPA, ASARCO became aware that codification of the permitting conditions would likely become necessary. Codification is only intended to address the EPA's concerns about ADEQ's current authority to issue voluntary permit conditions outside of the plain language of A.A.C. R18-2-306.01 so that the relevant SIP revision will be approved. This rulemaking will not place any additional burden on ASARCO or the regulated community in general, as it incorporates already binding permit conditions.

An identification of the persons who will be directly affected by, bear the cost of or directly benefit from the rulemaking:

a) ADEQ/State of Arizona;
b) ASARCO;
c) Hayden Pb Nonattainment Area; and
d) Hayden SO_2 Nonattainment Area.

A cost benefit analysis:

(a) Cost/benefit stakeholder matrix

The purpose of this rulemaking is to codify already existing permit conditions into state rule. These requirements are being codified into state rule to bolster the approvability of the Hayden Pb and Hayden SO_2 SIP revisions. Accordingly, ADEQ anticipates only minimal economic impacts as explained in the table below.

Description of Affected Groups	Description of Effect	Increased Cost/Decreased Revenue or Benefit	Decreased Cost/ Increased Revenue or Benefit
A. State and Local Government Agencies			
ADEQ/State of Arizona	The administrative burden of the rulemaking on ADEQ/State of Arizona is minimal. These permit conditions have already been agreed upon by all relevant parties and memorialized in two Title V permits. There is no associated increase in staff.	Minimal.	Minimal.
B. Private Businesses			
ASARCO	The economic effect of this rulemaking on ASARCO is minimal. The permit conditions codified into rule were already agreed upon during the permit revision process and have been memorialized in two Title V permits.	Minimal.	Minimal.
C. Public			
Hayden Pb Nonattainment Area	These rules codify permit conditions that apply only to the Hayden Smelter. The Hayden Smelter is already operating under these conditions. Further, incorporation of permit conditions into state rule will facilitate the approval of the Hayden Pb SIP. There are no sanctions in place for this area, so there are no economic benefits of this rulemaking on Hayden Pb Nonattainment Area.	Minimal.	Minimal.

Hayden SO_2 Nonattainment Area	These rules codify permit conditions that apply only to the Hayden Smelter. The Hayden Smelter is already operating under these conditions. However, the incorporation of permit conditions into state rule will facilitate the approval of the Hayden SO_2 SIP. This area is currently under sanctions, and EPA's approval of the Hayden SO_2 SIP Revision will lift them. Accordingly, there is a significant benefit of this rulemaking on the Hayden SO_2 Nonattainment Area.	Minimal.	Significant (approval of Hayden SO_2 nonattainment SIP revision lifts sanctions on the area).

Minimal	Moderate	Substantial	Significant	Marginal
$5,000 or less	$5,001 to $25,000	Greater than $25,000	Cost or benefit cannot be easily quantified, but ADEQ expects it to be significant.	Cost or benefit cannot be easily quantified, but ADEQ expects it to be marginal.

(b) Individual stakeholder summaries/calculations

ADEQ/State of Arizona

Amending the current state rule will address EPA's concerns about ADEQ's current authority to issue voluntary permit conditions outside of the plain language of A.A.C. R18-2-306.01 so that the relevant Hayden Pb and SO_2 SIP revisions can be approved.

ADEQ expects to incur minimal additional staffing costs related to implementing these control measures due to the fact that they are already included in Permits No. 39948 (As Amended by Significant Permit Revision No. 97168) and No. 39948 (As amended by Significant Permit Revision No. 96410). Accordingly, ADEQ will not require any new staff or any substantial contractor expenditures to implement the proposed amendments.

ADEQ will benefit from amending this rule because doing so will facilitate the approval of the Hayden Pb and SO_2 SIP revisions. The approval of these SIP revisions will protect public health and the environment, in alignment with ADEQ's mission statement.

ASARCO

The current implementation of Permits No. 39948 (As Amended by Significant Permit Revision No. 97168) and 39948 (As amended by Significant Permit Revision No. 96410) already required close coordination between ADEQ and ASARCO. Further, the draft rule language is pulled directly from the Title V permits that was agreed upon by ADEQ, EPA, and ASARCO. The terms included in the relevant permits were discussed and agreed upon by all parties. Accordingly, ASARCO is already bound by the Title V permits and must implement the control measures listed in the relevant Title V permits and proposed state rule. Codification is only intended to address the EPA's concerns about ADEQ's current authority to issue voluntary permit conditions outside of the plain language of A.A.C. R18-2-306.01 so that the relevant SIP revisions will be approved

Hayden SO_2 Nonattainment Area

Currently, the Hayden SO_2 Nonattainment Area is under sanctions because ADEQ didn't cure the deficiencies from, EPA's limited approval/limited disapproval and a partial approval/partial disapproval of the Final SIP Revision: 2017 Hayden Sulfur Dioxide Nonattainment Area for the 2010 SO_2 NAAQS. As mentioned above, ADEQ has since submitted the Final SIP Revision: 2023 Hayden Sulfur Dioxide Nonattainment Area for the 1971 and 2010 SO_2 NAAQS, which will cure the deficiencies and allow the sanctions to be lifed. The codification of permit conditions into state rule will facilitate the approval of the 2023 SIP Revision.

There are two types of sanctions under the Clean Air Act. Currently, the Hayden SO_2 Nonattainment Area is under both. The first sanction clock that starts on the effective date of a triggering action relates to the emission offset requirement under the nonattainment new source review program. This sanction applies 18 months after the effective date of the triggering action if the SIP deficiency has not been resolved. Specifically, a ratio of at least 2-to-1 is required for emissions reductions must be achieved within the nonattainment area to offset emissions from new or modified major facilities.

Accordingly, based on ADEQ not addressing the deficiencies in the limited approval/limited disapproval and partial approval/par-

tial disapproval of the 2017 SIP Revision, the Hayden SO_2 Nonattainment Area has been under this specific sanction since May 2022.

The second sanction clock begins on the effective date of a triggering action and relates to the imposition of certain restrictions on federal highway funding. This sanction applies 24 months after the effective date of the triggering action if the SIP deficiency has not been resolved.

Accordingly, based on ADEQ not addressing the deficiencies the limited approval/limited disapproval and partial approval/partial disapproval of the 2017 SIP Revision, the Hayden SO_2 Nonattainment Area has been under this specific sanction since November 2022.

Relieving this area of these sanctions is imperative to the area's economic growth and well-being.

Hayden Pb Nonattainment Area

Currently, the Hayden Pb Nonattainment area does not have an approved SIP in place. In September, 2024, ADEQ submitted a SIP revision to EPA. The codification of permit conditions into state rule will facilitate the approval of the SIP revision.

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

Since the rule updates proposed for Article 13 are only to codify existing control measures for the Hayden Smelter, the rule does not substantially change state or department operations or processes. As such there is no expected impact on public employment.

Similarly, ADEQ anticipates no employment impact codifying these control measures into state rule as these control measures have already been included in the relevant Title V permits.

A statement of the probable impact of the rulemaking on small businesses.

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

Under A.R.S. § 41-1001(23) "Small business" means a concern, including its affiliates, which is independently owned and operated, which is not dominant in its field and which employs fewer than one hundred full-time employees or which had gross annual receipts of less than four million dollars in its last fiscal year. For purposes of a specific rule, an agency may define small business to include more persons if it finds that such a definition is necessary to adapt the rule to the needs and problems of small businesses and organizations.

ADEQ does not believe that there are any small businesses that would be subject to this rulemaking.

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

N/A.

(c) A description of the methods that the agency may use to reduce the impact on small businesses.

N/A.

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

N/A.

A statement of the probable effect on state revenues

Since the proposed rule does not substantially affect commercial activity from which the state of Arizona would receive tax revenue, ADEQ projects no effect on state revenues resulting from the rulemaking.

A description of any less intrusive or less costly alternative methods of achieving the purpose of the rulemaking.

Since this rulemaking aligns with federal law (the Clean Air Act) and reflects permit conditions already agreed upon by all relevant parties, there is not a less intrusive or less costly alternative available at this time.

A description of any data on which a rule is based with a detailed explanation of how the data was obtained and why the data is acceptable data. An agency advocating that any data is acceptable data has the burden of proving that data is acceptable. For the purposes of this paragraph "acceptable data" means empirical, replicable, and testable data as evidenced in supporting documentation, statistics, reports, studies or research.

N/A.

10. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:

Name:	Lexi Ahmad
Title:	Environmental Legal Specialist II
Division:	Air Quality Division
Address:	Arizona Department of Environmental Quality 1110 W. Washington St. Phoenix, AZ 85007
Telephone:	(602) 771-4149
Email:	airplanning@azdeq.gov
Website:	https://azdeq.gov/

11. The time, place, and nature of the proceedings to make, amend, repeal, or renumber the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

A formal comment period will take place from the publication of this rule in the *Arizona Administrative Register* until 5 p.m., October 14, 2025.

Please email or submit written comments related to this rulemaking at any time during the public comment period to the contact in item 5 of the Preamble of this Notice.

ADEQ has scheduled an oral proceeding to receive oral comments on the rules, in accordance with A.R.S § 41-1023; the time, place, and location of the hearing are listed below:

Date:	October 14, 2025
Time:	10:30 a.m.
Location:	ONLINE – GoToWebinar hosted by ADEQ at https://attendee.gotowebinar.com/register/4027323525405662554.

After you register, you will receive a confirmation email with information on how to join the oral proceeding at the scheduled time. You can also dial in using your phone. Dialing in using your phone will NOT provide the opportunity for making public comments.

United States:	+1 (213) 929-4212
Webinar ID:	700-144-787

ADEQ will take reasonable measures to provide access to department services to individuals with limited ability to speak, write or understand English and/or to those with disabilities. Requests for language translation, ASL interpretation, CART captioning services or disability accommodations must be made at least 48 hours in advance by contacting the Title VI Nondiscrimination Coordinator, Joaquin Marruffo Ruiz, at 520-628-6744 or Marruffo.Joaquin@azdeq.gov. For a TTY or other device, Telecommunications Relay Services are available by calling 711.

ADEQ tomará las medidas razonables para proveer acceso a los servicios del departamento a personas con capacidad limitada para hablar, escribir o entender inglés y/o para personas con discapacidades. Las solicitudes de servicios de traducción de idiomas, interpretación ASL (lengua de signos americano), subtitulado de CART, o adaptaciones por discapacidad deben realizarse con al menos 48 horas de anticipación comunicándose con el Coordinador de Anti-Discriminación del Título VI, Joaquin Marruffo Ruiz, al 520-628-6744 o Marruffo.Joaquin@azdeq.gov. Para un TTY u otro dispositivo, los servicios de retransmisión de telecomunicaciones están disponible llamando al 711.

Nature: Oral Proceeding on the proposed rules, with opportunity for formal comments on the record.

Public comment period ends: October 14, 2025, 5 p.m.

Close of record: October 14, 2025, 5 p.m.

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

There are no other matters prescribed by statutes applicable specifically to ADEQ or this specific rulemaking.

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

This rulemaking does not require a permit.

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

This proposed rulemaking will help Arizona comply with the federal Clean Air Act. This rulemaking is no more stringent than required by 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:

Not Applicable.

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

Not Applicable.

14. The full text of the rules follows:

TITLE 18. ENVIRONMENTAL QUALITY

CHAPTER 2. DEPARTMENT OF ENVIRONMENTAL QUALITY AIR POLLUTION CONTROL

ARTICLE 13. STATE IMPLEMENTATION PLAN RULES FOR SPECIFIC LOCATIONS

PART B. HAYDEN, ARIZONA, PLANNING AREA

Section
R18-2-B1301. Limits on Lead Emissions from the Hayden Smelter
R18-2-B1301.01. Limits on Lead-Bearing Fugitive Dust from the Hayden Smelter
R18-2-B1302. Limits on SO_2 Emissions from the Hayden Smelter
A14. Appendix 14. Procedures for Sulfur Dioxide and Lead Fugitive Emissions Studies for the Hayden Smelter

ARTICLE 13. STATE IMPLEMENTATION PLAN RULES FOR SPECIFIC LOCATIONS

PART B. HAYDEN, ARIZONA, PLANNING AREA

R18-2-B1301. Limits on Lead Emissions from the Hayden Smelter

A. Applicability.
1. This Section applies to the owner or operator of the Hayden Smelter. It establishes limits on lead emissions from the Hayden Smelter and monitoring, recordkeeping and reporting requirements for those limits.
2. Effective date. ~~Except as otherwise provided, the requirements of this Section shall become applicable on the earlier of July 1, 2018 or 180 days after completion of all project improvements authorized by Significant Permit Revision No. 60647.~~With the exception of the following requirements, this rule is in effect. Additional requirements in subsections (C)(1), (C)(2), (D)(3), (D)(4), (D)(5), (E)(1), (E)(7), (F)(1), (F)(2), (F)(3), (F)(4) (F)(5), (F)(6), (G)(1), (G)(2), (G)(4), (G)(5), (H)(4), (H)(9), (H)(10), (I)(7), (1)(8), and (I)(9) take effect 60 days after the Hayden Smelter achieves maximum production after Smelter restart or 180 days after Smelter restart, whichever occurs first.

B. Definitions. In addition to general definitions contained in R18-2-101, the following definitions apply to this Section:
1. "ACFM" means actual cubic feet per minute.
2. "Anode furnace baghouse stack" means the dedicated stack that vents controlled off-gases from the anode furnaces to the Main Stack.
3. "Blowing" shall mean the introduction of air or oxygen-enriched air into the converter furnace molten bath through tuyeres that are submerged below the level of the molten bath. The flow of air through the tuyeres above the level of the molten bath or into an empty converter shall not constitute blowing.
4. "Capture system" means the collection of components used to capture gases and fumes released from one or more emission units, and to convey the captured gases and fumes to one or more control devices or a stack. A capture system may include, but is not limited to, the following components as applicable to a given capture system design: duct intake devices, hoods, enclosures, ductwork, dampers, manifolds, plenums, and fans.
5. "Control device" means a piece of equipment used to clean and remove pollutants from gases and fumes released from one or more emission units that would otherwise be released to the atmosphere. Control devices may include, but are not limited to, baghouses, Electrostatic Precipitators (ESPs), and sulfuric acid plants.
6. "Fuming ladle" means a ladle emitting an abnormal amount of fume after discharge of material.
~~6~~7. "Hayden Smelter" means the primary copper smelter located in Hayden, Gila County, Arizona at latitude 33º0'15"N and longitude 110º46'31"W.
8. "Ladle" means a piece of equipment used to move/pour molten material.
~~7~~9. "Main Stack" means the center and annular portions of the 1,000-foot stack, which vents controlled off-gases from the INCO flash furnace, the converters, and anode furnaces and also vents exhaust from the tertiary hoods.
10. "Maintenance downturn" means a scheduled maintenance period lasting at least eight working hours.
~~8~~11. "SCFM" means standard cubic feet per minute.
~~9~~12. "SLAMS monitor" means an ambient air monitor part of the State and Local Air Monitoring Stations network operated by State or local agencies for the purpose of demonstrating compliance with the National Ambient Air Quality Standards.
13. "Smelter restart" means the first day after the issuance of Significant Permit Revision No. 97168 that concentrate is processed through the INCO flash furnace to produce matte.
~~10~~14."Smelting process-related fugitive lead emissions" means uncaptured and/or uncontrolled lead emissions that are released into the atmosphere from smelting copper in the INCO flash furnace, converters, and anode furnaces.
15. "Table 1" means the table labeled "Uptake Improvement System Flow Conditions and Damper Positions," in the attachment labeled "Hayden Smelter Site-Specific SIP Requirements," to the current Class I permit.
16. "Table 2" means the table labeled "Uptake Improvement System Interlock Timing," in the attachment labeled "Hayden Smelter Site-Specific SIP Requirements," to the current Class I permit.
17. "Table 3" means the table labeled "Anode Secondary Hood System Flow Conditions and Damper Positions," in the attachment labeled "Hayden Smelter Site-Specific SIP Requirements," to the current Class I permit.
18. "Table 4" means the table labeled "Emergency Shutdown Ventilation Flue Emissions," in the attachment labeled "Hayden Smelter Site-Specific SIP Requirements," to the current Class I permit.

C. Lead ~~Emission Limit~~ Emissions Limitations. ~~Main Stack lead emissions shall not exceed 0.683 pound of lead per hour.~~
1. Notwithstanding the addition of emissions from the anode secondary hood baghouse, total lead emissions from the main stack shall not exceed 0.683 pounds of lead per hour.

2. Total process fugitive lead emissions from the Hayden Smelter furnaces and converters shall not exceed 0.326 pounds of lead per hour calculated as a 3-month rolling average in accordance with subsection (F).

D. Operational Standards.

1. Process equipment and control device operations. At all times, including periods of startup, shutdown, and malfunction, the owner or operator shall, to the extent practicable, maintain and operate smelter processes and associated emission capture and/or control equipment in a manner consistent with good air pollution control practices for minimizing lead emissions to the level required by subsection (C). Determination of whether acceptable operating and maintenance procedures are being used shall be based on all information available to the Department and EPA Region IX, which may include, but is not limited to, monitoring results, review of operating and maintenance procedures and records, and inspection of the relevant equipment.
2. Capture system and control device operations and maintenance plan. The owner or operator shall develop and implement an operations and maintenance plan for each capture system and/or control device used to ventilate or control process gas or emissions from the flash furnace, including matte tapping, slag skimming and slag return operations; converter primary hoods, converter secondary hoods, tertiary ventilation system; and anode refining operations. The operations and maintenance plan must address the following requirements as applicable to each capture system and/or control device.
    a. Monitoring devices. The plan shall provide for installation, operation, calibration, and maintenance of appropriate monitoring devices to measure and record operating limit values or settings at all times the required capture and control system is operating, except during periods of monitor calibration, repair, and malfunction. The initial plan shall provide for volumetric flow monitoring on the vent gas baghouse (inlet or outlet), each converter primary hood, each converter secondary hood, the tertiary ventilation system, and the anode furnace baghouse (inlet or outlet). All monitoring devices shall be accurate within +/- 10% and calibrated according to manufacturer's instructions. If direct measurement of the exhaust flow is infeasible due to physical limitations or exhaust characteristics, the owner or operator may propose a reliable equivalent method for approval. Initial monitoring may be adjusted as provided in subsection (D)(2)(e). Dampers that are manually set and remain in the same position while the capture system is operating are exempt from these monitoring requirements. Capture system damper position ~~setting(s)~~ setting or settings shall be specified in the plan.
    b. Operational limits. The owner or operator shall establish operating limits in the operations and maintenance plan for the capture systems and/or control devices that are representative and reliable indicators of the performance of the capture system and control device operations. Initial operating limits may be adjusted as provided in subsection (D)(2)(e). Initial operating limits shall include the following:
        i. A minimum air flow for the furnace ventilation system and associated damper positions for each matte tapping hood or slag skimming hood when operating to ensure that the ~~operation(s)~~ operation or operations are within the confines or influence of the capture system.
        ii. A minimum air flow for the secondary hood baghouse and associated damper positions for each slag return hood to ensure that the operation is within the confines or influence of the capture system's ventilation draft during times when the associated process is operating.
        iii. A minimum air infiltration ratio for the converter primary hoods of 1:1 averaged over 24 converter Blowing hours, rolled hourly measured as volumetric flow in primary hood less the volumetric flow of tuyere Blowing compared to the volumetric flow of tuyere Blowing.
        iv. A minimum secondary hood exhaust rate of 35,000 SCFM during converter Blowing, averaged over 24 converter Blowing hours, rolled hourly.
        v. A minimum secondary hood exhaust rate of 133,000 SCFM during all non-Blowing operating hours, averaged over 24 non-Blowing hours, rolled hourly.
        vi. A minimum negative pressure drop across the secondary hood when the doors are closed equivalent to 0.007 inches of water.
        vii. A minimum exhaust rate on the tertiary hooding of 400,000 ACFM during all times material is processed in the converter aisle, averaged over 24 hours and rolled hourly.
        viii. Fan amperes or minimum air flow for the anode furnace baghouse and associated damper positions for each anode furnace hood to ensure that the anode furnace off-gas port is within the confines or influence of the capture system's ventilation draft during times when the associated furnace is operating.
        ix. The anode furnace charge mouth shall be kept covered when the tuyeres are submerged in the metal bath except when copper is being charged to or transferred from the furnace.
    c. Preventative maintenance. The owner or operator shall perform preventative maintenance on each capture system and control device according to written procedures specified in the operations and maintenance plan. The procedures must include a preventative maintenance schedule that is consistent with the manufacturer's or engineer's instructions, or operator's experience working with the equipment, and frequency for routine and long-term maintenance. This provision does not prohibit additional maintenance beyond that required by the plan.
    d. Inspections. The owner or operator shall perform inspections in accordance with written procedures in the operations and maintenance plan for each capture system and control device that are consistent with the manufacturer's, engineer's, or operator's instructions for each system and device.
    e. Plan development and revisions.
        i. The owner or operator shall develop and keep current the plan required by this Section. Any plan or plan revision shall be consistent with this Section, shall be designed to ensure that the capture and control system performance conforms to the attainment demonstration in the ~~Hayden 2008 Lead National Ambient Air Quality Standards Nonattainment Area State Implementation Plan (SIP)~~ State Implementation Plan Revision: 2024 Hayden Lead (Pb) Nonattainment Area for 2008 Pb NAAQS, and shall be submitted to the Department for review. Any plan or plan revision submitted shall include the associated manufacturer's, engineer's or operator's recommendations and/or instructions used for capture system and control device operations and maintenance.

ii. The owner or operator shall submit the initial plan to the Department no later than May 1, 2018 and shall include the initial volumetric flow monitoring provisions in subsection (D)(2)(a), the initial operational limits in subsection (D)(2)(b), the preventative maintenance procedures in subsection (D)(2)(c), and the inspection procedures in subsection (D)(2)(d).

iii. The owner or operator shall submit to the Department for approval a plan revision with changes, if any, to the initial volumetric flow monitoring provisions in subsection (D)(2)(a) and initial operational limits in subsection (D)(2)(b) not later than six months after completing a fugitive emissions study conducted in accordance with Appendix 14. The Department shall submit the approved changes to the volumetric flow monitoring provisions and operational limits pursuant to this subsection to EPA Region IX as a SIP revision not later than 12 months after completion of a fugitive emissions study.

iv. Other plan revisions may be submitted at any time when necessary. All plans and plan revisions shall be designed to achieve operation of the capture system and/or control device consistent with the attainment demonstration in the ~~Hayden 2008 Lead National Ambient Air Quality Standards Nonattainment Area SIP~~ State Implementation Plan Revision: 2024 Hayden Lead (Pb) Nonattainment Area for 2008 Pb NAAQS. Except for changes to the volumetric flow monitoring provisions in subsection (D)(2)(a) and operational limits in subsection (D)(2)(b), which shall require prior approval, plans and plan revisions may be implemented upon submittal and shall remain in effect until superseded or until disapproved by the Department. Disapprovals are appealable Department actions.

3. Flash Furnace Area Capture Improvements

a. The owner or operator shall install additional hooding and interceptor walls (the "Uptake Improvement System") to improve the capture of fugitive emissions from the flash furnace area, matte tapping and slag skimming areas, route them to the existing converter secondary hood baghouse for fabric filter and high surface area lime injection control, and then to the annulus of the main stack.

b. The Uptake Improvement System shall have a design evacuation rate of 50,000 to 60,000 ACFM hourly average and shall operate when the flash furnace is in operation except for brief periods when slag is being returned to the flash furnace using the slag launder return. At those times, the ventilation for this system shall be switched to the slag return capture system and then switched back automatically to the Uptake Improvement System at the conclusion of the slag return cycle.

c. Establishment of Operational Ranges

i. The owner or operator shall establish a range of damper positions based upon the secondary hood baghouse flow monitor that provides reasonable assurance that the Uptake Improvement System exhaust flow is within the design range specified in (D)(3)(b). The ranges shall be established and verified by a stack test no later than 180 days after smelter restart and may be revised thereafter in the same fashion. The proposed ranges, stack test verifying evacuation rates compliant with (D)(3)(b) and proposed revision to Table 1 shall be submitted to the department within 45 days of the stack test. If the Director concurs that the proposed damper position ranges assure an exhaust flow compliant with (D)(3)(b), the Director shall issue a revised Table 1 reflecting the new damper position range. Thereafter, the owner or operator shall comply with the approved Table 1 range. Until the first submittal is approved, the owner or operator shall use ranges specified by the air pollution control designer. The current ranges can be found in Table 1 of the attachment labeled "Hayden Smelter Site-Specific SIP Requirements," to the current Class I permit.

ii. The owner or operator shall establish a timed interlock on the slag return launder such that when slag is returned to the flash furnace the ventilation air from the Uptake Improvement System is switched to the slag return capture system for a defined period of not less than 5 minutes nor more than 10 minutes and then returns to the Uptake Improvement System automatically. The owner or operator shall optimize the period within the five to 10-minute range during the initial 60-day optimization period by observation and analysis and thereafter as necessary. The first analysis, proposed time period, and proposed revisions to Table 2 shall be submitted no later than 75 days after smelter restart. The Director shall approve any period that falls within both the five to 10-minute range and a range between the mean and mean plus one standard deviation of observed slag return durations. If the Director concurs that the proposed range meets these requirements, the Director shall issue a revised Table 2. All analyses shall be submitted and approved by the Director. Until the first report is approved, the owner or operator shall use ranges specified by the air pollution control designer. The current ranges are specified in Table 2 of the attachment labeled "Hayden Smelter Site-Specific SIP Requirements" to the current Class I permit.

d. Operational requirements

i. The owner or operator shall operate the Uptake Improvement/Launder Return combined damper in accordance with the approved Table 1 range or ranges at all times the flash furnace is operating and at all times matte tapping, slag skimming or slag returning is occurring.

ii. The owner or operator shall operate the timed interlock in accordance with the approved Table 2 value. Operators shall trigger the interlock prior to starting slag return and may trigger the timed interlock again if slag is still returning at the end of the interlock cycle to minimize emissions.

iii. The owner or operator shall inspect the Uptake Improvement System during each scheduled maintenance downturn to ensure that the hooding and walls are in proper position and that there are no visible accretions of material in the mouth of the hooding that would preclude efficient operation. The owner or operator shall quarterly, evaluate the damper controlling air between the Uptake Improvement System and the slag return capture system to ensure it is operating properly. Records of these inspections shall be maintained for five years.

4. Converter and Material Transfer Area Capture Improvements

a. The owner or operator shall install a hood and interceptor walls (the "Fuming Ladle Capture System") to provide a system for the capture of fugitive emissions from fuming ladles in the converter aisle and material transfer areas, route them to the existing converter secondary hood baghouse for fabric filter and high surface area lime injection control, and then to the annulus of the main stack.

b. The Fuming Ladle Capture System shall have a design evacuation rate of 40,000 to 50,000 ACFM when a ladle is present within the hooded area. The capture system shall run until the ladle is removed or for at least 20 minutes after the ladle is placed in the containment. Fuming ladles shall not be removed from the fuming Ladle Capture System containment unless transported directly to the tunnel or within the capture area of a secondary hood.

c. The owner or operator shall, whenever a fuming ladle is detected, promptly move the fuming ladle into the Fuming Ladle Capture System, the tunnel or within the capture area of a secondary hood.

i. The owner or operator shall develop training for its employees responsible for ladle movement on identification of fuming ladles. The training shall be developed within 60 days of smelter restart. Existing employees shall be trained within 90 days of smelter restart and any new employees shall be trained before working ladle operations unsupervised by a trained operator. Employees shall be retrained once every five years. Training records for the operators shall be kept for five years. The training and records shall be available for inspections.

ii. The training program curriculum required for (D)(4)(b)(i) above shall include:

(1) Identification of fuming ladles, including oral description from experienced operators, written descriptions and, after smelter restart, photographs and video of fuming and nonfuming ladles;

(2) Procedures on observing ladles to determine when they are fuming;

(3) Instruction on when marginal ladles may be moved to the matte tunnels or a secondary hood for control and when they should be moved to the Fuming Ladle Capture System (FLCS);

(4) Prompt movement of ladles to, placement in, and operation of the FLCS;

(5) When and how ladles may be removed from the FLCS;

(6) Steps to take if a ladle remains fuming after initial time out of the FLCS; and

(7) Procedures for additional scrutiny of first slag and shell out ladles.

iii. The owner or operator shall submit the curriculum required under (D)(4)(b)(ii) above and any written and photographic/video training materials to the Department within 10 days of development of the curriculum and thereafter shall provide the curriculum and materials to inspectors upon request.

iv. The owner or operator shall keep a log of the occurrences of fuming ladle events. The log shall include the date of the event, duration of the event, severity of the fuming ladle, and the time elapsed between identification of the fuming ladle and the operator moving the fuming ladle into the Fuming Ladle Capture System, within a secondary hood or into the matte tunnel.

v. Training records for the operators shall be kept for five years. The training and records shall be available for inspection.

d. The owner or operator shall conduct an initial flow test within 180 days of smelter restart to verify that the system achieves the design flow. The results of this flow test shall be reported to the Department within 45 days of completion of the test.

e. The owner or operator shall inspect the Fuming Ladle Capture System during each scheduled maintenance downturn to ensure that it is actuating properly, that the hoods and walls are in proper position, and there are no visible accretions of material in the mouth of the hood that would preclude efficient operation. Records of these inspections shall be maintained for five years.

5. Anode Furnace Secondary Hood Capture Control System

a. The owner or operator shall install secondary hoods around each of the anode furnaces to improve the capture of fugitive emissions from the anode furnaces during charging, holding and processing, route the emissions to a new anode secondary hood baghouse for fabric filter control, and then to the annulus of the main stack. This is the Anode Secondary Hood system.

b. The Anode Secondary Hood System

i. The Anode Secondary Hood System shall have an overall design evacuation rate for the total system of 150,000 ACFM hourly average.

ii. The anode secondary hood baghouse shall have a maximum design particulate matter emission rate of 0.002 gr/scf.

iii. Each secondary hood shall be equipped with dampers that can close completely and operate with a range from 20 to 100% to modulate flows to the individual anode furnace.

iv. The Anode Secondary Hood System shall be operated to achieve balanced flows (± 15%) on the two operating anode furnaces when neither are charging. When one anode furnace is charging, the Anode Secondary Hood System shall be balanced so that the charging furnace achieves a minimum of 100,000 ACFM and the other operating furnace gets the balance.

c. The owner or operator shall establish a range of damper positions and total flow conditions based upon the anode secondary hood baghouse flow monitor that provides reasonable assurance that the Anode Secondary Hood system exhaust flow is within the design range. These ranges and flow conditions shall be verified during a performance test within 180 days of smelter restart and may be revised thereafter in the same fashion. The proposed ranges and flow conditions, stack test verifying evacuation rates compliant with (D)(5)(b)(iii) and (D)(5)(b)(iv) and proposed revision to Table 3 shall be submitted to the Department within 45 days of the stack test. If the Director concurs that the proposed damper position and flow ranges assure an exhaust flow compliant with (D)(5)(b)(iii) and (D)(5)(b)(iv), the Director shall issue a revised Table 3 reflecting the new approved Table 3 ranges. Until the first performance test, the owner or operator shall use ranges specified by the air pollution control designer. The current flows shall be specified in Table 3. Damper positions shall be logged and the logs kept for five years.

d. Operational requirements.

i. The owner or operator shall operate the Anode Secondary Hoods in accordance with the approved Table 3 range or ranges at all times the anode furnaces are operating.

ii. The owner or operator shall inspect the Anode Secondary Hood System during which scheduled maintenance down turn to ensure that the dampers are working properly, the hoods and walls are in proper position and that there are no

visible accretions of material in the mouth of the hoods that would preclude efficient operation. Records of these inspections shall be maintained for five years.

~~3~~6. Emissions from the anode furnace baghouse stack shall be routed to the Main Stack.

E. Performance Test Requirements.

1. Main stack performance tests. No later than 180 calendar days after ~~completion of all Converter Retrofit Project improvements authorized by Significant Permit Revision No. 60647~~Smelter restart, the owner or operator shall conduct initial performance tests on the following:
   a. The gas stream exiting the anode furnaces baghouse prior to mixing with other gas streams routed to the Main Stack.
   b. The gas stream exiting the acid plant at a location prior to mixing with other gas streams routed to the Main Stack.
   c. The gas stream exiting the converter secondary baghouse at a location prior to mixing with other gas streams routed to the Main Stack.
   d. The gas stream collected by the tertiary hooding at a location prior to mixing with other gas streams routed to the Main Stack.
   e. The gas stream exiting the vent gas baghouse at a location prior to mixing with other gas streams routed to the Main Stack.
   f. The gas stream exiting the anode secondary hood baghouse at a location prior to mixing with the other gas streams routed to the Main Stack.
2. Subsequent performance tests on the gas streams specified in subsection (E)(1) shall be conducted at least annually.
3. Performance tests shall be conducted under such conditions as the Department specifies to the owner or operator based on representative performance of the affected sources and in accordance with 40 CFR 60, Appendix A, Reference Method 29.
4. At least 30 calendar days prior to conducting a performance test pursuant to ~~subsection~~ subsections (E)(1) and (E)(2), the owner or operator shall submit a test plan, in accordance with R18-2-312(B) and the Arizona Testing Manual, to the Department for approval. The test plan must include the following:
   a. Test duration;
   b. Test ~~location(s)~~ location or locations;
   c. Test ~~method(s)~~ method or methods, including those for test method performance audits conducted in accordance with subsection (E)(6); and
   d. Source operation and other parameters that may affect the test result.
5. The owner or operator may use alternative or equivalent performance test methods as defined in 40 CFR § 60.2 when approved by the Department and EPA Region IX, as applicable, prior to the test.
6. The owner or operator shall include a test method performance audit during every performance test in accordance with 40 CFR § 60.8(g).
7. The owner or operator shall evaluate opacity at the time of each performance test. The opacity evaluation shall evaluate both the opacity at the roofline monitor and note the opacity exiting from the walls or other openings but shall not include dust entrained from vehicles passing through an entryway. The opacity evaluation of the flash furnace building and anode aisle shall be conducted in accordance with 40 CFR 60.13 and the opacity evaluation of the converter aisle shall be conducted in accordance with 40 CFR 63.1450(c). If complying with 40 CFR Part 63, Subpart QQQ, then testing to demonstrate compliance with that standard shall satisfy this requirement for the converter aisle.

F. Monitoring Requirements.

1. The owner or operator shall install, calibrate, maintain and operate a monitoring device that continuously records the volumetric flow rate, or alternative parameter that has a direct relationship to volumetric flow rate such as pressure drop (delta P), if approved by the Department, at a representative point in the anode secondary hood system, fuming ladle control system and uptake improvement hood system.
2. If the owner or operator seeks an alternative to a volumetric flow monitor, the owner or operator shall submit a proposal to the Department for review and approval. The proposal shall include the following:
   a. Identification of the parameter or parameters to be monitored in lieu of volumetric flow rate;
   b. Identification of the location in the hooding system where such monitors would be placed and how such location will give appropriate and representative measurements in accordance with good engineering practices;
   c. A detailed explanation, including sample calculations, of how such parameters or a parameter has a direct relationship to volumetric flow rate in the hooding system and how such parameter or parameters will ensure proper operation in accordance with design at all times, including detecting any degraded performance over time; and
   d. Proposed limit or limits including sample calculations, for the selected parameters that would be an enforceable demonstration of acceptable performance. Upon the Department's approval within 180 days of the effective date of this Section under (A)(2), this limit shall take effect and be enforceable thereafter until changed in accordance with this paragraph.
3. The owner or operator shall monitor the pressure drop across the anode secondary hood baghouse.
4. The owner or operator shall monitor the damper positions for the Uptake Improvement System and Fuming Ladle Control System at all times.
5. The owner or operator shall install, certify, calibrate, maintain and operate PM continuous emission monitoring systems (CEMS) at the locations specified in (F)(1) according to EPA Performance Specification 11 in 40 CFR Part 60, Appendix B (PS-11) and the quality assurance requirements of Procedure 2 in 40 CFR Part 60, Appendix F and in accordance with the requirements of the following subsections.
   a. No later than 180 days after the effective date of this rule, the owner or operator shall submit to the Department for review and approval a proposed Installation, Certification, and Quality Assurance/Quality Control (Installation, Certification, and QA/QC) Protocol, developed in consultation with the PM CEMS vendor or vendors, for the PM CEMS required on the anode secondary hood baghouse in (F)(4) of this subsection.
   b. The Installation, Certification, and QA/QC Protocol shall include a schedule and specifically describe a proposed testing plan that is designed to maximize the likelihood of successful certification of the PM CEMS. If certification is not

approved, then the owner or operator shall consult with the PM CEMS vendor and the Department. Within 60 days of completion of the PS-11 testing (including receipt of the results) that was conducted pursuant to the original Installation, Certification, and QA/QC Protocol for that PM CEMS, the owner or operator shall submit a revised Installation, Certification, and QA/QC Protocol for that PM CEMS to the Department and the EPA for review and approval.

c. Each PM CEMS shall include a continuous particle mass monitor to measure and record PM concentration, directly or indirectly, and gas stream flow rates on an hourly average basis.

d. The owner or operator shall maintain, in an electronic database, the hourly average emission values of all PM CEMS in milligrams per dry standard cubic meter (mg/dscm) and pounds per hour (lbs/hr).

e. In the event that no PM CEMS is successfully certified after the first round of testing, the owner or operator shall, within 90 days of certification failure, submit an updated Installation, Certification and QA/QC Protocol to EPA and the Department for review and approval. Upon completion of the second round of PS-11 testing (including receipt of the results), if the PM CEMS fails to certify, the owner or operator shall submit an alternative PM monitoring plan for such gas streams or stream for review and approval by the EPA and the Department. The alternative monitoring plan shall propose a methodology for using data from the PM CEMS as a continuous parametric monitoring system (CPMS) and stack performance test to ensure continuous compliance with operational limits in (D)(5). Upon approval by the EPA and Department, the owner or operator shall continuously operate the PM CEMS as a CPMS.

f. The owner or operator shall use reasonable efforts to keep each PM CEMS running and producing data whenever any gas at that location is being exhausted to the atmosphere. If operation of the PM CEMS cannot be maintained for a minimum of 12 months, the owner or operator may submit a demonstration to the Department and EPA that identifies the cause or causes of and explanation or explanations why the PM CEMS is infeasible to operate. The demonstration shall include an alternative PM monitoring plan for review and approval by the Department and the EPA. Operation of the PM CEMS shall be considered infeasible if:

i. The PM CEMS cannot be kept in working condition for sufficient periods of time to produce reliable, adequate, or useful data consistent with the Quality Assurance/Quality Control protocol (including, without limitation, PS-11 and Procedure 2); or

ii. Recurring, chronic, or unusual equipment adjustment, servicing, or replacement needs in relation to other types of continuous emission monitors cannot be resolved through reasonable expenditures of resources. If the Department and the EPA approve the owner or operator's demonstration that it is infeasible to continue operating a PM CEMS, the owner or operator shall be entitled to discontinue operation of and remove the PM CEMS. At that point, the owner or operator shall comply with the approved alternative PM monitoring plan. The Department's and the EPA's disapproval of the owner or operator's demonstration or alternative monitoring plan shall constitute and appealable agency action.

6. The owner or operator shall complete two fugitive emissions studies as required by Appendix 14.

a. The studies shall be completed according to the updated Fugitive Emissions Study Protocol submitted to the EPA on January 20, 2017 and approved by the EPA on May 31, 2017. The owner or operator may submit modifications to the protocol six months prior to each study for EPA approval and Department comment. Upon EPA approval, the modified protocol shall take effect.

b. The first fugitive study shall commence no later than six months after smelter restart or three months after EPA approval of a modified protocol. The owner or operator shall complete 12 months of monitoring and submit a report to the Department and EPA no later than three months after the conclusion of the study. The study shall evaluate the effectiveness of MiniVol samplers in providing high quality, replicable data; compare the MiniVol sampler data to estimates derived from lb/ton emission factors or other process parameters or surrogates; evaluate the accuracy and cost effectiveness of various monitoring approaches; and recommend either a new lb/ton concentrate emission factor or a SIP revision to incorporate an improved monitoring methodology. If the study concludes that the lb/ton concentrate emission factor should be retained, the owner or operator shall submit a justification for why an improved monitoring methodology (e.g., MiniVols) is not feasible and a justification for the selected lb/ton concentrate factor and how it may be revised to maintain accuracy representativeness. If the study concludes that a new methodology should be proposed, the owner or operator shall submit a petition to the Department to revise the SIP within 90 days after submitting the report unless either EPA or the Department provides comments upon the report, in which case the deadline is 60 days after the receipt of the final comments but no earlier than 90 days after the report submittal.

c. The second fugitive study shall be commenced within the same calendar quarter, but five years after, the date of commencement of the first study or three months after EPA approval of the protocol, if later, and shall run for 12 months. The second fugitive study shall evaluate whether the monitoring methodology remains appropriate. The owner or operator shall submit a report to EPA and the Department on the adequacy of the monitoring methodology within 90 days after completion of the fugitive monitoring. Based upon the study results, the owner or operator may petition the Department for a SIP revision. The Department or EPA may require the owner or operator to submit a revised monitoring methodology if, based upon the second fugitive study or other credible evidence, the then-current methodology underestimates emissions by 15 percent or more or overestimates emissions by 20 percent or more.

~~F~~**G.** Compliance Demonstration Requirements.

1. For purposes of determining compliance with the Main Stack emission limit in subsection ~~(C)~~ (C)(1), the owner or operator shall calculate the combined lead emissions in pounds per hour from the gas streams identified in subsection (E)(1) based on the most recent performance tests conducted in accordance with subsection (E). Continuous compliance with the emission limit in subsection (C)(1) is demonstrated if the most recent performance test under (E)(1) was 0.683 lbs/hr or less.
2. The owner or operator shall determine compliance with the requirements in subsection (D)(2) as follows:
   a. By ~~Maintaining~~ maintaining and operating the emissions capture and control equipment in accordance with the capture system and control device operations and maintenance plan required in subsection (D)(2) and recording operating parameters for capture and control equipment as required in subsection (D)(2)(b); and

b. By ~~Conducting~~ conducting a fugitive emissions study in accordance with Appendix 14 starting not later than six months after ~~completion of the Converter Retrofit Project authorized by Significant Permit Revision No. 60647~~smelter restart or three months after EPA approval of a modified protocol. The fugitive emissions study shall demonstrate, as set forth in Appendix 14, that fugitive emissions from the smelter are consistent with estimates used in the attainment demonstration in the ~~Hayden 2008 Lead National Ambient Air Quality Standards Nonattainment Area SIP~~ State Implementation Plan Revision: 2024 Hayden Lead (Pb) Nonattainment Area for 2008 Pb NAAQS.

3. The owner or operator shall include periods of startup, shutdown, malfunction, or other upset conditions when determining compliance with the emission limit in subsection (C).
4. Proper operation of the control and capture system shall be verified as follows:
   a. For each outlet identified in (E)(1) that is equipped with a certified PM CEMS, a 30-day average of PM CEMS mg/dscm shall be calculated based on the average of all valid hour data during the prior 30 operating days for each outlet and then across all outlets on a flow-weighted basis using the following equation:

$$E = \frac{\left(\sum_{i=1}^{n} C_i \times VF_i\right)}{\sum_{i=1}^{n} VF_i}$$

   Where:
   E = Main stack concentration PM, mg/dscm.
   i = ith certified PM CEMS identified in (G)(1).
   n = number of certified PM CEMS covered by (G)(1).
   C = 30-day average of PM CEMS i, mg/dcsm.
   VF1 = 30-day average of volumetric flow measured at PM CEMS i, dscm.
   b. For each outlet identified in (E)(1) that is not equipped with a certified PM CEMS, a 30-day average of the continuous parametric data shall be calculated based on the approved alternative monitoring rate.
   c. Proper operation of the control and capture system is verified if "E" in (G)(4)(a) is 23 mg/dscm or less, and any outlet subject to an approved alternative monitoring plan is in compliance.
5. The owner or operator shall demonstrate compliance with the process fugitive limit in (D)(5)(f):
   a. By demonstrating that all work practice standards set forth in (D)(5), (F)(1), (F)(2), and (F)(3) are being met with no more than a three-hour consecutive period out of manufacturer's specification before the underlying process unit was shut down or idled; and
   b. Until the fugitive study required under (F)(5) is completed, by the fifth working day of each month, the owner or operator shall calculate rates of process fugitive lead emissions by multiplying the tons of concentrate processed through the flash furnaces during the three prior calendar months by 0.0018 lb lead/ton of concentrate and then dividing that value by the number of operating hours during the same three calendar months, where an operating is defined as 24 hours for each operating day as defined in R18-2-B1302(B)(2) less any maintenance downturn hours during an operating day in that month, with compliance demonstrated if the calculated value is 0.326 lb/hr or less. The lb/ton concentrate factor provisions in (G)(5) shall remain in effect until a SIP revision replacing them is approved, as modified by (G)(5)(c).
   c. After the fugitive emissions studies described in (F)(5) are completed, by the fifth working day of each month, the owner or operator shall calculate rates of process fugitive lead emissions by multiplying the tons of concentrate processed during the three prior calendar month by the factor for lead that is developed in the most recent fugitive study and then dividing that value by the number of operating hours, as defined in (F)(5), in the same three calendar months to calculate an average pound/hour with compliance demonstrated if the calculated value is 0.326 lb/hr or less.

~~G~~**H.** Recordkeeping. The owner or operator shall maintain the following records for at least five years and keep on-site for at least two years:

1. All records as specified in the operations and maintenance plan required under subsection ~~(D)(2)~~(D).
2. All records of major maintenance activities and inspections conducted on emission units, capture systems, monitoring devices, and air pollution control equipment, including those set forth in the operations and maintenance plan required by subsection ~~(D)(2)~~(D).
3. All records of performance tests, test plans, and audits required by subsection (E).
4. The output of the PM CEMS and 30-day flow weighted average value required in (D)(3).
~~4~~5. All records of compliance calculations required by subsection ~~(F)~~(G).
~~5~~6. All records of fugitive emission studies and study protocols conducted in accordance with Appendix 14.
~~6~~7. All records of the occurrence and duration of any startup, shutdown, or malfunction in the operation of concentrate drying, smelting, converting, anode refining, and casting emission units; and any malfunction of the associated air pollution control equipment that is inoperative or not operating correctly.
~~7~~8. All records of reports and notifications required by subsection ~~(H)~~(I).
9. Records of the fugitive studies and their supporting data required by (F)(5), in accordance with Appendix 14.
10. Records of daily concentrate processed and operating hours and the corresponding calculation of 90-day average fugitive lead emissions required by (G)(5).

~~H~~**I.** Reporting. The owner or operator shall provide the following to the Department:

1. Notification of commencement of construction of any equipment necessary to comply with the operational or emission limits.
2. Semiannual progress reports on construction of any such equipment postmarked by July 30 for the preceding January-June period and January 30 for the preceding July-December period.
3. Notification of initial startup of any such equipment within 15 business days of such startup.

4. Whenever the owner or operator becomes aware of any exceedance of the emission limit set forth in subsection (C), the owner or operator shall notify the Department orally or by electronic or facsimile transmission as soon as practicable, but no later than two business days after the owner or operator first knew of the exceedance.
5. Within 30 days after the end of each calendar-year quarter, the owner or operator shall submit a quarterly report to the Department for the preceding quarter that shall include dates, times, and descriptions of deviations when the owner or operator operated smelting processes and related control equipment in a manner inconsistent with the operations and maintenance plan required by subsection (D)(2).
6. Reports from performance testing conducted pursuant to subsection (E) shall be submitted to the Department within 60 calendar days of completion of the performance test. The reports shall be submitted in accordance with the Arizona Testing Manual and A.A.C. R18-2-312(A).
7. The owner or operator shall submit reports to the Department providing the results of the fugitive studies required in (F)(5) within six months of completion of each study.
8. The owner or operator shall submit quarterly, by 30 days after the end of each calendar quarter, a summary report showing the date, time and magnitude of any exceedance of the PM CEMS (or approved alternative monitoring system) calculated in accordance with (G)(4) and any exceedance of the fugitive parameters calculation in accordance with (G)(5).
9. The owner or operator shall submit a report to the Department showing that contingency measures required in (J) were implemented within 90 days of receipt of notice from the Department or EPA Region 9 that the requirement for implementing the contingency measures is triggered.

R18-2-B1301.01. Limits on Lead-Bearing Fugitive Dust from the Hayden Smelter

A. Applicability.
1. This Section applies to the owner or operator of the Hayden Smelter.
2. Effective Date. Except as otherwise provided, the requirements of this Section shall become applicable on December 1, 2018.

B. Definitions. In addition to definitions contained in R18-2-101 and R18-2-B1301, the following definitions apply to this Section:
1. "Acid plant scrubber blowdown drying system" means the process in which Venturi scrubber blowdown solids are dried and packaged via a thickener, filter press, electric dryer, and supersack filling stations.
2. "Control measure" means a piece of equipment used, or actions taken, to minimize lead-bearing fugitive dust emissions that would otherwise be released to the atmosphere. Control equipment may include, but are not limited to, wind fences, chemical dust suppressants, and water sprayers. Actions may include, but are not limited to, relocating sources, curtailing operations, or ceasing operations.
3. "Hayden Lead Nonattainment Area" means the townships in Gila and Pinal Counties, as identified and codified in 40 CFR § 81.303, that are designated nonattainment for the 2008 Lead National Ambient Air Quality Standards.
4. "High wind event" means any period of time beginning when the average wind speed, as measured at a meteorological station maintained by the owner or operator that is approved by the Department, is greater than or equal to 15 mph over a 15 minute period, and ending when the average wind speed, as measured at the approved meteorological station maintained by the owner or operator, falls below 15 mph over a 15 minute period.
5. "Lead-bearing fugitive dust" means uncaptured and/or uncontrolled particulate matter containing lead that is entrained in the ambient air and is caused by activities, including, but not limited to, the movement of soil, vehicles, equipment, and wind.
6. "Material pile" means material, including concentrate, uncrushed reverts, crushed reverts, and bedding material, that is stored in a pile outside a building or warehouse and is capable of producing lead-bearing fugitive dust.
7. "Non-smelting process sources" means sources of lead-bearing fugitive dust that are not part of the hot metal process, which includes smelting in the INCO flash furnace, converting, and anode refining and casting. Non-smelting process sources include storage, handling, and unloading of concentrate, uncrushed reverts, crushed reverts, and bedding material; acid plant scrubber blowdown solids; and paved and unpaved roads.
8. "Ongoing visible emissions" means observed emissions to the outside air that are not brief in duration.
9. "Road" means any surface on which vehicles pass for the purpose of carrying people or materials from one place to another in the normal course of business at the Hayden Smelter.
10. "Slag" means the inorganic molten material that is formed during the smelting process and has a lower specific gravity than copper-bearing matte.
11. "Slag hauler" means any vehicle used to transport molten slag.
12. "Storage and handling" means all activities associated with the handling and storage of materials that take place at the Hayden Smelter, including, but not limited to, stockpiling, transport on conveyor belts, transport or storage in rail cars, crushing and milling, arrival and handling of offsite concentrate, bedding, and handling of reverts.
13. "Trackout/carry-out" means any materials that adhere to and agglomerate on the surfaces of motor vehicles, haul trucks, and/or equipment (including tires) and that may then fall onto the road.

C. Operational Standards.
1. Equipment operations. At all times, the owner or operator shall operate and maintain all non-smelting process sources, including all associated air pollution control equipment, control measures, and monitoring equipment, in a manner consistent with good air pollution control practices for minimizing lead-bearing fugitive dust, and in accordance with the fugitive dust plan required by subsection (C)(2) and performance and housekeeping requirements in subsection (D). A determination of whether acceptable operating and maintenance procedures are being used shall be based on all available information to the Department and EPA Region IX, which may include, but is not limited to, monitoring results, review of operating and maintenance procedures and records, review of fugitive dust plans, and inspection of the relevant equipment.
2. Fugitive dust plan. The owner or operator shall develop, implement, and follow a fugitive dust plan that is designed to minimize lead-bearing fugitive dust from non-smelting process sources. At minimum, the fugitive dust plan shall contain the following:
   a. Performance and housekeeping requirements in subsection (D).

b. Design plans and specifications for each wind fence to be installed to control lead-bearing fugitive dust from non-smelting process sources identified in subsections (D)(11) through (D)(14). The dust plan shall contain height limits for the materials being stored in each wind fence, consistent with the design plans and specifications for that particular wind fence. Wind fence design and specifications shall:
   i. Require full encircling of the source to be controlled, with reasonable and sufficient openings for ingress and egress;
   ii. Consider the orientation of the wind fence to the prevailing winds;
   iii. Consider the strength of the winds in the area where the fence will be located;
   iv. Consider the porosity of the material to be used, which shall not exceed 50%; and
   v. Consider the height of the fence relative to the height of the material being stored. At minimum, wind fence height shall be greater than or equal to the material pile height.

c. Design plans and specifications for each new or modified water sprayer system used to control lead-bearing fugitive dust from non-smelting process sources specified in subsections (D)(11) through (D)(14). The number, type, location, watering intensity, flow rates, and other operational parameters of the water sprayers must meet moisture content objectives for sources specified in subsections (D)(11) through (D)(14). The owner or operator may include in the dust plan an exemption to the water requirements at times when the materials are sufficiently moist or it is raining and thus there is no need for additional wetting until the next scheduled watering to meet moisture content objectives. The dust plan shall include the following for each water sprayer:
   i. Watering schedule;
   ii. Watering intensity;
   iii. Minimum flow rate or pressure drop;
   iv. Appropriate and/or continuous monitoring;
   v. Schedule for calibration based on the manufacturer's recommended calibration schedule;
   vi. Preventative maintenance schedule; and
   vii. Other applicable operational parameters.

d. Necessary improvements and/or modifications to material conveyor systems, along with a schedule for implementing improvements or modifications, targeted to minimize lead-bearing fugitive dust from non-smelting process sources specified in subsections (D)(11) through (D)(14), as applicable, to the greatest extent practicable. The improvements or modifications may include, but is not limited to, hooding of transfer points, utilizing water sprayers, and employing scrapers, brushes, or cleaning systems at all points where belts loop around themselves to catch and contain material before it falls to the ground.

e. Design plans for the concrete pads for the non-smelting process sources specified in subsections (D)(11) and (D)(13). The concrete pads shall be designed to capture, store, and control stormwater or sprayed water to minimize emissions to the greatest extent practicable, including curbing around the outer edges of the concrete pad where feasible.

f. Additional controls and measures for sources specified in subsections (D)(11) through (D)(14) to be implemented during high wind events. These additional controls or measures, which must include curtailment or other alteration of activity when appropriate, must be implemented at these sources during all periods of high wind.

g. Sample inspection sheets, checklists, or logsheets for each of the inspections identified in subsection (D)(6), and in accordance with the following:
   i. The inspection sheets or checklists shall include:
      (1) Specific descriptions of the equipment being inspected and the specific functions being evaluated;
      (2) The findings of the inspection;
      (3) The date, time, and location of inspections; and
      (4) An identification of who performed the inspection or logged the results.
   ii. The logsheets for high wind events shall include:
      (1) High wind event start time;
      (2) High wind event end time;
      (3) Description of area or activity inspected; and
      (4) Description of corrective action taken if necessary.

h. Design plans of the new acid plant scrubber blowdown drying system specified in subsection (D)(15).

i. The name and location of the meteorological station, which must be approved by the Department, that is to be used by the owner or operator for determining high wind events pursuant to subsection (B)(4) and for implementing control requirements pursuant to subsection (D)(5).

3. Plan development and revisions. The owner or operator shall develop and keep current the fugitive dust plan required by subsection (C)(2). Any plan or plan revision shall be consistent with this Section and shall be submitted to the Department for review. The initial plan shall be submitted to the Department for review no later than May 1, 2017. Plans and plan revisions shall be consistent with good air pollution control practice for fugitive dust. Except for the meteorological station to be used for high wind events pursuant to subsection (D)(5), which shall require prior approval, plans and plan revisions may be implemented upon submittal and shall remain in effect until superseded or until disapproved by the Department. Disapprovals are appealable Department actions.

D. Performance and Housekeeping Requirements. The owner or operator shall comply with these requirements at all times regardless of a fugitive dust plan.

1. Water sprayers. The owner or operator shall implement a recordkeeping system to capture sprayer operations, including identification of the particular operation, lead-bearing fugitive dust source, timing and intensity of watering, and data regarding the quantity of water used at each water sprayer.
2. Wind fences. The owner or operator shall ensure that wind fences used to control lead-bearing fugitive dust from the non-smelting process sources specified in subsections (D)(11) through (D)(14) meet the following requirements:

a. Wind fence height shall be greater than or equal to the material pile height. The allowed material pile height shall be posted in a readily visible location at each wind fence.
b. Wind fence porosity shall not exceed 50%.

3. Material conveyor systems. For sources specified in subsections (D)(11) through (D)(14), as applicable, the owner or operator shall:
   a. Minimize conveyor drop heights to the greatest extent practicable.
   b. Clean any spills from conveyors within 30 minutes of discovery. The material collected must be handled in such a way so as to minimize lead-bearing fugitive dust to the maximum extent practicable.
4. Vehicle transport of materials. The owner or operator shall maintain vehicle cargo compartments used to transport materials capable of producing lead-bearing fugitive dust so that the cargo compartment is free of holes or other openings and is covered by a tarp.
5. High wind event requirements.
   a. During high wind events, the owner or operator shall evaluate the non-smelting process sources specified in subsections (D)(11) through (D)(14) for ongoing visible emissions using the appropriate logsheet for each source.
   b. If ongoing visible emissions are observed, the owner or operator shall promptly wet the source of emissions with the objective of mitigating further emissions.
   c. If wetting does not appear to mitigate the ongoing visible emissions to 20% opacity or less, the owner or operator shall postpone associated handling of the source until the high wind event has ceased.
6. Physical inspections. The owner or operator shall conduct physical inspections as follows:
   a. Daily inspections of all water sprayers to make sure they are functioning and are in accordance with the dust plan;
   b. Daily visual inspections of all material piles to make sure they are maintained within areas protected by a wind fence, that they are not higher than allowed for the wind fence, and to verify that moisture content requirements are met;
   c. Daily inspections of all material handling areas to identify and clean up track out or spills of materials;
   d. Daily inspections of conveyor systems to identify and clean up material spills;
   e. Daily inspections of rumble grates sump levels;
   f. Daily spot inspections of vehicles carrying lead-bearing fugitive dust-producing materials when vehicles are in use to ensure that material is not overloaded, is properly covered, and cargo compartments are intact;
   g. Weekly inspections of wind fences for material integrity and structural stability;
   h. Daily inspections of all paved roads to identify and clean up track out or spills of materials;
   i. Daily inspections of unpaved roads in subsection (D)(10)(a) to identify areas where chemical dust suppressant coverage has broken down; and
   j. Bi-weekly inspections of the acid plant scrubber blowdown drying system enclosure.
7. Opacity limit and Method 9 readings.
   a. Opacity from lead-bearing fugitive dust emissions shall not exceed 20% from any part of the facility at any time. Opacity shall be determined by using 40 CFR 60, Appendix A, Reference Method 9, except for unpaved roads, in which opacity shall be determined pursuant to subsection (D)(10)(c).
   b. In the event that an employee observes ongoing visible emissions at a non-smelting process source covered by this Section, that employee shall promptly contact a Reference Method 9-certified observer, who shall promptly evaluate the emissions and conduct a Reference Method 9 reading, if possible.
   c. A Reference Method 9-certified observer shall conduct a weekly visible emissions survey of all non-smelting process sources covered by this Section and perform a Reference Method 9 reading for any plumes that on an instantaneous basis appear to exceed 15% opacity.
8. Corrective actions.
   a. At any time that visible emissions from the non-smelting process sources covered by this Section appear to exceed 15% opacity, the owner or operator shall take prompt corrective action to identify the source of the emissions and abate such emissions, with the corrective action starting within 30 minutes after discovery. For any non-smelting process source that produces visible emissions that appear to exceed 15% opacity, the owner or operator shall perform an analysis of the root cause, and implement a strategy designed to prevent, to the extent feasible, the ongoing recurrence of the source of visible emissions. Within 14 days of completion of its analysis, if appropriate, the owner or operator shall modify the fugitive dust plan in subsection (C)(2) for any changes identified from the analysis differing from the current provisions of the fugitive dust plan.
   b. At any time that the owner or operator becomes aware that provisions of the fugitive dust plan and/or performance and housekeeping provisions required by this Section are not being met, the owner or operator shall take prompt action to return to compliance, which may include modifications to monitoring, recordkeeping, and reporting requirements in the fugitive dust plan. This includes, but is not limited to, the following actions:
      i. Return water sprayers to full operational status;
      ii. Repair damaged conveyor hoodings or other enclosures;
      iii. Apply additional water to ensure that sources are meeting moisture content requirements;
      iv. Clean any trackout or spillage of dust-producing material, including dropoff of dust producing material from conveyors, using a street sweeper, vacuum, or wet broom with sufficient water and at the speed recommended by the manufacturer;
      v. Reapplication of chemical dust suppressants in areas where the coating has broken down on unpaved roads; and
      vi. Revisions to the fugitive dust plan to undertake improved monitoring, recordkeeping, and reporting requirements necessary to ensure that the controls contained in the fugitive dust plan are being implemented as contemplated by the fugitive dust plan.

9. Paved Roads. These requirements apply to all roads at the facility currently paved and roads to be paved in the future. The owner or operator shall:
   a. Clean roads at least ~~once~~ twice daily with a sweeper, vacuum, or wet broom in accordance with applicable manufacturer recommendations.
   b. Maintain the integrity of the road surface.
   c. Clean up trackout and carry-out of material on the following schedule:
      i. As expeditiously as practicable, when trackout and carry-out extends a cumulative distance of 50 linear feet or more; and
      ii. At the end of the workday, for all other trackout and carry-out.
   d. Comply with a speed limit not to exceed 15 mph for all vehicular traffic. At minimum, speed limit signs shall be posted at all entrances and truck loading and unloading areas and/or at conspicuous areas along the roadway.
10. Unpaved Roads. These requirements apply to the unpaved roads identified in subsections (D)(10)(a)(i) through (D)(10)(a)(iii) below, including any access points where the unpaved roads adjoin paved roads and any areas of vehicular handling of material. The owner or operator shall:
   a. Implement a chemical dust suppressant application intensity and schedule, which at minimum shall be:
      i. For the slag hauler road and all other unpaved roads used or to be used by the slag hauler, chemical dust suppressant shall be applied at least once per week during the summer, and once per every two weeks during the winter.
      ii. For the main road to the secondary crusher, chemical dust suppressant shall be applied at least once every six weeks, year-round.
      iii. For unpaved roads near reverts and silica flux crushing operations, chemical dust suppressant shall be applied at least once per two weeks during the summer, and once per month in the winter.
   b. Increase the frequency of chemical dust suppressant application if necessary to reduce fugitive dust emissions from unpaved roads.
   c. Not allow visible emissions to exceed 20% opacity and shall not allow silt loading equal to or greater than 0.33 oz/ft2. However, if silt loading is equal to or greater than 0.33 oz/ft2, then the owner or operator shall not allow the average percent silt content to exceed 6%. Compliance with these requirements shall be determined by the test methods described in Appendix 15.
   d. Maintain sufficient watering trucks and personnel to operate such trucks to be employed as an interim measure whenever visible emissions or a breakdown in dust suppressant covering are observed at any point along the treated unpaved road system.
   e. Immediately, but no later than 30 minutes after initial observation of any visible emissions, apply water or chemical dust suppressant to the portion of the unpaved road where the visible emissions were observed.
   f. Reapply chemical dust suppressant within 24 hours of discovery of any area where the surface chemical dust suppressant coverage has broken down.
   g. Collect and prevent from becoming airborne any runoff or material from rinsing or sweeping as soon as practicable.
   h. Comply with a speed limit not to exceed 15 mph for all vehicular traffic. At minimum, speed limit signs shall be posted at all entrances and truck loading and unloading areas and/or at conspicuous areas along the roadway.
11. Concentrate Storage, Handling, and Unloading. The owner or operator shall:
   a. Consolidate and manage all concentrate storage piles in one or more concrete storage pads.
   b. Store concentrate in an area with a wind fence in accordance with requirements set forth in the fugitive dust plan and pursuant to subsection (D)(2).
   c. Maintain water sprayers in accordance with requirements set forth in the fugitive dust plan and to ensure the surfaces of concentrate piles are wetted to maintain a nominal 10% surface moisture content as determined from representative samples using ASTM Method D2216-10 or other equivalent methods approved by the Department and EPA Region IX.
   d. Minimize the footprint of the concentrate storage piles by pushing into the stockpile with a front end loader and sweeping open areas of the pads with a self-powered vacuum sweeper at least daily during use.
12. Uncrushed Reverts Handling and Storage. The owner or operator shall:
   a. Manage uncrushed revert material only in areas protected by a wind fence in accordance with requirements set forth in the fugitive dust plan and pursuant to subsection (D)(2).
   b. Maintain water sprayers in accordance with requirements set forth in the fugitive dust plan and to ensure the surface of uncrushed revert material is wetted with the objective to minimize lead-bearing fugitive dust emissions to the greatest extent practicable.
13. Reverts Crushing Operations and Crushed Reverts Storage. The owner or operator shall:
   a. Crush revert and store crushed revert only on one or more concrete pads.
   b. Crush revert and store crushed revert only within an area protected by a wind fence in accordance with requirements set forth in the fugitive dust plan and pursuant to subsection (D)(2).
   c. Maintain water sprayers in accordance with requirements set forth in the fugitive dust plan and to ensure the surfaces of all crushed revert material, including revert managed after it is crushed, is wetted to maintain a nominal 10% surface moisture content as determined from representative samples using ASTM Method D2216-10 or other equivalent methods approved by the Department and EPA Region IX.
   d. By October 2017, relocate all revert crushing operations to 33º 00’ 25.84” N, 110º 46’ 26.55” W and shall crush revert only at this new location.
14. Bedding Operations, Including Handling, Storage, and Unloading. The owner or operator shall:
   a. Perform all bedding activities, including loading and unloading of materials to be blended, only within an area protected by a wind fence in accordance with requirements set forth in the fugitive dust plan and pursuant to subsection (D)(2). These

activities include the storage and handling areas for potentially lead-bearing fugitive dust-producing material within the bedding plant area.

b. Maintain water sprayers in accordance with requirements set forth in the fugitive dust plan and to ensure the surfaces of material in the bedding area is wetted to maintain a nominal 10% surface moisture content as determined from representative samples using ASTM Method D2216-10 or other equivalent methods approved by the Department and EPA Region IX.

c. Maintain rumble grates at all of the bedding plant's entrances and exits to shake off material on the loader tires as they enter and exit the area. Material that is tracked out of the bedding area must be cleaned up at the end of the workday.

d. Operate its bedding activities in a manner designed to avoid any trackout outside an area protected by a wind fence. Areas of material spillage or trackout, whether inside or outside of an area protected by a wind fence, shall be rinsed or cleaned daily.

15. Acid Plant Scrubber Blowdown Drying System.

a. The owner or operator shall dry acid plant scrubber blowdown solids only in an enclosed system that uses a venturi scrubber, thickener, filter press, and electric dryer that is maintained under negative pressure at all times that materials are being dried.

b. The owner or operator shall maintain the negative pressure of the electric dryer using a 2,500 ACFM dryer ventilation fan that must run at all times the electric dryer is operational. Monitoring of the negative pressure shall be demonstrated through the run and stop states of the ventilation fan and electric dryer.

c. The acid plant scrubber blowdown drying system shall include the following elements:

i. Venturi scrubber slurry that reports to a new thickener.

ii. Underflow from the thickener that goes to a filter press for further liquid removal, with the resulting filter cake sent to two electric dryers operating in parallel to provide final drying of the dust cake.

iii. Exhaust from the dryers sent to the packed gas cooling tower inlet duct.

iv. Dried cake discharged directly into bags.

d. The owner or operator shall clean all areas previously used for scrubber blowdown drying and no longer use previous areas for scrubber blowdown drying.

E. Contingency Requirements.

1. ~~If the owner or operator does not meet the compliance schedule below in subsection (E)(3), or if the Hayden Lead Nonattainment Area does not attain the 2008 Lead National Ambient Air Quality Standards by the attainment date established in the Act, whichever occurs first, then the owner or operator shall increase the paved road cleaning frequency specified in subsection (D)(9) to twice per day.~~Contingency measures

a. The owner or operator shall install wind fencing starting west of the filter plant and proceeding around its northern perimeter for an approximate length of 790 feet. The fence shall be at least 20 feet high or greater than or equal to the material pile height at the filter plant, whichever is greater. The allowed material pile height shall be posted in a readily visible location at the wind fence. Wind fence porosity shall not exceed 50 percent.

b. The owner or operator shall install a wind fence along the south perimeter road starting at the east end of the former SmithCo processing area and extending for an approximate length of 655 feet. The fence shall be at least 20 feet high or greater than or equal to the material pile height, whichever is greater. The allowed material pile height shall be posted in a readily visible location at the wind fence. Wind fence porosity shall not exceed 50 percent.

c. The owner or operator shall install a new perimeter fence on the southwest corner of the property extending from the south entry gateway area toward the chlorinator area and then reconnecting to the existing perimeter at the former SmithCo area. The fence shall be at least six feet high and shall be posted for no trespassing.

d. The fencing shall approximate that shown in Figure 4-3 of the State Implementation Plan Revision: 2024 Hayden Lead (Pb) Nonattainment Area for 2008 Pb NAAQS.

2. ~~The owner or operator shall implement the contingency measure in subsection (E)(1) within 60 days of notification by EPA Region IX of either a failure to meet the compliance schedule in subsection (E)(3) or a failure to attain by the attainment date established in the Act, whichever occurs first.~~Triggers. The owner or operator shall implement the contingency measures set forth in subsection (H)(1) no later than 60 days after receiving notice from the Department or EPA Region 9 that any of the following have occurred:

a. Failure to attain the 2008 Pb NAAQS by the January 31, 2027, attainment date.

b. Failure to make reasonable further progress (RFP).

3. ~~The compliance schedule is as follows. The Fugitive Dust Plan referred to in the compliance schedule shall mean the Fugitive Dust Plan submitted to the Administrator by the owner or operator to comply with requirements set forth in Consent Decree No. CV-15-02206-PHX-DLR, which became effective on December 30, 2015 in the United States District Court for the District of Arizona, as that plan may be later revised pursuant to subsection (C)(3):~~The owner or operator shall complete construction of the contingency measures as expeditiously as possible, but no later than 120 to 180 days after initiation.

~~Control Measure~~	~~Date of Implementation~~
~~Implementation of chemical dust suppression for unpaved roads.~~	~~Within 30 days of Administrator approval of application intensity and schedules in Fugitive Dust Plan.~~

~~Implementation of wind fences for materials piles (unerushed reverts, reverts crushing and crushed reverts, bedding materials, and concentrate).~~	~~Within 120 days of Administrator approval of the Fugitive Dust Plan or the date of completion in the approved Fugitive Dust Plan, whichever is later.~~
~~Implementation of water sprays for materials piles (unerushed reverts, reverts crushing and crushed reverts, bedding materials, and concentrate).~~	~~Within 120 days of Administrator approval of the Fugitive Dust Plan or the date of completion in the approved Fugitive Dust Plan, whichever is later.~~
~~Implementation of new acid plant scrubber blowdown drying system.~~	~~November 30, 2016~~
~~Implementation of new primary, secondary, and tertiary hooding systems for converter aisle for purposes of complying with requirements in R18-2-B1301.~~	~~July 1, 2018~~
~~Implementation of new ventilation system for matte tapping and slag skimming for flash furnace for purposes of complying with requirements in R18-2-B1301.~~	~~July 1, 2018~~

F. Ambient Air and Meteorological Monitoring Requirements.

1. The owner or operator shall conduct ambient air monitoring and sampling for lead as follows:
   a. At minimum, the owner or operator shall continue to maintain and operate the ambient lead monitors located at ST-14 (the smelter parking lot), ST-23 (Hillcrest area), ST-26 (post office), and ST-18 (next to the concentrate handling area).
   b. Samples must be collected continuously at all monitor sites specified in subsection (F)(1)(a). For the purposes of this requirement, "continuously" means that 24-hour filters are placed and collected at minimum, every six calendar days at all sites consistent with 40 CFR § 58.12.
   c. The owner or operator shall follow the Hayden Smelter's Quality Assurance Project Plan (QAPP) applicable to these monitors.
   d. The monitors must be operated and maintained in accordance with 40 CFR 58, Appendix A.
   e. The owner or operator shall submit each filter removed from each monitor to a certified laboratory for analysis no later than 18 calendar days after the filter's removal. The owner or operator shall ensure that the laboratory performs its analysis and submits the results to the owner or operator no later than 21 calendar days from the lab's receipt of the filter.
   f. The owner or operator shall calculate, update, and maintain as a record the following data within 14 calendar days of receipt of any results pertaining to the monitor filters received from a certified lab:
      i. The total pollutants on the filters collected and analyzed; and
      ii. Calculations of 30-day rolling average ambient air levels of lead for the ST-23, ST-26, and ST-18 monitors, and 60-day rolling average ambient air levels of lead for the ST-14 monitor, expressed as µg/m3.
   g. The owner or operator shall retain lead samples collected pursuant to this Section for at least three years. The samples shall be stored in individually sealed containers and labeled with the applicable monitor and date. Upon request, the samples shall be provided to the Department within five business days.
2. The owner or operator shall conduct meteorological monitoring as follows:
   a. Continuously monitor and record wind speed and direction data using equipment and a meteorological station approved by the Department.
   b. The owner or operator shall calculate and record average wind speed in miles per hour over 15 minutes, rolled each minute.
   c. Conduct wind speed and direction measurements using methods in accordance with EPA's Quality Assurance Handbook for Air Pollution Measurement Systems, Volume IV, Meteorological Measurements, Version 2.0.
3. The ambient air and meteorological monitoring stations required by this Section may be discontinued at the end of three full calendar years after the Hayden Lead Nonattainment Area is redesignated attainment for the 2008 Lead National Ambient Air Quality Standards.

G. Compliance Demonstration Requirements. The owner or operator shall demonstrate compliance with this Section by complying with all requirements in the fugitive dust plan pursuant to subsection (C)(2) and implementing all housekeeping and performance requirements pursuant to subsection (D).

H. Recordkeeping.
1. The owner or operator shall maintain the following records for at least five years and keep on-site for at least two years:
   a. Current and past fugitive dust plans required by subsection (C)(2).
   b. Physical inspection sheets, checklists, and logsheets for inspections conducted in accordance with subsection (D)(6).
   c. All records of opacity and stabilization tests, if any, conducted in accordance with subsection (D)(10)(c).
   d. All records of surface moisture content tests, if any, conducted in accordance with subsection (D)(11), subsection (D)(13), and subsection (D)(14).
   e. All records of major maintenance activities and inspections conducted on monitors required by subsection (F).
   f. All records of quality assurance and quality control activities for the monitors required by subsection (F).
   g. All air quality monitoring samples, rolling averages of ambient lead concentrations and necessary calculations, and data required by subsection (F).
   h. All records of wind data from the meteorological station required by subsection (F).
   i. All records of any periods during which a monitoring device required by subsection (F) is inoperative or not operating correctly.
   j. All records of reports and notifications required by subsection (I).
2. All of the following records maintained for the purposes of the fugitive dust plan required by subsection (C)(2) must be maintained in a recordkeeping log or recordkeeping system. As part of the records, the owner or operator shall include the dates and times for each of the following observations or activities, the name of the employee documenting each activity or observation, and the nature and location of each observation activity:
   a. Each instance of observed visible emissions of 15% opacity or greater, along with a description of any corrective action undertaken and its success.
   b. Water sprayer operations, including timing and intensity of watering to be captured in the water sprayer recordkeeping system.
   c. Timing, location, type, and amount of chemical suppressant and water applied to unpaved roads, and a description of the nature and timing of any additional corrective action taken, as necessary, to minimize emissions to the greatest extent practicable.
   d. Timing and location of all sweeping and cleaning of trackout or spillage material.
   e. Timing and location of all washdown of concrete areas.
   f. Timing and location of sump cleanouts.
   g. Results of all visible emissions surveys and Reference Method 9 readings.
   h. Appropriate records for operating conditions, including electric dryer ventilation fan start and stop times for the newly designed acid plant scrubber blowdown drying system.
   i. Calibration records for all measurement devices, including maintenance of manufacturer's manuals or other documentation for suggested calibration schedules and accuracy levels for each measurement device.
   j. Dates, times, and descriptions of deviations when the owner or operator's operations was carried out in a manner inconsistent with the fugitive dust plan required by subsection (C)(2).

I. Reporting. Within 30 days after the end of each calendar-year quarter, the owner or operator shall submit a report to the Department covering the prior quarter that includes the following:
1. All instances where observed fugitive emissions coming from sources covered in this Section were 15% or greater.
2. The date of all high wind events, with an identification of the location of the reading, wind speed, and duration of the event, and a description of actions taken as a result of the event on a source-by-source basis.
3. All instances where corrective action was required with identification of the emission source involved, what triggered the corrective action, what action the owner or operator undertook to abate or mitigate the problem, and whether the corrective action achieved the intended results.
4. A summary of all times when the electronic recordkeeping system was not recording data, and a summary and indication of the period when recorded data was outside of established operating parameters.
5. A summary of progress of all new construction, installation, upgrades, or modifications to equipment or structures at the facility required by the fugitive dust plan and subsection (D), including dates of commencement and completion of construction, dates of operations of new or modified equipment or structures, and dates old or outdated equipment or structures were permanently retired.
6. Raw monitoring data and calculated ambient lead concentrations from the ambient air monitoring stations required by subsection (F).

R18-2-B1302. Limits on SO_2 Emissions from the Hayden Smelter

A. Applicability.
1. This Section applies to the owner or operator of the Hayden Smelter. It establishes limits on sulfur dioxide emissions from the Hayden Smelter and monitoring, recordkeeping and reporting requirements for those limits.
2. Effective date. Except as otherwise provided, the requirements of this Section shall become applicable ~~on the earlier of July 1, 2018 or 180 days after completion of all project improvements authorized by Significant Permit Revision No. 60647~~upon smelter restart.
3. The sulfur dioxide emissions limitations contained in subsection (C)(3) shall become effective 60 days after the Hayden smelter achieves maximum production after smelter restart or 180 days after smelter restart, whichever occurs first.
4. The operational controls and limitations contained in subsection (D) shall be implemented upon smelter restart or the time specified as otherwise provided in subsection (D).

B. Definitions. In addition to definitions contained in R18-2-101 and R18-2-B1301, the following definitions apply to this rule.

1. "Anode Secondary Hood System" means the secondary hoods installed around each of the anode furnaces to improve the capture of fugitive emissions from the anode furnaces during charging, holding and processing, route the emissions to a new anode secondary hood baghouse for fabric filter control, and then to the annulus of the main stack.
~~1~~2. "Continuous emissions monitoring system" or "CEMS" means the total equipment, required under the emission monitoring provisions in this Chapter, used to sample, condition (if applicable), analyze, and to provide, on a continuous basis, a permanent record of emissions.
3. "Fuming ladle" means a ladle emitting an abnormal amount of fume after discharge of material.
4. "Maintenance downturn" means a scheduled maintenance period lasting at least eight working hours.
~~2~~5. "Operating day" means any calendar day in which any of the following occurs:
   a. Concentrate is smelted in the smelting furnace;
   b. Copper or sulfur bearing materials are processed in the converters;
   c. Blister or scrap copper is processed in the anode furnaces;
   d. Molten metal, including slag, matte or blister copper, is transferred between vessels; or
   e. Molten metal is cast into anodes or other intermediate or final products.
~~3~~6. "Out of control period" means the time that begins with the completion of the fifth, consecutive, daily calibration drift check with a calibration drift in excess of two times the allowable limit, or the time corresponding to the completion of the daily calibration drift check preceding the daily calibration drift check that results in a calibration drift in excess of four times the allowable limit, and the time that ends with the completion of the calibration check following corrective action that results in the calibration drifts at both the zero (or low-level) and high-level measurement points being within the corresponding allowable calibration drift limit.
7. "Smelter restart" means the first day after the issuance of Permit No. 96410 that concentrate is processed through the INCO flash furnace to produce matte.
8. "Table 1" means the table labeled "Uptake Improvement System, Flow Conditions and Damper Positions," in Appendix 1 of the attachment labeled "Hayden Smelter Site-Specific SIP Requirements," in the current Class I Air Quality Permit issued to the Hayden smelter.
9. "Table 2" means the table labeled "Uptake Improvement System Interlock Timing," in Appendix 1 of the attachment labeled "Hayden Smelter Site-Specific SIP Requirements," in the current Class I Air Quality Permit issued to the Hayden smelter.
10. "Table 3" means the table labeled "Anode Secondary Hood System Flow Conditions and Damper Positions," in Appendix 1 of the attachment labeled "Hayden Smelter Site-Specific SIP Requirements," in the current Class I Air Quality Permit issued to the Hayden smelter.
11. "Table 4" means the table labeled "Emergency Shutdown Ventilation Flue Emissions," in Appendix 1 of the attachment labeled "Hayden Smelter Site-Specific SIP Requirements," in the current Class I Air Quality Permit issued to the Hayden smelter.

C. Sulfur Dioxide Emissions Limitations.

1. Sulfur dioxide ~~Emissions~~ emissions from the Main Stack shall not exceed 1069.1 pounds per hour on a 14-operating day average. ~~unless 1,518 pounds or less is emitted during each hour of the 14-operating day period.~~
2. The owner ~~and~~ or operator shall not cause to be discharged into the atmosphere from any affected unit subject to 40 CFR 60 subpart P any gases which contain sulfur dioxide in excess of the limit set forth in 40 CFR § 60.163(a) (as in effect on July 1, 2016 and no later editions).
3. Fugitive emissions limits. These limits shall apply when the underlying processes are in operation, including periods of startup, shutdown and malfunction.
   a. Fugitive emissions of SO_2 from the flash furnace, matte tapping and slag skimming areas shall not exceed 38.5 pounds/hour, as measured by the flash furnace roofline monitoring system.
   b. Fugitive emissions of SO_2 from the converter aisle area shall not exceed 10.0 pounds/hour, as measured by the converter aisle roofline monitoring system.
   c. Fugitive emissions of SO_2 from the anode furnaces shall not exceed 9.0 pounds/hour, as measured by the anode furnace roofline monitoring system.
   d. The owner or operator may apply for a significant permit revision to change the applicable fugitive emissions limits in (a), (b), and (c) of this subsection to another set of limits provided in the following table:

Rebalanced Fugitive Emissions Limits	Fugitive emissions of SO_2 from the flash furnace, matte tapping, and slag skimming areas (pounds/hour)	Fugitive emissions of SO_2 from the converter aisle area (pounds/hour)	Fugitive emissions of SO_2 from the anode furnaces (pounds/hour)
Scenario 1	37	10	10
Scenario 2	35.5	10	11
Scenario 3	34	10	12
Scenario 4	36.5	11	9
Scenario 5	35	11	10
Scenario 6	34	11	11
Scenario 7	32.5	11	12
Scenario 8	35	12	9
Scenario 9	33.5	12	10
Scenario 10	32	12	11
Scenario 11	30.5	12	12
Scenario 12	33	13	9
Scenario 13	32	13	10
Scenario 14	30.5	13	11

Scenario 15	29.1	13	12

D. Operational Standards.

1. Process equipment and control device operations. At all times, including periods of startup, shutdown, and malfunction, the owner or operator shall, to the extent practicable, maintain and operate smelter processes and associated emission ~~control~~ capture and/or control equipment in a manner consistent with good air pollution control practices for minimizing SO_2 emissions to the levels required by subsection (C). Determination of whether acceptable operating and maintenance procedures are being used will be based on all information available to the Director and EPA Region IX, which may include, but is not limited to, monitoring results, review of operating and maintenance procedures and records, and inspection of the relevant equipment.
2. Capture system and control device operations and maintenance plan. The owner or operator shall develop and implement an operations and maintenance plan for each capture system and/or control device used to ventilate or control process gas or emissions from the flash furnace including matte tapping, slag skimming, and slag return operations; converter primary hoods, converter secondary hoods, tertiary ventilation system, and anode refining operations. The operations and maintenance plan must address the following requirements as applicable to each capture system and/or control device.
   a. Monitoring devices. The plan shall provide for installation, operation, calibration, and maintenance of appropriate monitoring devices to measure and record operating limit values or settings at all times the required capture and control system is operating, except during periods of monitor calibration, repair and malfunction. The initial plan shall provide for volumetric flow monitoring on the vent gas baghouse (inlet or outlet), each converter primary hood, each converter secondary hood, the tertiary ventilation system and the anode furnace baghouse (inlet or outlet). All monitoring devices shall be accurate within +/- 10% and calibrated according to manufacturer's instructions. If direct measurement of the exhaust flow is infeasible due to physical limitations or exhaust characteristics, the owner or operator may propose a reliable equivalent method for approval. Initial monitoring may be adjusted as provided in subsection (D)(2)(e). Dampers that are manually set and remain in the same position while the capture system is operating are exempt from these monitoring requirements. Capture system damper position ~~setting(s)~~ setting or settings shall be specified in the plan.
   b. Operational limits. The owner or operator shall establish operating limits in the operations and maintenance plan for the capture systems and/or control devices that are representative and reliable indicators of the performance of the capture system and control device operations. The initial operating limits may be adjusted as provided in subsection (D)(2)(e). Initial operating limits shall include the following:
      i. Identification of those modes of operation when the double dampers between the flash furnace vessel and the vent gas system will be closed and the interstitial space evacuated to the acid plant.
      ii. A minimum air flow for the furnace ventilation system and associated damper positions for each matte tapping hood or slag skimming hood when operating to ensure that the ~~operation(s)~~ operation or operations are within the confines or influence of the capture system.
      iii. A minimum air flow for the secondary hood baghouse and associated damper positions for each slag return hood to ensure that the operation is within the confines or influence of the capture system's ventilation draft during times when the associated process is operating.
      iv. A minimum air infiltration ratio for the converter primary hoods of 1:1 averaged over 24 converter Blowing hours, rolled hourly measured as volumetric flow in primary hood less the volumetric flow of tuyere Blowing compared to the volumetric flow of tuyere Blowing.
      v. A minimum secondary hood exhaust rate of 35,000 SCFM during converter Blowing, averaged over 24 converter Blowing hours, rolled hourly.
      vi. A minimum secondary hood exhaust rate of 133,000 SCFM during all non-Blowing operating hours, averaged over 24 non-Blowing hours, rolled hourly.
      vii. A minimum negative pressure drop across the secondary hood when the doors are closed equivalent to 0.007 inches of water.
      viii. A minimum exhaust rate on the tertiary hooding of 400,000 ACFM during all times material is processed in the converter aisle, averaged over 24 hours and rolled hourly.
      ix. Fan amperes or minimum air flow for the anode furnace baghouse and associated damper positions for each anode furnace hood to ensure that the anode furnace off-gas port is within the confines or influence of the capture system's ventilation draft during times when the associated furnace is operating.
      x. The anode furnace charge mouth shall be kept covered when the tuyeres are submerged in the metal bath except when copper is being charged to or transferred from the furnace.
      xi. The temperatures of the acid plant catalyst bed, which shall at minimum, meet the manufacturer's recommendations.
      xii. The acid plant catalyst replenishment criteria, which shall at minimum, meet the manufacturer's recommendations.
   c. Preventative maintenance. The owner or operator must perform preventative maintenance on each capture system and control device according to written procedures specified in the operation and maintenance plan. The procedures must include a preventative maintenance schedule that is consistent with the manufacturer's or engineer's instructions, or operator's experience working with equipment, and frequency for routine and long-term maintenance. This provision does not prohibit additional maintenance beyond that required by the plan.
   d. Inspections. The owner or operator must perform inspections in accordance with written procedures in the operations and maintenance plan for each capture system and control device that are consistent with the manufacturer's, engineer's or operator's instructions for each system and device.
   e. Plan development and revisions.
      i. The owner or operator shall develop and keep current the plan required by this Section. Any plan or plan revision shall be consistent with this Section, shall be designed to ensure that the capture and control system performance conforms to the attainment demonstration in the ~~Hayden 2010 Sulfur Dioxide National Ambient Air Quality Standards Nonattainment Area State Implementation Plan (SIP)~~ Final SIP Revision: 2023 Hayden Sulfur Dioxide Nonattainment Area

for the 1971 and 2010 SO_2 NAAQS, and shall be submitted to the Department for review. Any plan or plan revision submitted shall include the associated manufacturer's recommendations and/or instructions used for capture system and control device operations and maintenance.

ii. The owner or operator shall submit the ~~initial~~ revised plan to the Department ~~no later than May 1, 2018~~ within 180 days of smelter restart and shall include the initial volumetric flow monitoring provisions in subsection (D)(2)(a), the initial operational limits in subsection (D)(2)(b), the preventative maintenance procedures in subsection (D)(2)(c), and the inspection procedures in subsection (D)(2)(d).

iii. The owner or operator shall submit to the Department for approval a plan revision with changes, if any, to the initial volumetric flow monitoring provisions in subsection (D)(2)(a) and initial operational limits in subsection (D)(2)(b) not later than six months after completing a fugitive emissions study conducted in accordance with Appendix 14. The Department shall submit the approved changes to the volumetric flow monitoring provisions and operational limits pursuant to this subsection to EPA Region IX as a SIP revision not later than 12 months after completion of a fugitive emissions study.

iv. Other plan revisions may be submitted at any time when necessary. All plans and plan revisions shall be designed to achieve operation of the capture system and/or control device consistent with the attainment demonstration in the ~~Hayden 2010 Sulfur Dioxide National Ambient Air Quality Standards Nonattainment Area SIP~~ Final SIP Revision: 2023 Hayden Sulfur Dioxide Nonattainment Area for the 1971 and 2010 SO_2 NAAQS. Except for changes to the volumetric flow monitoring provisions in subsection (D)(2)(a) and operational limits in subsection (D)(2)(b), which shall require prior approval, plans and plan revisions may be implemented upon submittal and shall remain in effect until superseded or until disapproved by the Department. Disapprovals are appealable Department actions.

3. Flash Furnace Area Capture Improvements

a. Prior to smelter restart after issuance of Significant Permit Revision No. 96410, the owner or operator shall install additional hooding and interceptor walls (the "Uptake Improvement System") to improve the capture of fugitive emissions from the flash furnace area, matte tapping and slag skimming areas, route them to the existing converter secondary hood baghouse for fabric filter and high surface area lime injection control, and then to the annulus of the main stack.

b. The Uptake Improvement System shall have a design evaluation rate of 50,000 to 60,000 ACFM hourly average and shall operate when the flash furnace is in operation except for brief periods when slag is being returned to the flash furnace using the slag launder return. At those times, the ventilation for this system shall be switched to the slag return capture system and then switched back automatically to the Uptake Improvement System at the conclusion of the slag return cycle.

c. Establishment of Operational Ranges

i. The owner or operator shall establish a range of damper positions based upon the secondary hood baghouse flow monitor that provides reasonable assurance that the Uptake Improvement System exhaust flow is within the design range specified in (D)(3)(b). The ranges shall be established and verified by a stack test no later than 180 days after smelter restart and may be revised thereafter in the same fashion. The proposed ranges, stack test verifying evacuation rates compliant with (D)(3)(b) and proposed revision to Table 1 shall be submitted to the department within 45 days of the stack test. If the Director concurs that the proposed damper position ranges assure an exhaust flow compliant with (D)(3)(b), the Director shall issue a revised Table 1 reflecting the new damper position range. Thereafter, the owner or operator shall comply with the approved Table 1 range. Until the first submittal is approved, the owner or operator shall use ranges specified in Table 1 of Appendix I of Significant Permit Revision 96410. The current ranges shall be specified in Table 1 of the "Hayden Smelter Site-Specific SIP Requirements" attachment to the Class I Air Quality Permit for the smelter.

ii. The owner or operator shall establish a timed interlock on the slag return launder such that when slag is returned to the flash furnace the ventilation air from the Uptake Improvement System is switched to the slag return capture system for a defined period of not less than 5 minutes nor more than 10 minutes and then returns to the Uptake Improvement System automatically. The owner or operator shall optimize the period within the five to 10-minute range established during the initial 60-day optimization period by observation and analysis and thereafter as necessary. The first analysis, proposed time period, and proposed revisions to Table 2 shall be submitted no later than 75 days after the smelter restart. The Director shall approve any period that falls within both the five to 10-minute range and a range between the mean and mean plus a standard deviation of the observed slag return durations. If the Director concurs that the proposed range meets these requirements, the Director shall issue a revised Table 2. All analyses shall be submitted and approved by the Director. Until the first report is approved, the owner or operator shall use ranges specified in Table 2 of Appendix I of Significant Permit Revision No. 96410. The current ranges shall be specified in Table 2 the "Hayden Smelter Site-Specific SIP Requirements" attachment to the Class I Air Quality Permit for the smelter.

d. Operational requirements

i. The owner or operator shall operate the Uptake Improvement/Launder Return combined damper in accordance with the approved Table 1 range or ranges at all times the flash furnace is operating and at all times matte tapping, slag skimming or slag returning is occurring.

ii. The owner or operator shall operate the timed interlock in accordance with the approved Table 2 value. Operators shall trigger the interlock prior to starting slag return and may trigger the timed interlock again if slag is still returning at the end of the interlock cycle to minimize emissions.

iii. The owner or operator shall inspect the Uptake Improvement System during each scheduled maintenance downturn to ensure that the hooding and walls are in proper position and that there are no visible accretions of material in the mouth of the hooding that would preclude efficient operation. The owner or operator shall quarterly, evaluate the damper controlling air between the Uptake Improvement System and the slag return capture system to ensure it is operating properly. Records of these inspections shall be maintained for five years.

4. Converter and Material Transfer Area Capture Improvements

a. Prior to smelter restart after issuance of significant Permit Revision No. 96410, the owner or operator shall install a Fuming Ladle Capture System, which shall have a design evacuation rate of 40,000 to 50,000 ACFM when a ladle is present within the hooded area. The capture system shall run until the ladle is removed or for at least 20 minutes after the ladle is placed in the containment. Fuming ladles shall not be removed from the fuming Ladle Capture System containment unless fuming has stopped or the ladle is transported directly to the tunnel or within the capture area of a secondary hood.

b. The owner or operator shall develop training for its employees responsible for ladle movement on identification of fuming ladles. The training shall be developed within 60 days of smelter restart. Existing employees shall be trained within 90 days of smelter restart and any new employees shall be trained before working ladle operations unsupervised by a trained operator. Employees shall be retrained once every five years. Training records for the operators shall be kept for five years. The training and records shall be available for inspections.

c. The owner or operator shall, whenever a fuming ladle is detected, promptly move the fuming ladle into the Fuming Ladle Capture System.

d. The owner or operator shall conduct an initial flow test within 180 days of smelter restart to verify that the system achieves the design flow. The results of this flow test shall be reported to the Department within 45 days of completion of the test.

e. The owner or operator shall inspect the Fuming Ladle Capture System during each scheduled maintenance downturn to ensure that it is actuating properly, that the hoods and walls are in proper position, and there are no visible accretions of material in the mouth of the hood that would preclude efficient operation. Records of these inspections shall be maintained for five years.

5. Anode Furnace Secondary Hood Capture Control System

a. Prior to smelter restart after issuance of Significant Permit Revision No. 96410, the owner or operator shall install secondary hoods around each of the anode furnaces to improve the capture of fugitive emissions from the anode furnaces during charging, holding and processing, route the emissions to a new anode secondary hood baghouse for fabric filter control, and then to the annulus of the main stack. This is the Anode Secondary Hood system.

b. The Anode Secondary Hood System

i. The Anode Secondary Hood System shall have an overall design evacuation rate for the total system of 150,000 ACFM hourly average.

ii. The anode secondary hood baghouse shall have a maximum design emission rate of 0.002 gr/scf.

iii. Each secondary hood shall be equipped with dampers that can close completely and operate with a range from 20 to 100% to modulate flows to the individual anode furnace.

iv. The Anode Secondary Hood System shall be operated to achieve balanced flows (± 15%) on the two operating anode furnaces when neither are charging. When one anode furnace is charging, the Anode Secondary Hood System shall be balanced so that the charging furnace achieves a minimum of 100,000 ACFM and the other operating furnace gets the balance.

c. The owner or operator shall establish a range of damper positions and total flow conditions based upon the anode secondary hood baghouse flow monitor that provides reasonable assurance that the Anode Secondary Hood system exhaust flow is within the design range. These ranges and flow conditions shall be verified during a performance test within 180 days of smelter restart and may be revised thereafter in the same fashion. The proposed ranges and flow conditions, stack test verifying evacuation rates compliant with (D)(5)(b)(i) and (D)(5)(b)(iv) and proposed revision to Table 3 of Appendix 1 shall be submitted to the Department within 45 days of the stack test. If the Director concurs that the proposed damper position and flow ranges assure an exhaust flow compliant with (D)(5)(b)(i) and (D)(5)(b)(iv), the Director shall issue a revised Table 3 of Appendix 1 reflecting the new approved Table 3 ranges. Until the first performance test, the owner or operator shall use ranges specified by the air pollution control designer in Table 3 of Attachment I of Significant Permit Revision 96410. The current flows shall be specified in Table 3 of Appendix 1 of the "Hayden Smelter Site-specific SIP attachment" to the Class I air quality permit for the smelter. Damper positions shall be logged and the logs kept for five years.

d. Operational requirements. The owner or operator shall operate the Anode Secondary Hoods in accordance with the approved Table 3 range or ranges at all times the anode furnaces are operating.

e. The owner or operator shall inspect the Anode Secondary Hood System during scheduled maintenance down turn to ensure that the dampers are working properly, the hoods and walls are in proper position and that there are no visible accretions of material in the mouth of the hoods that would preclude efficient operation. Records of these inspections shall be maintained for five years.

~~3~~6. Emissions from the anode furnace baghouse stack shall be routed to the Main Stack.

E. Main Stack Monitoring.

1. To determine compliance with subsection (C)(1) the owner or operator of the Hayden Smelter shall install, calibrate, maintain, and operate a CEMS for continuously monitoring and recording SO_2 concentrations and stack gas volumetric flow rates at the following locations.
   a. The exit of the acid plant;
   b. The exit of the secondary hood particulate control device after the High Surface Area (HSA) lime injection system;
   c. The exit of the flash furnace particulate control device after the HSA lime injection system;
   d. The tertiary ventilation system prior to mixing with any other exhaust streams; ~~and~~
   e. The anode furnace baghouse stack prior to mixing with any other exhaust streams~~.~~; and
   f. The exit of the Anode Secondary Hood Baghouse. This system shall be installed and a relative accuracy test audit (RATA) successfully completed within 180 days of the effective date of this section under (A)(3).
2. Except during periods of systems breakdown, repairs, maintenance, out-of-control periods, calibration checks, and zero and span adjustments, the owner or operator shall continuously monitor SO_2 concentrations and stack gas volumetric flow rates at each location in subsection (E)(1).

3. For purposes of this Section, continuous monitoring means the taking and recording of at least one measurement of SO_2 concentration and stack gas flow rate reading from the effluent of each affected stack, outlet, or other approved measurement location in each 15-minute period when the associated process units are operating. Fifteen-minute periods start at the beginning of each clock hour, and run consecutively. All CEMS required by subsection (E)(1) shall complete at least one cycle of operation (sampling, analyzing, and data recording) for each successive 15-minute period.

~~4. If the owner or operator can demonstrate to the Director that measurement of stack gas volumetric flow rate in the outlet of any particular piece of SO_2 control equipment would yield inaccurate results or would be technologically infeasible, then the Director may allow measurement of the flow rate at an alternative sampling point.~~

5~~4~~. The owner or operator shall demonstrate that the CEMS required by subsection (E)(1) meet all of the following requirements:

a. The SO_2 CEMS installed and operated under this Section meets the requirements of 40 CFR 60, Appendix B, Performance Specification 2 and Performance Specification 6. The CEMS on the anode furnace baghouse stack and tertiary ventilation system shall complete an initial Relative Accuracy Test Audit (RATA) in accordance with Performance Specification 2. The RATA runs shall be tied to when the anode furnace is in use and, for the tertiary system, when the converters are in operation and/or material is being transferred in the converter aisle. Asarco may petition the Department and EPA Region IX on the criteria for subsequent RATAs for the anode furnace baghouse stack or tertiary ventilation system CEMS. The petition shall include submittal of CEMS data during the year.

b. The SO_2 CEMS installed and operated under this Section meets the quality assurance requirements of 40 CFR 60, Appendix F.

c. The owner or operator shall notify the Director in writing at least 30 days in advance of the start of the relative accuracy test audit (RATA) performed on the CEMS.

d. The Director shall approve the location of all sampling points for monitoring SO_2 concentration and stack gas volumetric flow rates and the appropriate span values for the monitoring systems. This approval shall be in writing before installation and operation of the measurement instruments.

e. The measurement system installed and used under this subsection is subject to the manufacturer's recommended zero adjustment and calibration procedures at least once per operating day unless the manufacturer specifies or recommends calibration at shorter intervals, in which case the owner or operator shall follow those specifications or recommendations. The owner or operator shall make available a record of these procedures that clearly shows instrument readings before and after zero adjustment and calibration.

f. The owner or operator shall maintain on hand and ready for immediate installation sufficient spare parts or duplicate systems for the CEMS required by this Section to allow for the replacement within six hours of any monitoring equipment part that fails or malfunctions during operation.

6~~5~~. ~~The owner or operator of the Hayden Smelter may petition the Department to substitute annual stack testing for the tertiary ventilation or the anode furnace baghouse stack CEMS if the owner or operator demonstrates, for a period of two years, that either CEMS contribute(s) less than 5% individually of the total sulfur dioxide emissions. The Department must determine the demonstration adequate to approve the petition.~~ Annual stack testing shall use EPA Methods 1, 4, and 6C in 40 CFR 60 Appendix A or an alternate method approved by the Department and EPA Region IX. Annual stack testing shall commence no later than the one year after the date the continuous emission monitoring system was removed. The owner or operator shall submit a test protocol to the Department at least 30 days in advance of testing. The protocol shall provide for three or more 24-hour runs unless the owner or operator justifies a different period and the Department approves such different period. Reports of testing shall be submitted to the Department no later than 60 days after testing or 30 days after receipt, whichever is later. The report shall provide an emissions rate, in the form of a pound per hour or pound per unit of production factor, that shall be used in the compliance demonstration in subsection ~~(F)(1)~~ (H)(1). Except as provided herein, the owner or operator shall otherwise comply with Section R18-2-312 in conducting such testing.

F. Fugitive Emissions Monitoring.

1. To determine compliance with subsection (C)(3) the owner or operator of the Hayden Smelter shall install, calibrate, maintain and operate a CEMS for continuously monitoring and recording SO_2 emissions and volumetric flows at the roofline of the following areas when the underlying process units are operating:
   a. Flash furnace roofline system, located on the penthouse and roof of the flash furnace building;
   b. Converter aisle roofline system, located at the north and south ends of the converter aisle, and
   c. Anode aisle roofline system, located over the anode furnaces.
2. These systems shall be installed and certified successfully completed within 180 days of the effective date of this section under (C)(3). The owner or operator shall notify the Director in writing at least 30 days in advance of the initial certification testing performed on the CEMS.
3. The CEMS shall meet the requirements of (E)(4) except that everywhere those provisions specify a relative accuracy test audit (RATA) a cylinder gas audit (CGA) shall be used instead.
4. The owner or operator shall develop a roofline monitoring system operations and maintenance plan (Roofline Plan) that addresses the roofline monitoring system required by (F)(1). The roofline Plan shall include the following elements:
   a. A diagram showing the location of each intake point and which intake points are directed to which CEMS;
   b. A protocol for how the intake points will be sampled by the CEMS;
   c. A description of each CEMS, its required Quality Assurance/Quality Control procedures and span;
   d. Manufacturer's or installer's recommended zero adjustment and calibration procedures, which must provide for instrument readings before and after zero adjustments and calibrations, to be implemented at least once per operating day on the CEMS and at a frequency set forth in the protocol for flow meters;
   e. A list of replacement parts that shall be maintained on hand and ready for immediate installation on the CEMs within 6 hours and to allow fabrication of new sample runs and installation within 10 days; and
   f. Equations showing how mass emission rates will be calculated.

5. The owner or operator shall submit the roofline Plan to the Department and EPA Region IX at least 90 days prior to smelter restart. The owner or operator may submit other revisions at any time when necessary. All revisions shall be designed to achieve data collection at the roofline monitoring system consistent with the attainment demonstration in Final SIP Revision: 2023 Hayden Sulfur Dioxide Nonattainment Area for the 1971 and 2010 SO_2 NAAQS. Plans and plan revisions may be implemented upon submittal and shall remain in effect until superseded or until disapproved by the Department or EPA Region IX.

G. Emergency Shutdown Ventilation Flue Monitoring. The owner or operator shall install instrumentation on the Emergency Shutdown Ventilation Flue to detect and record all periods that the bypass is in operation. The owner or operator shall keep a log of all times of both damper positions and, when both dampers are open, whether the period is a planned or unplanned maintenance period. The owner or operator shall log any periods when one damper is open and the other damper is closed stating when the malfunctioning damper was repaired. For purposes of this rule, "planned maintenance" means any period where the owner or operator has shut down the associated emissions units and run the evacuation system until the inlet meter at the acid plant registers the equivalent of 53.5 lbs/hr or less before opening the emergency Shutdown Ventilation Flue. The inlet concentration shall be documented in the operating log.

~~F~~**H.** Compliance Demonstration Requirements.

1. For purposes of determining compliance with the emission limit in subsection (C)(1) the owner or operator shall calculate emissions for each operating day as follows:
   a. Sum the hourly pounds of SO_2 vented to each uncontrolled shutdown ventilation flue and through each monitoring point listed in subsection (E)(1) for the current operating day and the preceding 13-operating days to calculate the total pounds of SO_2 emissions over the 14-operating day averaging period, as applicable.
   b. Divide the total amount of SO_2 emissions calculated from subsection ~~(F)(1)(a)~~ (H)(1)(a) by 336 to calculate the 14-operating day average SO_2 emissions.
   ~~c. If the calculation in subsection (F)(1)(b) exceeds 1069.1 pounds per hour, then the owner or operator shall sum the hourly pounds of SO_2 vented to each uncontrolled shutdown ventilation flue and through each monitoring point listed in subsection (E)(1) for each hour of the current operating day and each hour of the preceding 13-operating days to ascertain if any hour exceeded 1,518 pounds per hour.~~
2. When no valid hour or hours of data have been recorded by a continuous monitoring system required by subsections (E)(1) and (E)(2) and the associated process unit is operating, the owner or operator shall calculate substitute data for each such period according to the following procedures:
   a. For a missing data period less than or equal to 24 hours, substitute the average of the hourly SO_2 concentrations recorded by the system for the hour before and the hour after the missing data period.
   b. For a missing data period greater than 24 hours, substitute the greater of:
      i. The 90th percentile hourly SO_2 concentrations recorded by the system during the previous 720 quality-assured monitor operating hours.
      ii. The average of the hourly SO_2 concentrations recorded by the system for the hour before and the four hours after the missing data period.
   c. Notwithstanding subsections ~~(F)(3)(a)~~ (H)(3)(a) and ~~(F)(3)(b)~~ (H)(3)(b), the owner or operator may present any credible evidence as to the quantity or concentration of emissions during any period of missing data.
3. The owner or operator shall determine compliance with the requirements in subsection (D)(2) as follows:
   ~~a.~~ Maintaining and operating the emissions capture and control equipment in accordance with the capture system and control device operations and maintenance plan required in subsection (D)(2) and recording operating parameters for capture and control equipment as required in subsection (D)(2)(b)~~; and.~~
   ~~b. Conducting a fugitive study in accordance with Appendix 14 starting not later than six months after completion of the Converter Retrofit Project authorized by Significant Permit Revision No. 60647. The fugitive study shall demonstrate, as set forth in Appendix 14, that fugitive emissions from the smelter are consistent with estimates used in the attainment demonstration in the Hayden 2010 Sulfur Dioxide National Ambient Air Quality Standards Nonattainment Area SIP.~~
4. The owner or operator shall include periods of startup, shutdown, malfunction, or other upset conditions when determining compliance with the emission limits in subsection (C).
5. The owner and operator shall demonstrate compliance with the limit in subsection (C)(2) in accordance with 40 CFR §§ 60.165 and 60.166 (as in effect on July 1, 2016 and not later editions).
6. Notwithstanding subsections (H)(2)(a) and (H)(2)(b), the owner or operator may present any credible evidence as to the quantity or concentration of emissions during any period of missing data.
7. For purposes of demonstrating compliance with the main stack limit in (C)(1) and (H)(2)(a), the pounds of SO_2 in the emergency shutdown vent shall be calculated for unplanned use of the emergency shutdown ventilation system as the total volume of the emergency shutdown system at the maximum expected SO_2 concentrations in each segment and 10 percent of that amount for planned shutdowns when the evacuation system is run until SO_2 emissions shown on the combined CEMS system are less than 53.5 lb/hr. Future changes to the design volume of the emergency shutdown system or to the maximum SO_2 concentrations used in the calculation shall be submitted to the Department with a written justification for the change and revised calculations showing the newly calculated planned and unplanned shutdown emissions. This justification may be included as part of a required permit or permit revision. The change shall not be made until approved by the Director. A copy of the current calculations and planned and unplanned shutdown emissions values shall be included in Table 4.

I. Fugitive Limit Compliance Demonstration Requirements.

1. Compliance with the fugitive emission limits in (C)(3) shall be demonstrated as follows:
   a. Each valid hour of calculated emissions from the flash furnace roofline system in (F)(1)(a) shall be compared to the limit in (C)(3) to demonstrate compliance.
   b. Each valid hour of calculated emissions from the converter aisle roofline system in (F)(1)(b) shall be compared to the limit in (C)(3) to demonstrate compliance.

c. Each valid hour of calculated emissions from the anode aisle roofline system in (F)(1)(c) shall be compared to the limit in (C)(3).
d. The owner or operator shall maintain 95% or more valid hours for each system listed in (F)(1).
e. The owner or operator shall include periods of startup, shutdown, malfunction, or other upset condition when determining compliance with the limits in (C)(3).

2. Conducting a fugitive study in accordance with Appendix 14 starting not later than six months after completion of the Converter Retrofit Project authorized by Significant Permit Revision No. 60647. The fugitive study shall demonstrate, as set forth in Appendix 14, that fugitive emissions from the smelter are consistent with estimates used in the attainment demonstration in the Final SIP Revision: 2023 Hayden Sulfur Dioxide Nonattainment Area for the 1971 and 2010 SO_2 NAAQS.

J. For the purposes of demonstrating compliance with the limits in subsection (C), all CEMS listed in (C), (E), and (F) shall use the following data validity requirements:

1. Except as provided under (J)(3) for a full operating hour (any clock hour with 60 minutes of unit operation), at least four valid data points are required to calculate the hourly average, i.e., one data point in each of the 15-minute quadrants of the hour.
2. Except as provided under (J)(3) for a partial operating hour (any clock hour with less than 60 minutes of unit operation), at least one valid data point in each 15-minute quadrant of the hour in which the unit operates is required to calculate the hourly average.
3. For any operating hour in which required maintenance or quality-assurance activities are performed:
   a. If the unit operates in two or more quadrants of the hour, a minimum of two valid data points, separated by at least 15 minutes, is required to calculate the hourly average; or
   b. If the unit operates in only one quadrant of the hour, at least one valid data point is required to calculate the hourly average.
4. If a daily calibration error check is failed during any operating hour, all data for that hour shall be invalidated, unless a subsequent calibration error test is passed in the same hour and the requirements of (J)(3) are met, based solely on valid data recorded after the successful celebration.
5. For each full or partial operating hour, all valid data points shall be used to calculate the hourly average.
6. Data recorded during periods of continuous monitoring system breakdown, repair, maintenance, out of control periods, calibration checks, and zero and span adjustments shall not be included in the data averages computed under (H) and (I).
7. Either arithmetic or integrated averaging of all data may be used to calculate the hourly average. The data may be recorded in reduced or non-reduced form.

~~G.~~**K.** Recordkeeping.

1. The owner or operator shall maintain a record of each operation and maintenance plan required under subsection ~~(D)(2)~~ (D)(1).
2. The owner or operator shall maintain the following records for at least five years:
   a. All measurements from the continuous monitoring system required by ~~subsection~~ subsections (E)(1) and (F)(1), including the date, place, and time of sampling or measurement; parameters sampled or measured; and results. All measurements will be calculated daily.
   b. All records of quality assurance and quality control activities for emissions measuring systems required by subsections (E)(1) and (F)(1).
   c. All records of calibration checks, adjustments, maintenance, and repairs conducted on the continuous monitoring systems required by ~~subsection~~ subsections (E) and (F); including records of all compliance calculations required by ~~subsection~~ subsections (H) and ~~(F)~~(I).
   d. All records of the occurrence and duration of any startup, shutdown, or malfunction in the operation of concentrate drying, smelting, converting, anode refining and casting emission units; any malfunction of the associated air pollution control equipment; or any periods during which a continuous monitoring system or monitoring device required by ~~subsection~~ subsections (E)(1) or (F)(1) is inoperative or not operating correctly.
   e. All records of planned and unplanned shutdown ventilation flue utilization events and calculations used to determine emissions from shutdown ventilation flue utilization events if the owner or operator chooses to use the alternative compliance determination method.
   f. All records of major maintenance activities and inspections conducted on emission units, capture system, air pollution control equipment, and CEMS, including those set forth in the operations and maintenance plan required by subsection (D)(2).
   g. All records of operating days and production records required for calculations in subsection ~~(F)~~(I).
   h. All records of fugitive emissions studies and study protocols conducted in accordance with Appendix 14.
   i. All records of reports and notifications required by subsection ~~(H)~~(L).

~~H.~~**L.** Reporting.

1. The owner or operator shall notify the Director in writing at least 30 days in advance of the start of relative accuracy test audit (RATA) procedures performed on the continuous monitoring systems required by subsection (E)(1)~~.~~.
2. Within 30 days after the end of each calendar quarter, the owner or operator shall submit a data assessment report to the Director in accordance with 40 CFR Part 60, Appendix F for the continuous monitoring systems required by ~~subsection~~ subsections (E) and (F).
3. The owner or operator shall submit an excess emissions and monitoring systems performance report or summary report form in accordance with 40 CFR § 60.7(c) to the Director quarterly for the continuous monitoring systems required by subsection (E)(1). Excess emissions means any 14-operating day average as calculated in subsection ~~(F)~~(H) in excess of the emission limit in subsection (C)(1), any period in which the capture and control system was operating outside of its parameters specified in the capture system and control device operation and maintenance plan in subsection (D)(2). ~~For any 14-operating day period exceeding 1069.1 pounds per hour that the owner or operator claims does not exceed the limit in subsection (C)(1) because all hours in the operating period are below 1,518 pounds per hour, the owner or operator shall submit the CEMS data for each hour during that period.~~ All reports shall be postmarked by the 30th day following the end of each calendar quarter time period.
4. The owner or operator shall provide the following to the Director:

a. The owner or operator shall notify the Director of commencement of construction of any equipment necessary to comply with the operational or emission limits.
b. The owner or operator shall submit semiannual progress reports on construction of any such equipment postmarked by July 30 for the preceding January-June period and January 30 for the preceding July-December period.
c. The owner or operator shall submit notification of initial startup of any such equipment within 15 business days of such startup.

5. The owner or operator shall notify the Director of any control equipment malfunctions that cause an exceedance of an applicable limit within two working days within discovery.

~~I.~~**M.** Preconstruction review. This Section is determined to be Reasonably Available Control Technology (RACT) for SO_2 emissions from the operations subject to subsection (C) for purposes of minor source NSR requirement addressed in R18-2-334.

A14. Appendix 14. Procedures for Sulfur Dioxide and Lead Fugitive Emissions Studies for the Hayden Smelter

A14.1. Applicability

This Appendix applies to the owner or operator of the primary copper smelter located in Hayden, Arizona at latitude 33º0'15"N and longitude 110º46'31"W.

A14.2. Study Objectives

The owner or operator shall conduct fugitive emissions studies to derive a measurement or accurate estimate of total fugitive sulfur dioxide and lead emissions from the Hayden smelter during operations, including planned and unplanned start-up and shutdown periods and malfunctions, for the processes identified in A14.3 below. The studies shall include uncaptured fugitive sulfur dioxide emissions from the smelter processing units, but not emissions due solely to the use of fuel for space heating or steam generation, burners at anode casting, or slag pouring at the slag dump. The studies shall evaluate the extent to which correlations may exist between fugitive sulfur dioxide, lead, and particulate matter ($PM/PM_{10}/PM_{2.5}$) emissions, and shall develop such correlations as feasible.

The studies shall also be used to help validate that the operating conditions or ranges specified in the capture and control device maintenance and operations plans required in R18-2-B1301(D)(2) and R18-2-B1302(D)(2) are consistent with operating conditions demonstrating attainment of the 2008 Lead National Ambient Air Quality Standards (NAAQS) in the ~~Hayden 2008 Lead NAAQS Nonattainment Area State Implementation Plan (SIP) and the 2010 Sulfur Dioxide NAAQS in the Hayden 2010 Sulfur Dioxide NAAQS Nonattainment Area SIP~~ State Implementation Plan Revision: 2024 Hayden Lead (Pb) Nonattainment Area for 2008 Pb NAAQS and the Final State Implementation Plan Revision: 2023 Hayden Sulfur Dioxide Nonattainment Area for the 1971 and 2010 SO_2 NAAQS.

A14.3. Processes Evaluated

From the fugitive emissions studies, the owner or operator shall develop an emission factor or accurate estimate of fugitive emissions for sulfur dioxide and lead during operations, including planned and unplanned start-up and shutdown periods and malfunctions, produced by each of the following smelting processes:

i. Flash furnace building, including flash furnace and dryer operations
ii. Converter aisle, including converter and related operations
iii. Anode furnace aisle, including oxidizing, poling and related operations

A14.4. Averaging Periods

The emission estimate shall include the average pounds per hour emission factor for the fugitive lead and sulfur dioxide emissions from each step in the smelting process identified in A14.3. The estimate shall include all time periods, including planned and unplanned start-up and shutdown periods and malfunctions.

A14.5. Methods and Study Protocols

A14.5.1. Sulfur Dioxide Fugitive Emissions Studies

The fugitive emissions studies for Sulfur Dioxide shall be completed according to the updated Fugitive Emissions Study Protocol submitted to the EPA on January 20, 2017 and approved by the EPA on May 31, 2017. The owner or operator may submit modifications to the protocol six months prior to each study for EPA approval and Department comment. Upon EPA approval, the modified protocol shall take effect. Study protocols shall specify the method or methods used to meet the study objectives as described in A14.2, including during all recurring operating scenarios from all processes identified in A14.3.

~~The owner or operator shall submit to the Department and EPA Region IX for review and approval study protocols at least six months prior to conducting fugitive emission studies. Study protocols must be approved by the Department and EPA Region IX prior to commencement of fugitive emissions studies. Study protocols shall specify the method(s) used to meet the study objectives as described in A14.2, including during all recurring operating scenarios from all processes identified in A14.3.~~

Each fugitive emissions measurement system shall include validation of adequate velocity for flow measurements (i.e., the expected exhaust velocity is within the measurement range of the instrument), and have a sufficient number of flow and temperature sensors to ensure calculation of representative exhaust flows through each roof monitor vent. The number of such sensors and their locations for each monitoring system shall account for the physical configuration of the roof monitor vent, the locations of emitting activities relative to the roof monitor vent, and heat generated by the equipment served by the roof monitor vent.

The fugitive emissions studies shall include operation and process information to help understand the emission impacts of startup, shutdown, malfunctions, and significant changes in process operations. This shall include, for example, dates, times and duration of these events, cause of malfunctions, and descriptions of process changes.

After the completion of each fugitive emissions study, the owner or operator shall modify study methods based on data and lessons learned from previous studies, and submit such modified methods in the proceeding study protocols prior to conducting future emissions studies.

A14.5.2. Lead Fugitive Emissions Studies

The fugitive emissions studies for Lead shall be completed according to the updated Fugitive Emissions Study Protocol submitted to the EPA on January 20, 2017 and approved by the EPA on May 31, 2017. The owner or operator may submit modifica-

tions to the protocol six months prior to each study for EPA approval and Department comment. Upon EPA approval, the modified protocol shall take effect. Study protocols shall specify the method or methods used to meet the study objectives as described in A14.2, including during all recurring operating scenarios from all processes identified in A14.3.

Each fugitive emissions measurement system shall include validation of adequate velocity for flow measurements (i.e., the expected exhaust velocity is within the measurement range of the instrument), and have a sufficient number of flow and temperature sensors to ensure calculation of representative exhaust flows through each roof monitor vent. The number of such sensors and their locations for each monitoring system shall account for the physical configuration of the roof monitor vent, the locations of emitting activities relative to the roof monitor vent, and heat generated by the equipment served by the roof monitor vent.

The fugitive emissions studies shall include operation and process information to help understand the emission impacts of startup, shutdown, malfunctions, and significant changes in process operations. This shall include, for example, dates, times and duration of these events, cause of malfunctions, and descriptions of process changes.

After the completion of each fugitive emissions study, the owner or operator shall modify study methods based on data and lessons learned from previous studies, and submit such modified methods in the proceeding study protocols prior to conducting future emissions studies.

A14.6. Study Duration, Frequency, and Submission Schedule

A14.6.1. Sulfur Dioxide Fugitive Emissions Studies

The first fugitive emissions study must commence not later than six months after the completion of ~~the Converter Retrofit Project~~ all project improvements authorized by Significant Permit Revision No. ~~60647~~96410. The second study commencement date shall occur within the same calendar quarter, but five years later from the date of commencement of the first study. The owner or operator shall submit the results of each fugitive emissions study in a report to the Department and EPA Region IX for review and approval not later than six months after completing a study. The data collection portion of the first and second fugitive emissions studies shall be conducted for a period of 12 months to assess the content and quantity of fugitive sulfur dioxide and lead emissions.

A14.6.2. Lead Fugitive Emissions Studies

The first fugitive emissions study must commence within six months after restart of the smelter following the 2019 shutdown or three months after EPA approval of a modified protocol, whichever is later. The second study commencement date shall occur within the same calendar quarter, but five years after the date of commencement of the first study. The owner or operator shall submit the results of each fugitive emissions study in a report to the Department and EPA Region IX for review and approval not later than six months after completing a study. The data collection portion of the first and second fugitive emissions studies shall be conducted for a period of 12 months to assess the content and quantity of fugitive lead emissions.

A14.7. Study Reports and Subsequent Studies

At minimum, fugitive emission study reports submitted pursuant to A14.6 must include:

i. Resultant emission factors used to determine fugitive emissions of sulfur dioxide and lead.
ii. Resultant average fugitive lead emissions for each process identified in A14.3.
iii. Resultant peak one-hour fugitive sulfur dioxide emissions for each process identified in A14.3.
iv. Seasonal differences, if any.
v. Comparisons of results from past studies, if any.
vi. Descriptions and identification of volumetric flow monitoring provisions in R18-2-B1301(D)(2)(a) and R18-2-B1302(D)(2)(a) and operational limits R18-2-B1301(D)(2)(b) and R18-2-B1302(D)(2)(b) that are associated with fugitive emissions.
vii. An analysis of whether the results from a study demonstrate that the volumetric flow monitoring provisions in R18-2-B1301(D)(2)(a) and R18-2-B1302(D)(2)(a) and the operational limits in R18-2-B1301(D)(2)(b) and R18-2-B1302(D)(2)(b) continuously ensure that actual fugitive sulfur dioxide and lead emissions are consistent with the modeled emission rates used in the attainment demonstrations in the ~~Hayden 2008 Lead NAAQS Nonattainment Area SIP and the Hayden 2010 Sulfur Dioxide NAAQS Nonattainment Area SIP~~ State Implementation Plan Revision: 2024 Hayden Lead (Pb) Nonattainment Area for 2008 Pb NAAQS and the Final State Implementation Plan Revision: 2023 Hayden Sulfur Dioxide Nonattainment Area for the 1971 and 2010 SO_2 NAAQS. The analysis must also identify subsequent fugitive emissions studies, if any, needed to remedy inaccurate operational limits and volumetric flow monitoring provisions and to ensure attainment of the 2008 Lead NAAQS and 2010 Sulfur Dioxide NAAQS. The scope, duration, and frequency of any subsequent fugitive emissions studies must also be identified. This provision and the report's conclusion neither require nor prohibit future fugitive emission studies.
viii. An analysis of whether supplemental modeling is needed to ~~demonstrate that resultant fugitive emissions from a study provide attainment of the 2008 Lead NAAQS and 2010 Sulfur Dioxide NAAQS.~~ evaluate whether the 2010 Sulfur Dioxide NAAQS and/or 2008 Lead NAAQS will be attained at the emissions rates determined by the study.
ix. A summary of methods as followed per approved study protocols.

A14.7.1. Lead Specific

For lead fugitive emissions, a study shall also

i. Evaluate the effectiveness of MiniVol samplers in providing high quality, replicable data.
ii. Compare the MiniVol sampler data to estimates derived from lb/ton emission factors or other process parameters or surrogates.
iii. Evaluate the accuracy and cost effectiveness of various monitoring approaches.
iv. Recommend either a new lb/ton concentrate emission factor or a SIP revision to incorporate an improved monitoring methodology.

If the lead fugitive emissions study concludes that the lb/ton concentrate emission factor should be retained, permittee shall submit a justification for why an improved monitoring methodology (e.g., MiniVols) is not feasible and a justification for the

selected lb/ton concentrate factor and how it may be revised to maintain accuracy and representativeness. If the study concludes that a new methodology should be proposed, the owner or operator shall submit a petition to the Department to revise the SIP within 90 days after submitting the report unless either EPA or the Department provides comments upon the report, in which case the deadline is 60 days after the receipt of the final comments but no earlier than 90 days after the report submittal.

A14.8. Revisions to Operations and Maintenance Plan

If an analysis conducted in accordance with A14.7(vi) demonstrates that fugitive emissions associated with volumetric flow monitoring provisions in R18-2-B1301(D)(2)(a) and R18-2-B1302(D)(2)(a) and operational limits in R18-2-B1301(D)(2)(b) and R18-2-B1302(D)(2)(b) may exceed the modeled emission rates used in the ~~Hayden 2008 Lead NAAQS Nonattainment Area SIP attainment demonstration and/or the Hayden 2010 Sulfur Dioxide NAAQS Nonattainment Area SIP attainment demonstration~~ State Implementation Plan Revision: 2024 Hayden Lead (Pb) Nonattainment Area for 2008 Pb NAAQS and/or the Final State Implementation Plan Revision: 2023 Hayden Sulfur Dioxide Nonattainment Area for the 1971 and 2010 SO_2 NAAQS, and result in an increased likelihood of a NAAQS exceedance based on modeling required under A14.9, then the owner or operator shall submit to the Department for approval, not later than six months after completing a study, recommended changes to operational limits and volumetric flow monitoring provisions as an operations and maintenance plan revision pursuant to R18-2-B1301(D)(2)(e) and R18-2-B1302(D)(2)(e) that would achieve necessary fugitive emissions levels to demonstrate attainment of the NAAQS at the same level of assurance as in the attainment demonstrations. Until receiving approval of the plan revision, the owner or operator shall operate and maintain the volumetric flow monitoring provisions and the operational limits in accordance with the plan as initially submitted pursuant to R18-2-B1301(D)(2)(e) and R18-2-B1302(D)(2)(e). Additionally, the owner and operator shall submit new attainment demonstrations pursuant to A14.9, making appropriate demonstrations of attainment at adjusted fugitive emissions levels.

Similarly, if an analysis conducted in accordance with A14.7(vi) demonstrates that fugitive emissions associated with the volumetric flow monitoring provisions in R18-2-B1301(D)(2)(a) and R18-2-B1302(D)(2)(a) and operational limits in R18-2-B1301(D)(2)(b) and R18-2-B1302(D)(2)(b) may exceed the modeled emission rates used in the ~~Hayden 2008 Lead NAAQS Nonattainment Area SIP attainment demonstration and/or the Hayden 2010 Sulfur Dioxide NAAQS Nonattainment Area SIP attainment demonstration~~ State Implementation Plan Revision: 2024 Hayden Lead (Pb) Nonattainment Area for 2008 Pb NAAQS and/or the Final State Implementation Plan Revision: 2023 Hayden Sulfur Dioxide Nonattainment Area for the 1971 and 2010 SO_2 NAAQS, and result in an increased likelihood of a NAAQS exceedance based on modeling required under A14.9, then the Department shall submit appropriate changes to the operational limits and volumetric flow monitoring provisions, and any revised attainment demonstration pursuant to A14.9, if applicable, to EPA Region IX as a SIP revision not later than 12 months after completion of a fugitive emissions study.

A14.9. Supplemental Modeling

If an analysis conducted in accordance with A14.7(vii) demonstrates that fugitive emissions associated with volumetric flow monitoring provisions in R18-2-B1301(D)(2)(a) and R18-2-B1302(D)(2)(a) and operational limits in R18-2-B1301(D)(2)(b) and R18-2-B1302(D)(2)(b) are greater than the modeled emission rates used in the ~~Hayden 2008 Lead NAAQS Nonattainment Area SIP attainment demonstration and/or the Hayden 2010 Sulfur Dioxide NAAQS Nonattainment Area SIP attainment demonstration~~ State Implementation Plan Revision: 2024 Hayden Lead (Pb) Nonattainment Area for 2008 Pb NAAQS and/or the Final State Implementation Plan Revision: 2023 Hayden Sulfur Dioxide Nonattainment Area for the 1971 and 2010 SO_2 NAAQS, the owner or operator shall remodel to ~~demonstrate~~ evaluate whether the 2010 Sulfur Dioxide NAAQS and/or 2008 Lead NAAQS will be attained as such higher rates. The owner or operator shall submit such modeling to the Department and EPA Region IX for review and approval not later than six months after completing a fugitive emissions study.

If the revised modeling demonstrates that the 2010 Sulfur Dioxide NAAQS and/or 2008 Lead NAAQS will be attained, the Department shall submit such modeling demonstration and revised fugitive emissions assumptions as a SIP revision to EPA Region IX not later than 12 months after completion of a fugitive emissions study. Alternatively, the owner or operator shall propose additional emission control requirements to revise the SIP, or any combination of revised control measures and modeled attainment, to demonstrate attainment of the 2010 Sulfur Dioxide NAAQS and/or 2008 Lead NAAQS.

NOTICE OF PROPOSED RULEMAKING

TITLE 21. CHILD SAFETY

CHAPTER 1. DEPARTMENT OF CHILD SAFETY ADMINISTRATION

[R25-209]

PREAMBLE

1. Permission to proceed with this proposed rulemaking was granted under A.R.S. § 41-1039 by the governor on:

May 19, 2025

2. Article, Part, or Section Affected (as applicable)	**Rulemaking Action**
R21-1-501	Amend
R21-1-502	Amend
R21-1-504	Amend
R21-1-505	Amend
R21-1-506	Amend
R21-1-507	Amend

R21-1-508	Amend
R21-1-509	New Section
R21-1-510	New Section

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

Authorizing statute: A.R.S. § 8-453(A)(5)
Implementing statute: A.R.S. §§ 8-804, 8-804.02 and 8-811

4. Citations to all related notices published in the *Register* that pertain to the current record of the proposed rule:

Notice of Rulemaking Docket Opening: 31 A.A.R. 2946, September 12, 2025 (*in this issue*); File Number: R25-213

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

Name:	Karen Wouters
Title:	Rule Development Specialist
Address:	3003 N. Central Ave. Phoenix, AZ 85012
Telephone:	(602) 255-3461
Fax:	(480) 681-4000
Email:	Karen.Wouters@azdcs.gov
Website:	https://dcs.az.gov/about/dcs-rules-rulemaking

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

The rules under 21 A.A.C. 1, Article 5 pertain to the Department of Child Safety (Department) process for proposing to substantiate and unsubstantiating findings of abuse or neglect against an alleged perpetrator. The rules also describe the processes of notifying those affected by a proposed substantiation of abuse or neglect and informing them of their due process rights. There are a few reasons for proposing amending the rules in 21 A.A.C. 1, Article 5. First, necessary changes were identified in the Five-Year-Review Report approved by the Governor's Regulatory Review Council on June 6, 2023, including updating statutory references that have changed and detailing the process for the Director to review and make final decisions regarding administrative law judges' findings. Additionally, rules must be updated to reflect that A.R.S. § 8-811 changed the standard of proof for substantiating allegations of abuse or neglect from probable cause to a preponderance of the evidence. Finally, amendments to A.R.S. § 8-804 and the addition of A.R.S. § 8-804.02 require the Department to adopt rules for a tiered Central Registry. The updated rules detail the acts and omissions included on different tiers and considerations for early removal.

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

The Department of Child Safety 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. The preliminary summary of the economic, small business, and consumer impact:

The rules under 21 A.A.C. 1, Article 5 pertain to substantiation of abuse or neglect against an alleged perpetrator and the maintenance of the State's Central Registry. The rules also provide information on how an alleged perpetrator can appeal, request a hearing contesting the proposed substantiated findings, and request early removal from the Central Registry. The Department's Protective Services Review Team (PSRT) administers reviews and appeals related to the proposed substantiated findings of child abuse and neglect. The proposed amendments will allow the Director of the Department to modify or reject an Administrative Law Judge's Recommended Decision if it is factually or legally incorrect, among other conditions. The proposed amendments, as summarized under #6 of this Preamble, do not add a fee on the public, or require the Department to incur additional costs. One benefit of establishing a tiered registry system is individuals that may have previously remained on the registry for 25 years will be eligible for shorter timeframes under the new rules and have an opportunity for early removal of their name from the Central Registry. This will provide an economic benefit to the individual and businesses as individuals may be eligible sooner for more employment opportunities after their name is removed from the Registry. Aligning the rules with statutory updates will provide an overall benefit to affected individuals and the general public while also continuing to prioritize child safety.

10. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:

Name: Karen Wouters
Title: Rule Development Specialist
Division: Department of Child Safety
Address: 3003 N. Central Ave.
Phoenix AZ 85012
Telephone: (602) 255-3461
Fax: (480) 681-4000
Email: Karen.Wouters@azdcs.gov
Website: dcs.az.gov/about/policy/rulemaking

11. The time, place, and nature of the proceedings to make, amend, repeal, or renumber the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Written comments should be directed to the person listed in #5, Monday through Friday from 8 a.m. to 5 p.m., except for state holidays. Comments will also be accepted via email at the email address provided under item #5. All comments must be received by 5:00pm on close of public record. Mailed written comments shall be postmarked within 30 days of this published notice. The Department has scheduled an oral proceeding for public comments:

Date: October 15, 2025
Time: 10 a.m. – Noon
Location: Virtual Oral Proceeding via Microsoft Teams
Meeting ID: 212 571 792 487
Passcode: 8uN6DR2m
or
Dial in by phone
+1 480-561-6122
Phone conference ID: 556 824 516#

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 rules pertain to actions taken when the Department of Child Safety is proposing to substantiate findings of abuse or neglect against an alleged perpetrator and the appeal and hearing process. A general permit is not used.

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:

42 U.S.C. 5106 and 34 U.S.C. Ch. 209 are applicable to the subject of the rule. The rules are not more stringent than federal law.

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

Not applicable.

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

Not applicable.

14. The full text of the rules follows:

TITLE 21. CHILD SAFETY

CHAPTER 1. DEPARTMENT OF CHILD SAFETY ADMINISTRATION

ARTICLE 5. SUBSTANTIATION OF REPORT FINDINGS

Section
R21-1-501. Definitions

ARTICLE 5. SUBSTANTIATION OF REPORT FINDINGS

R21-1-501. Definitions

The following definitions apply to this Article.

1. "Abuse" No change
2. "Administrative law judge's decision" means the same as defined under A.R.S. § 41-1092.
3. "Amend the finding" means the same as defined under ~~A.R.S. § 8-811 (L)(1)~~ A.R.S. § 8-811.
4. ~~"Case Record"~~ "Case record" means the Report of child abuse and neglect and related records the Department intends to submit at the hearing, including information from internal and external sources.
5. "Central Registry" No change
6. "Completed Investigation" means the case record and the proposed substantiated finding for the report of child abuse or neglect have been reviewed and approved by a supervisor and contains ~~all of the~~ information ~~required~~ to support a finding of proposed substantiation.
7. "Dangerous drug" means the same as defined under A.R.S. § 13-3401.
8. "Day" No change
9. "Department" or "DCS" No change
10. "Ineligibility Letter" No change
11. "Initial Notification Letter" means a notice sent from the Department via first class mail to an alleged perpetrator informing the person of the proposed substantiated finding of child abuse or neglect to be entered into the Central Registry and describing appeal rights to challenge the proposed finding.
12. "Legally excluded" means that an alleged perpetrator is not entitled to an administrative hearing under A.R.S. § 8-811, because:
    a. The person is a party in a pending civil, criminal or administrative proceeding in which the allegations of abuse or neglect are at issue;
    b. The person is a party in a pending juvenile proceeding in which the allegations of abuse or neglect are at issue;
    ~~a~~c. A court or administrative law judge has made ~~a finding of~~ findings as to the alleged abuse or neglect ~~based on the same allegations as in the proposed substantiated finding~~; or
    ~~b~~d. A court has found that a child is dependent~~,~~ or has terminated a parent's rights based ~~upon~~ on ~~the same~~ an ~~allegations~~ allegation of abuse or neglect ~~as in the proposed substantiated finding~~.
13. "Medical Child Abuse" is a term used to describe when a child receives unnecessary and harmful, or potentially harmful, medical care at the instigation of a caregiver.
14. "Neglect" or "neglected" means the same as defined under ~~A.R.S. § 8-201(24)~~ A.R.S. § 8-201.
15. "Perpetrator" No change
16. ~~"Probable Cause" means some credible evidence that abuse or neglect occurred.~~ "Preponderance of the Evidence" means more probable than not an incident of abuse or neglect occurred.
17. "Proposed Substantiated Finding" means the Department has investigated and found ~~probable cause to support~~ that the preponderance of the evidence supports an allegation of abuse or neglect sufficient to place the alleged perpetrator's name into the Central Registry, subject to the alleged perpetrator's right to notice and a hearing.
18. "PSRT" No change
19. ~~"Report For Investigation"~~ "Report for Investigation" means the same as DCS Report as defined under ~~A.R.S. § 8-201(30)~~ A.R.S. § 8-201.
20. "Serious physical injury" means the same as defined under A.R.S. § 8-201.
21. "Substantiated Finding means a proposed substantiated finding that:
    a. An administrative law judge found to be true by a ~~probable cause~~ preponderance of the evidence standard of proof after notice and an administrative hearing and the ~~Department~~ Director accepted the ~~decision~~ administrative law judge's recommended decision;
    b. The Director upon independent review of the evidence presented at the administrative hearing has found to be true by a preponderance of the evidence standard of proof and either rejected or modified the administrative law judge's recommended decision under R21-1-507 in which case the Director's decision is the final administrative decision;
    ~~b~~c. The alleged perpetrator did not make a timely ~~appeal~~ request for an administrative hearing; ~~or~~
    d. The alleged perpetrator requested a hearing and failed to appear;
    e. The alleged perpetrator agreed to settlement language and the hearing was vacated;
    ~~c~~f. The alleged perpetrator was not entitled to an administrative hearing because the alleged perpetrator was legally excluded as defined ~~in~~ under subsection ~~(11).~~ (10); or
    g. The alleged perpetrator failed to respond after receiving notice of the Initial Notification Letter as required under A.R.S. § 8-811.

R21-1-502. Initial Notification Letter

A. When PSRT receives a proposed substantiated finding, PSRT shall notify an alleged perpetrator that:

1. The Department intends to substantiate the proposed finding and place the alleged perpetrator's name in the Central Registry;

2. The alleged perpetrator may obtain a copy of the Report for Investigation; and
3. The alleged perpetrator has the right to an administrative hearing before the person's name is entered ~~in~~ into the Central Registry.

B. The Department shall send the Initial Notification Letter to the alleged perpetrator no more than 14 days after the Completed Investigation.

R21-1-504. PSRT Review

A. Upon receiving a timely request for an administrative hearing, the PSRT shall within 60 days review the ~~Case Record~~ case record and shall:
1. Determine ~~there is no probable cause that the alleged perpetrator committed~~ the allegation of child abuse or neglect is not supported by a preponderance of the evidence and amend the proposed substantiated finding to unsubstantiated; or
2. Determine ~~there is probable cause~~ the allegation of abuse or neglect is supported by a preponderance of the evidence and send the alleged perpetrator a hearing notice unless the alleged perpetrator is ineligible under R21-1-505.

B. The hearing notice shall include:
1. The date and time of the hearing;
2. Notification of the right to request a settlement conference no later than 20 days before the hearing; and
3. Notification of the right, upon oral or written request to the Department, to receive a copy of the case record, redacted as required by A.R.S. § 8-807.

R21-1-505. Exceptions to Right to a Hearing

A. An alleged perpetrator shall be eligible to have an administrative hearing unless the alleged perpetrator is legally excluded.

B. The Department shall mail an alleged perpetrator who is legally excluded an Ineligibility Letter within seven days of the PSRT determination of ineligibility for an appeal.

C. The Department shall not schedule an administrative hearing if ~~the alleged perpetrator~~:
1. The alleged perpetrator ~~Is~~ is a party in a pending civil, criminal, or administrative proceeding in which the same allegations of child abuse or neglect are at issue; ~~or~~
2. The alleged perpetrator ~~Has~~ has a pending juvenile proceeding in which the same allegations of child abuse or neglect are at issue.~~;~~
3. A court or administrative law judge has made findings as to the alleged abuse or neglect; or
4. A court has found that a child is dependent or has terminated a parent's rights based on an allegation of abuse or neglect.

D. An alleged perpetrator whose hearing is not scheduled under subsection (C)(1) shall have six months from the date of the Ineligibility Letter to provide court documentation to the Department showing:
1. The results of the legal action;
2. That the proceedings are still pending; or
3. That the legal action did not ~~determine~~ result in a finding as to the ~~allegations~~ allegation of child abuse ~~and~~ or neglect.

E. If the alleged perpetrator does not contact the Department within six months of the date of the Ineligibility Letter with the information listed in subsection (D), the Department shall enter the person's name and the finding in the Central Registry.

F. Notwithstanding subsection (E), if the alleged perpetrator contacts the Department after six months and provides the documentation in subsection (D) the alleged perpetrator may be entitled to a hearing subject to the provisions of R21-1-508.

R21-1-506. Dependency Adjudication

~~If the court in a proceeding described in A.R.S. § 8-811(F)(3), makes a finding of dependency based on child abuse or neglect against a person, the Department shall enter the person's name and the fact of the dependency finding in the Central Registry.~~ If the court has found that a child is dependent or has terminated a parent's rights based on an allegation of abuse or neglect, PSRT shall enter the name of the person found to have abused or neglected the child and the fact of the dependency finding or termination of parental rights into the Central Registry if the person was a party to the dependency or termination of parental rights proceeding in that court. The Department shall determine the person's placement in a tier as described under R21-1-509.

R21-1-507. ~~Director Review and Further Appeal After the Administrative Hearing~~ Final Administrative Decision and Review

A. An administrative law judge's recommended decision is not the final administrative decision until the ~~Department~~ Director reviews the recommended decision. The Director has 30 days to review the administrative decision. The Director may accept, reject or modify ~~an~~ the administrative law judge's recommended decision under A.R.S. § 41-1092.08.

B. The Director shall review the pertinent portions of the factual record presented at the hearing, including the transcript or recording and the exhibits before the Director decides to reject or modify a Finding of Fact.

C. If the Director rejects or modifies the administrative law judge's Conclusion of Law, the Director shall provide written justification for the rejection or modification of the recommended administrative law judge's Conclusions of Law to the President of the Senate and the Speaker of the House of Representatives.

D. The Director shall only reject or modify an administrative law judge's recommended decision when:
1. The Director concludes that the ALJ's decision is not supported by a preponderance of the evidence or is arbitrary and capricious; or
2. The administrative law judge incorrectly applied the law in reaching its decision.

E. If the Director rejects or modifies the administrative law judge's recommended decision, the Director's decision is the final administrative decision. If the final administrative decision is to substantiate the finding, PSRT shall enter the perpetrator's name and substantiated finding in the Central Registry as outlined under R21-1-508(B).

~~B~~F. A perpetrator may appeal the final administrative decision under A.R.S. Title 12, Chapter 7, Article 6.

R1-1-508. Entry into the Central Registry

A. If the perpetrator does not appeal the proposed substantiation, PSRT shall enter the person's name and the substantiated finding ~~in~~ into the Central Registry.

B. ~~If the administrative decision upholds the substantiation and the Department Director accepts the decision,~~ PSRT shall enter the perpetrator's name and the substantiated finding in the Central Registry no later than ~~20~~35 days after the date of the final administrative decision if the decision is to substantiate the allegation of abuse or neglect.

C. ~~The Department shall not enter the person's name or the finding in the Central Registry if the:~~ If the court ruling described under R21-1-505(C) finds abuse or neglect by the perpetrator, PSRT shall enter the person's name and the substantiated finding in the Central Registry.

~~1. Final administrative decision holds that the allegations of abuse or neglect are not substantiated; or~~

~~2. A court ruling described in R21-1-505(C) finds no abuse or neglect by the alleged perpetrator.~~

D. ~~If the court ruling described in R21-1-505(C) finds abuse or neglect by the perpetrator, the PSRT shall enter the person's name and the substantiated finding in the Central Registry.~~PSRT shall not enter the person's name and the substantiated finding in the Central Registry if:

1. The administrative law judge's recommended decision finds that the allegation of abuse or neglect is not substantiated and the Director accepts the administrative recommendation; or
2. The court or administrative law judge in a proceeding described under R21-1-505(C) does not make a finding of abuse or neglect by the alleged perpetrator.

R21-1-509. Maintenance of the Central Registry

A. PSRT shall maintain the person's name and the substantiated finding in the Central Registry for a designated length of time of 0, 5, 15 or 25 years based on the severity and type of abuse or neglect and the potential risk the person may pose if the person were in a position or setting that involves the care of or substantial contact with children. The designated length of time on the registry is not appealable.

B. If an administrative law judge, a state or federal court, or the Director finds that the parent, guardian, custodian, or employee of a child welfare agency abused the child or the parent, guardian or custodian neglected the child, PSRT shall maintain the person's name and substantiated finding in the Central Registry for 25 years for any of the following acts or omissions:

1. Death of a child due to abuse or neglect;
2. Sexual assault or molestation after allowing a known sexual predator access to a child;
3. Aggravated domestic violence in front of a child by a parent, guardian, or custodian as defined under A.R.S. § 13-3601.02;
4. A diagnosis by a medical professional of non-medical malnutrition or failure to thrive without a previous diagnosis of a health condition;
5. Physical injury to a child by allowing the child to enter or remain in any structure or vehicle in which volatile, toxic or flammable chemicals are found or equipment by any person for the purpose of manufacturing a dangerous drug as defined under A.R.S. § 13-3401;
6. Inflicting or allowing sexual abuse under A.R.S. § 13-1404, sexual conduct with a minor under A.R.S. § 13-1405, sexual assault under A.R.S. § 13-1406, molestation of a child under A.R.S. § 13-1410, commercial sexual exploitation of a minor under A.R.S. § 13-3552, sexual exploitation of a minor under A.R.S. § 13-3553, incest under A.R.S. § 13-3608, child sex trafficking under A.R.S. § 13-3212 or other sexual abuse.
7. Inflicting or allowing a serious physical injury to a child that creates a reasonable risk of death or causes serious or permanent disfigurement, serious impairment of health, or loss or protracted impairment of the function of any bodily organ or limb.
8. Any other act of abuse or neglect that presents a serious physical injury that creates a reasonable risk of death, or serious emotional abuse to the child, and the Department determines there is a nexus between the act of abuse or neglect and the potential risk the perpetrator may pose if the perpetrator were in a position or setting that involves the care of or substantial contact with children.

C. If an administrative law judge, a state or federal court, or the Director finds that the parent, guardian, custodian, or employee of a child welfare agency abused the child or the parent, guardian or custodian neglected the child, PSRT shall maintain the person's name and substantiated finding in the Central Registry for 15 years for any of the following acts or omissions:

1. Inflicting or allowing of physical injury, impairment of bodily function or disfigurement; including bone fracture or fractures; serious injuries to the face or head; non-accidental burns; substantial bruising; and injuries on multiple parts of the body if the injuries include disfigurement, scarring, impairment, or loss of use;
2. Positive toxicology of the child for schedule 1 or 2 non-prescribed drugs that were supplied to the child by the parent, guardian or custodian or an employee of a child welfare agency;
3. Medical child abuse by a parent, guardian or custodian;
4. Unreasonable confinement of a child including binding the child's arms and/or legs together, binding the child to an object, or locking the child in a cage or confined space, unless medically prescribed;
5. Physical injury to a child during a domestic violence incident;
6. Leaving the child unattended in a vehicle or other conveyance by a parent, guardian, custodian or an employee of a child welfare agency, resulting in conditions or symptoms requiring medical attention;
7. Accidental drowning of a child due to recklessness;
8. Physically or verbally imposing, which means brandishing weapons, throwing objects intentionally at a child with the intent to hit or cause harm, or behaving in a manner that intends to cause the child to fear for their physical safety;
9. Recklessly or deliberately exposing a child to sexually explicit materials or acts;
10. A parent, guardian, or custodian is unwilling to meet the child's needs for supervision, food, clothing, shelter, or medical care as determined by a juvenile court adjudication or criminal conviction;
11. Inability to provide supervision of a child due to driving under the influence with the child in the vehicle, causing substantial risk of harm to the child;
12. Any other act of abuse or neglect of a child that could be classified as class 4, class 5, or class 6 felony child abuse, including but not limited to:
    a. Emotional abuse by a parent, guardian, custodian or an employee of a child welfare agency, or

b. A parent, guardian, or custodian, or an employee of a child welfare agency taking a child from the lawful custody of the Department.

D. If an administrative law judge, a state or federal court, or the Director finds that the parent, guardian, custodian, or employee of a child welfare agency abused the child or the parent, guardian or custodian neglected the child, PSRT shall maintain the person's name and substantiated finding in the Central Registry for 5 years for any of the following acts or omissions:
1. Physical abuse resulting in minor physical injury to the child;
2. Driving without properly restraining a child resulting in injury to the child;
3. Intentionally leaving the child unattended in a vehicle, placing the child at substantial risk of harm or physical injury;
4. Accidental drowning of a child due to negligence;
5. Unwillingness to protect the child from another person the individual knows is abusing or neglecting the child;

E. If an administrative law judge, a state or federal court, or the Director finds that the parent, guardian, custodian, or employee of a child welfare agency abused the child or the parent, guardian or custodian neglected the child, PSRT shall not enter or maintain the person's name and substantiated finding in the Central Registry for any of the following acts or omissions:
1. The parent, guardian or custodian is unable to protect themselves and the child from domestic violence without risk of harm to the child;
2. Child is born substance exposed or diagnosed with fetal alcohol syndrome;
3. The parent, guardian or custodian is unable to meet the child's needs for supervision, food, clothing, shelter, or medical care solely due to a lack of financial resources available to the parent, guardian or custodian; or
4. Positive toxicology with a substantial risk of physical injury of the child for non-schedule 1 or 2 illegal or non-prescribed drugs that were supplied by the parent, guardian, custodian or employee of a child welfare agency.

F. In determining the tier level for acts or omissions not specifically addressed in this Rule, the Department may consider:
1. The type of abuse or neglect identified in the substantiated finding;
2. The acts or omissions set forth in the substantiated finding;
3. The age of the child;
4. The likelihood of harm to a child as a result of the person's acts or omissions;
5. The severity of physical or emotional harm that may result from the acts or omissions;
6. Harm that did result from the person's acts or omissions; and
7. The extent to which the acts or omissions are relevant to the person's future contact with children and vulnerable adults.

R21-1-510. Early Removal from the Central Registry

A. To request early removal from the Central Registry, the person shall submit an application to the Department for early removal of their name from the Central Registry. The application shall include a written statement from the person whose name is on the Central Registry explaining how the person has demonstrated the rehabilitation necessary for early removal from the Central Registry.

B. The Department shall not accept applications for review until the person's name and substantiated finding has been on the Central Registry for a specified period of time as follows:
1. A person whose name is entered into the Central Registry for 25 years may apply for early removal after the person's name and substantiated finding has been on the Central Registry for at least 12.5 years.
2. A person whose name is entered into the Central Registry for 15 years may apply for early removal after the person's name and substantiated finding has been on the Central Registry for at least 7.5 years.
3. A person whose name is entered into the Central Registry for 5 years may apply for early removal after the person's name and substantiated finding has been on the Central Registry for at least 2.5 years.

C. To determine whether a person has demonstrated the rehabilitation necessary for an early removal from the Central Registry, the Department may consider a number of factors including:
1. The extent of the person's DCS history;
2. The length of time that has elapsed since the act was committed;
3. The potential future risk of harm to children from the perpetrator;
4. The nature of the act;
5. Any applicable mitigating circumstances;
6. The degree to which the person participated in the act;
7. The extent of the person's rehabilitation, including:
   a. Completion of recommended drug treatment programs;
   b. Completion of recommended behavioral treatment programs; and
   c. Counseling.

D. The Department shall issue a letter granting or denying the application for early removal of the person's name from the Central Registry 60 days after receiving the application. When the Department denies an application for early removal from the Central Registry, the Department shall include a determination regarding why early removal criteria were not met and a timeframe by which the applicant can re-apply.

NOTICES OF SUPPLEMENTAL PROPOSED RULEMAKING

This section of the *Arizona Administrative Register* contains Notices of Supplemental Proposed Rulemakings. After an agency has filed a Notice of Proposed Rulemaking and it is published in the *Register*, an agency may decide to make substantial changes to the rule after it is proposed.

The agency prepares a Notice of Supplemental Proposed Rulemaking with these proposed changes. When filed, the notice is published under the deadline schedule in the back of the *Register*.

The Notice of Supplemental Proposed Rulemaking shall be published in the *Register* before holding any oral proceedings (A.R.S. § 41-1022).

The Office of the Secretary of State is the filing office and publisher of these rules. Questions about the interpretation of the proposed rules should be addressed to the agency that promulgated the rules. Refer to item #4 below to contact the person charged with the rulemaking and item #11 for the close of record and information related to public hearings and oral comments.

NOTICE OF SUPPLEMENTAL PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R25-210]

PREAMBLE

1. Permission to proceed with this supplemental proposed rulemaking was granted under A.R.S. § 41-1039 by the governor on:

May 16, 2025

2. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the current record of the supplemental proposed rule:

Notice of Rulemaking Docket Opening: 31 A.A.R. 1843; Issue date: June 6, 2025; Issue Number: 23; File Number: R25-109

Notice of Proposed Rulemaking: 31 A.A.R. 1743; Issue date: June 6, 2025; Issue Number: 23; File Number: R25-103

3.

Article, Part, or Section Affected (as applicable)	Rulemaking Action
R9-22-712.35	Amend
R9-22-712.61	Amend
R9-22-712.71	Amend
R9-22-712.90	Amend

4. 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)

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

Name:	Sladjana Kuzmanovic
Title:	Sr. Rules Analyst
Division:	AHCCCS Office of General Counsel
Address:	150 N. 18th Ave. Phoenix, AZ 85007
Telephone:	(602) 417-4116
Fax:	(602) 253-9115
Email:	AHCCCSRules@azahcccs.gov
Website:	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 AHCCCS Differential Adjusted Payment (DAP) initiative is strategically designed to reward quality outcomes and reduce growth in the cost of health care. The objective of DAP delineated in this proposed rulemaking is to reward hospitals and hospital-based free standing emergency departments who have taken designated actions that improve patients' care experience, improve members' health, and reduce the cost of care. Hospitals and hospital-based emergency departments that meet the outlined criteria delineated in the proposed rule for the time period of October 1, 2025, through September 30, 2026 (CYE 2026), will be eligible for increased reimbursement from AHCCCS and its contracted health plans for both inpatient and outpatient services. This initiative reflects the AHCCCS Administration's continued commitment to promoting greater accountability within the health care delivery system.

The proposed rule will amend and clarify the conditions under which hospitals and hospital-based emergency departments may qualify for DAP during the specified timeframe. Key qualifying activities include engagement with the Health Information

Exchange, participation in the Naloxone Distribution Program, Maternal Syphilis Program, and/or Medications for Opioid Use Disorder Program. The proposed rulemaking will authorize AHCCCS to support the ongoing efforts to recognize innovation and expand the reach of its value-based care model, emphasizing improved patient care and reduced growth in the cost of care.

7. A reference to any study relevant to the rule that the agency reviewed and 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:

A study was not referenced or relied upon when revising these regulations.

8. An explanation of the substantial change which resulted in the supplemental notice:

AHCCCS has been required to make significant recent modifications to the DAP program in order to comply with newly communicated federal requirements.

9. 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:

Not applicable

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

The Administration anticipates that the DAP rulemaking will result in approximately $58.9 million of additional payments for the contract year October 1, 2025 through September 30, 2026 to 128 hospitals.

11. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:

Name:	Sladjana Kuzmanovic
Title:	Sr. Rules Analyst
Division:	AHCCCS Office of General Counsel
Address:	150 N. 18th Ave. Phoenix, AZ 85007
Telephone:	(602) 417-4116
Fax:	(602) 253-9115
Email:	AHCCCSRules@azahcccs.gov
Website:	www.azahcccs.gov

12. The time, place, and nature of the proceedings to make, amend, renumber, or repeal the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the supplemental proposed rule:

Written comments about this proposed rulemaking will be accepted in person at the address provided under item #5, Monday through Friday from 8 a.m. to 5 p.m., except for state holidays. Comments will also be accepted via email at the email address provided under item #5. Mailed written comments shall be postmarked within 30 days of this published notice.

An oral proceeding is scheduled on this supplemental proposed rulemaking.

Date:	October 14, 2025
Time:	2:00 p.m.
Location:	Virtual – Teams Meeting Meeting ID: 241 785 065 494 7 Passcode: 9gp3fK74 or Dial in by phone - (480) 561-5941 Conf. ID: 979386106#
Nature:	Public Hearing

Public comment period ends: October 14, 2025 at 5:00 p.m.

Close of record: October 14, 2025 at 5:00 p.m.

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

There are no other matters prescribed by the statute applicable specifically to the Administration or this specific rulemaking.

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

The rule does not require the issuance of a regulatory permit. Therefore, a general permit is not applicable.

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

The rules are not more stringent than federal law.

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

Not applicable

14. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:
Not applicable

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees
R9-22-712.61. DRG Payments: Exceptions
R9-22-712.71. Final DRG Payment
R9-22-712.90. Reimbursement of Hospital-based Freestanding Emergency Departments

ARTICLE 7. STANDARDS FOR PAYMENTS

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

A. For all claims with a begin date of service on or before September 30, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:
1. By 48 percent for public hospitals on July 1, 2005, and hospitals that were public anytime during the calendar year 2004;
2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
4. By 115 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the criteria during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
5. By 113 percent for a Freestanding Children's Hospital with at least 110 pediatric beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective; or
6. By 14 percent for a University Affiliated Hospital which is a hospital that has a majority of the members of its board of directors appointed by the Board of Regents during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective.

B. For all claims with a begin date of service on or after October 1, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services) for the following hospitals. A hospital shall receive an increase from only one of the following categories:
1. By 73 percent for public hospitals;
2. By 31 percent for hospitals in counties other than Maricopa and Pima with more than 100 licensed beds as of October 1 of that contract year;
3. By 37 percent for hospitals in counties other than Maricopa and Pima with 100 or fewer licensed beds as of October 1 of that contract year;
4. By 100 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the critical access criteria;
5. By 78 percent for a Freestanding Children's Hospital with at least 110 pediatric beds as of October 1 of that contract year; or
6. By 41 percent for a University Affiliated Hospital, this is a hospital that has a majority of the members of its board of directors appointed by the Arizona Board of Regents.

C. In addition to subsections (A) and (B), an Arizona Level 1 trauma center as defined by R9-22-2101 shall receive a 50 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services and out-of-state hospital services) for Level 2 and 3 emergency department procedures.

D. Hospitals with greater than 100 pediatric beds not receiving an increase under subsection (B) shall receive an 18 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services).

~~**E.** For outpatient services with dates of service from October 1, 2023 through September 30, 2024 (CYE 2024), the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2023. If a hospital receives a DAP for CYE 2024 but fails to meet all of the requirements in subsection (F), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2024 through September 30, 2025 (CYE 2025), if a DAP would be available at that time. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.~~
~~1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c) or (d):~~
~~a. No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE.~~

The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

i. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system.

ii. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.

iii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

iv. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.

v. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.

b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.

i. For hospitals that have participated in DAP HIE requirements in CYE 2023:

(1) No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization.

(2) After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry.

ii. For hospitals that have not participated in DAP HIE requirements in CYE 2023:

(1) No later than November 1, 2023, complete the AzHDR Participant Agreement, and

(2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.

c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.

i. For hospitals that have participated in DAP SDOH requirements in CYE 2023:

(1) No later than September 30, 2023, initiate use of the Community Cares referral system operated by the HIE organization.

(2) No later than May 1, 2024: After all the onboarding requirements have been met and the provider has access to the system and through September 30, 2024, the hospital must regularly utilize the Community Cares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month per registered AHCCCS ID that resulted from utilizing the social needs screening tool in Community Cares. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024.

ii. For hospitals that have not participated in DAP SDOH requirements in CYE 2023:

(1) No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required, and

(2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.

d. No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs. gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.

i. No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.

ii. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facility's policy.

2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in subsection (2)(a), (b), (c) or (d). No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
   a. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system.
      i. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
      ii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
      iii. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.
      iv. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.
   b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
      i. For hospitals that have participated in DAP HIE requirements in CYE 2023:
         (1) No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization.
         (2) After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry.
      ii. For hospitals that have not participated in DAP HIE requirements in CYE 2023:
         (1) No later than November 1, 2023, complete the AzHDR Participant Agreement, and
         (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.
   c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
      i. For hospitals that have participated in DAP SDOH requirements in CYE 2023:
         (1) No later than September 30, 2023, initiate use of the Community Cares referral system operated by the HIE organization.
         (2) No later than May 1, 2024: After all the onboarding requirements have been met and the provider has access to the system and through September 30, 2024, the hospital must regularly utilize the Community Cares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month per registered AHCCCS ID that resulted from utilizing the social needs screening tool in Community Cares. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024.
      ii. For hospitals that have not participated in DAP SDOH requirements in CYE 2023:
         (1) No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required, and
         (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.
   d. No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs. gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.

i. No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
ii. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facility's policy.

3. A hospital designated as type: hospital, subtype: long term, psychiatric, or rehabilitation by the Arizona Department of Health Services Division of Licensing Services will qualify for an increase if it meets the criteria specified in subsection (3)(a), (b), (c), (d), (e), or (f):
a. No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
i. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system.
ii. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
iii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
iv. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.
v. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.
b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
i. For hospitals that have participated in DAP HIE requirements in CYE 2023:
(1) No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization.
(2) After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry.
ii. For hospitals that have not participated in DAP HIE requirements in CYE 2023:
(1) No later than November 1, 2023, complete the AzHDR Participant Agreement, and
(2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.
c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
i. For hospitals that have participated in DAP SDOH requirements in CYE 2023:
(1) No later than September 30, 2023, initiate use of the Community Cares referral system operated by the HIE organization.
(2) No later than May 1, 2024: After all the onboarding requirements have been met and the provider has access to the system and through September 30, 2024, the hospital must regularly utilize the Community Cares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month per registered AHCCCS ID that resulted from utilizing the social needs screening tool in Community Cares. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024.
ii. For hospitals that have not participated in DAP SDOH requirements in CYE 2023:
(1) No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required, and
(2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.

~~d. On March 15, 2023 a hospital that is identified as a Medicare Annual Payment Update (APU) recipient on the QualityNet.org website will qualify for the DAP increase. APU recipients are those hospitals that satisfactorily meet the requirements for the Inpatient Psychiatric Facility Quality Reporting Program, which includes multiple clinical quality measures.~~

~~e. On March 15, 2023, long-term care hospitals that meet or fall below the national average for the pressure ulcers performance measure will qualify for the DAP increase. The national average will be downloaded from the most current data from the Medicare Provider Data Catalog website for the rate of changes in skin integrity post-acute care: Pressure Ulcer/Injury for long-term care hospitals. Facility results will be compared to the national average results for the measure.~~

~~f. On March 15, 2023, rehabilitation hospitals that meet or fall below the national average for the pressure ulcers performance measure will qualify for the DAP increase. The national average will be downloaded from the most current data from the Medicare Provider Data Catalog website for the rate of changes in skin integrity post-acute care: Pressure Ulcer/Injury rehabilitation hospitals. Facility results will be compared to the national average results for the measure.~~

~~4. A hospital designated as type: hospital by the Arizona Department of Health Services Division of Licensing Services and is owned and/or operated by Indian Health Services (IHS) or under Tribal authority will qualify for an increase if it meets these criteria specified in subsection (4)(a) or (b);~~

~~a. No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.~~

~~i. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system.~~

~~ii. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.~~

~~iii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.~~

~~iv. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.~~

~~v. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.~~

~~b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.~~

~~i. No later than November 1, 2023, complete the AzHDR Participant Agreement.~~

~~ii. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.~~

~~c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.~~

~~i. No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required.~~

~~ii. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.~~

~~d. No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs. gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.~~

~~i. No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.~~

~~ii. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facility's policy.~~

~~F~~**E.** For outpatient services with dates of service from October 1, 2024 through September 30, 2025 (CYE 2025), the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2024. If a hospital receives a DAP for CYE 2025 but fails to meet all of the requirements in subsection (F), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2025 through Septem-

ber 30, 2026 (CYE 2026), if a DAP would be available at that time. A hospital can and will qualify for an increase if it meets the criteria specified below for any of the applicable hospital subtypes.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c), (d) (e) or (f):
   a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
      i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the hospital's Electronic Health Record (EHR) system.
      iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
      iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
      v. No later than May 1, 2024, hospitals must complete their HIE Integration workbook in its entirety to connect data sender interfaces to ONE Platform.
      vi. No later than May 1, 2024, the hospital must submit a signed Picture Archiving and Communication System (PACS) Statement of Work (SOW) to participate in sharing images via the HIE.
      vii. No later than September 1, 2024, hospitals must launch the integration implementation project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
      viii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
      ix. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
         (1) HIE Participation Agreement for ONE Platform.
         (2) Statement of Work (SOW) to access the ONE Platform Portal.
         (3) Statement of Work (SOW) to send data to ONE Platform.
      x. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
      xi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform HIE portal.
   b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.
      i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.
      iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.
      iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
         (1) HIE Participation Agreement for ONE Platform.
         (2) Statement of Work (SOW) to access the ONE Platform Portal.
         (3) Statement of Work (SOW) to send data to ONE Platform.
      v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.

vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.
vii. No later than August 1, 2025, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
viii. No later than August 1, 2025, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
ix. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.

c. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI) that the hospital requests to participate in the DAP.
ii. Within 30 days of sending data into the test environment but no later than December 1, 2024, the hospital must review the results of up to 217 parameters from the HIE Data Quality Report with the HIE organization, identifying the high-risk (red) and moderate risk (orange) scores for each parameter.
iii. Within 60 days of sending data into the test environment, but no later than December 1, 2024, the hospital must achieve an HIE Data Quality Report with 0 high-risk (red) test parameters prior to sending data into the HIE production environment.
iv. No later than December 1, 2024, the hospital must submit a written resolution plan to Contexture along with an expected timeline and detailed action plan for resolution to correct the moderate risk (orange) parameters on the HIE Data Quality Report.

d. Hospitals who participated in the DAP SDOH program in CYE 2023 and/or CYE 2024.
i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.
iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screening/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater. This goal will be defined and discussed in the post-live meeting with the hospital's assigned SDOH Advisor.
iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).

e. Hospitals who have not participated in the DAP SDOH program in CYE 2023 or CYE 2024.
i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings/referrals within CommunityCares per facility location.
iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
iv. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

v. No later than November 30, 2024, the hospital must develop and submit a current facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
vi. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

f. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for an NDP.
iii. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
iv. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in (2)(a),(b), (c), (d), (e), (f), (g) or (h):

a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the facility's (EHR) system.
iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
v. No later than May 1, 2024, the hospital must complete their HIE Integration workbook in its entirety to connect data sender interfaces to ONE platform.
vi. No later than May 1, 2024, the hospital must submit a signed Picture Archiving and Communication System (PACS) Statement of Work (SOW) to participate in sharing images via the HIE.
vii. No later than September 1, 2024, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
viii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
ix. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
(1) HIE Participation Agreement for ONE Platform.
(2) Statement of Work (SOW) to access the ONE Platform Portal.
(3) Statement of Work (SOW) to send data to ONE Platform.
x. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
xi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.

b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.
i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organiza-

tion. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.

iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.

iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).

(1) HIE Participation Agreement for ONE Platform.

(2) Statement of Work (SOW) to access the ONE Platform Portal.

(3) Statement of Work (SOW) to send data to ONE Platform.

v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.

vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.

vii. No later than August 1, 2025, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.

viii. No later than August 1, 2025, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.

ix. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.

c. Hospitals who participated in the DAP AzHDR program in CYE 2023 and/or CYE 2024.

i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 patient document uploads of advanced directives and 15 searches of advance directives per month per registered AHCCCS ID.

d. Hospitals who have not participated in the DAP AzHDR program in CYE 2023 or CYE 2024.

i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. No later than November 1, 2024, the hospital must submit the AzHDR Subscription Agreement to the HIE organization.

iii. No later than April 1, 2025, the hospital must have onboarding completed by working with AzHDR to submit user information to gain credentials to access AzHDR and complete training.

iv. No later than May 1, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 searches/uploads of advance directives per month per AHCCCS ID.

e. Hospitals who participated in the DAP SDOH program in CYE 2023 and/or CYE 2024.

i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.

iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screening/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater. This goal will be defined and discussed in the post-live meeting with the hospital's assigned SDOH Advisor.

iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).

f. Hospitals who have not participated in the DAP SDOH program in CYE 2023 or CYE 2024.
   i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP, and the total number of patient visits per year.
   ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings and referrals within CommunityCares per facility location.
   iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist hospitals in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).

g. Hospitals with an Emergency Department that participated in the NDP DAP in CYE 2024.
   i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
   ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
   iii. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

h. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
   i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
   ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
   iii. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
   iv. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

3. A hospital designated as type: hospital, subtype: long term, psychiatric, or rehabilitation by the Arizona Department of Health Services Division of Licensing Services will qualify for an increase if it meets the criteria specified in (3)(a), (b), (c), (d) or (e):
   a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
      i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the hospital's Electronic Health Record (EHR) system.
      iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
      iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable), laboratory, and radiology information (if applicable), transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
      v. No later than May 1, 2024, hospitals must complete their HIE Integration workbook in its entirety to connect data sender interfaces to the ONE platform.
      vi. No later than May 1, 2024, the hospital must submit a signed Picture Archiving and Communication System (PACS) Statement of Work (SOW) to participate in sharing images via the HIE.
      vii. No later than September 1, 2024, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.

viii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.

ix. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
(1) HIE Participation Agreement for ONE Platform.
(2) Statement of Work (SOW) to access the ONE Platform Portal.
(3) Statement of Work (SOW) to send data to ONE Platform.

x. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.

xi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.

b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.

i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.

iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.

iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
(1) HIE Participation Agreement for ONE Platform.
(2) Statement of Work (SOW) to access the ONE Platform Portal.
(3) Statement of Work (SOW) to send data to ONE Platform.

v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.

vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.

vii. No later than August 1, 2025, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.

viii. No later than August 1, 2025, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.

ix. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.

c. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.

i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI).

ii. Within 30 days of sending data into the test environment but no later than December 1, 2024, the hospital must review the results of up to 217 parameters from the HIE Data Quality Report with the HIE organization, identifying the high-risk (red) and moderate risk (orange) scores for each parameter.

iii. Within 60 days of sending data into the test environment, but no later than December 1, 2024, the hospital must achieve an HIE Data Quality Report with 0 high-risk (red) test parameters prior to sending data into the HIE production environment.

iv. No later than December 1, 2024, the hospital must submit a written resolution plan to Contexture along with an expected timeline and detailed action plan for resolution to correct the moderate risk (orange) parameters on the HIE Data Quality Report.

d. Hospitals who participated in the DAP SDOH program in CYE 2023 and/or CYE 2024.

i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.
iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screenings/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater.
iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).

e. Hospitals who have not participated in the DAP SDOH program in CYE 2023 or CYE 2024.
i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP, and the total number of patient visits per year.
ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings and referrals within CommunityCares per facility location.
iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
iv. Hospitals that meet or fall below the national average for the pressure ulcer performance measure will qualify for a 2.0% DAP increase. On March 15, 2024, AHCCCS will download the most current data from the Medicare Provider Data Catalog website for the rate of changes in skin integrity post-acute care: Pressure Ulcer/Injury. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.
v. Hospitals that meet or fall below the national average for the pressure ulcer performance measure will qualify for a 2.0% DAP increase. On March 15, 2024, AHCCCS will download the most current data from the Medicare Provider Data Catalog website for the rate of changes in skin integrity post-acute care: Pressure Ulcer/Injury. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.

4. A hospital designated as type: hospital by the Arizona Department of Health Services Division of Licensing Services and is owned and/or operated by Indian Health Services (IHS) or under Tribal authority will qualify for an increase if it meets these criteria specified in (4)(a), (b), (c), (d), (e), (f), (g) or (h):
a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the hospital's Electronic Health Record (EHR) system.
iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If the hospital has ambulatory and/or behavioral health practices, then the facility must submit the following patient identifiable information to the production environment of the HIE: registration, encounter summary, and data elements defined by the HIE specific to individuals with a serious mental illness. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
v. No later than May 1, 2024, the hospital must complete their HIE Integration workbook in its entirety to connect data sender interfaces to the ONE Platform.

vi. No later than September 1, 2024, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.

vii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If the hospital has ambulatory and/or behavioral health practices, then the facility must submit the following patient identifiable information to the production environment of the HIE: registration, encounter summary, and data elements defined by the HIE specific to individuals with a serious mental illness.

viii. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).

(1) HIE Participation Agreement for ONE Platform.

(2) Statement of Work (SOW) to access the ONE Platform Portal.

(3) Statement of Work (SOW) to send data to ONE Platform.

ix. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.

x. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.

b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.

i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.

iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.

iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).

(1) HIE Participation Agreement for ONE Platform.

(2) Statement of Work (SOW) to access the ONE Platform Portal.

v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.

vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.

c. Hospitals who participated in the DAP AzHDR program in CYE 2024.

i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 patient document uploads of advanced directives and 15 searches of advance directives per month per registered AHCCCS ID.

d. Hospitals who have not participated in the DAP AzHDR program CYE 2023 or CYE 2024.

i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. No later than November 1, 2024, the hospital must complete the AzHDR Subscription Agreement.

iii. No later than April 1, 2025, the hospital must have onboarding completed by working with AzHDR to submit user information to gain credentials to access AzHDR and complete training.

iv. No later than May 1, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 searches/uploads of advance directives per month per registered AHCCCS ID.

e. Hospitals who participated in the DAP SDOH program in CYE 2024.

i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.
iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screenings/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/ referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater. This goal will be defined and discussed in the post-live meeting with the hospital's assigned SDOH Advisor.
iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).

f. Hospitals that have not participated in the DAP SDOH program in CYE 2024.
i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP, and the total number of patient visits per year.
ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings and referrals within CommunityCares per facility location.
iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).

g. Hospitals with an Emergency Department that participated in the NDP DAP in CYE 2024.
i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
iii. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

h. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
iii. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
iv. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

F. For outpatient services with dates of service from October 1, 2025 through September 30, 2026 (CYE 2026), the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the Administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2025. If a hospital receives a DAP for CYE 2026 but fails to meet all of the requirements in subsection (F), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2026 through September 30, 2027 (CYE 2027), if a DAP would be available at that time. A hospital can and will qualify for an increase if it meets the criteria specified below for any of the applicable hospital subtypes.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c), (d), (e) and (f):
a. To be eligible for this DAP, hospitals must have participated in the DAP HIE program in CYE 2024 and/or CYE 2025.
b. No later than April 1, 2025, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI) that the hospital requests to participate in the DAP.
c. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: including standard Admission, Discharge, and Transfer (ADT) information; data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a

new EHR system, the hospital must notify the HIE organization and have the implementation timeline approved to continue meeting DAP requirements.

d. No later than March 1, 2026, the hospital must complete the data quality profile, based on January 2026 data, with the HIE organization. Data elements in the following measure categories will be included within the data quality profile:
   i. Data source and data site information must be submitted on ADT transactions;
   ii. Patient demographic information must be submitted on ADT transactions;
   iii. Race must be submitted on ADT transactions;
   iv. Ethnicity must be submitted on ADT transactions; and
   v. Language must be submitted on ADT transactions.

e. No later than April 1, 2026, the hospital must complete a data quality improvement plan as defined by the HIE organization to improve the quality of data elements by 3.0% collectively over the March 1, 2026 data quality profile. The quality improvement plan is not required if the data quality profile results are greater than 90% for each measure.

f. No later than September 1, 2026, a final data quality profile will be completed, based on July 2026 data to reassess data elements and performance improvement. Hospitals must have improved the quality of data elements by 3.0% collectively from its March 2026 data quality profile. This requirement does not apply if the data quality profile results are greater than 90% for each measure.

2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets the criteria in subsection (2)(a) or (b):
   a. Hospitals that participated in the DAP HIE program in CYE 2024 and/or CYE 2025.
      i. No later than April 1, 2025, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      ii. No later than March 1, 2025, the hospital must launch the integration implementations project, have a Virtual Private Network (VPN) connection in place with the HIE, and electronically submit test patient information to the HIE test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
      iii. No later than May 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the facility's Electronic Health Record (EHR) system.
      iv. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
   b. Hospitals that have not participated in the DAP HIE program in CYE 2024 or CYE 2025. No later than April 1, 2025, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      i. To request a HIE Participation Agreement and a DAP SOW, email DAP@contexture.org.
      ii. No later than March 1, 2026, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization portal.
      iii. No later than March 1, 2026, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
      iv. No later than March 1, 2026, the hospital must launch the integration implementations project, have a Virtual Private Network (VPN) connection in place with the HIE, and electronically submit test patient information to the HIE test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
      v. No later than August 1, 2026, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

3. A hospital designated as type: hospital, subtype: long term, psychiatric, or rehabilitation by the Arizona Department of Health Services Division of Licensing Services will qualify for an increase if it meets the criteria specified in: (3)(a), (b), (c), (d), (e) and (f):
   a. To be eligible for this DAP, Hospitals must have participated in the DAP HIE program in CYE 2024 and/or CYE 2025.
   b. No later than April 1, 2025, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization.

The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI) that the hospital requests to participate in the DAP.

c. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: including standard Admission, Discharge, and Transfer (ADT) information, data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and have the implementation timeline approved to continue meeting DAP requirements.

d. No later than March 1, 2026, the hospital must complete the data quality profile, based on January 2026 data, with the HIE organization. Data elements in the following measure categories will be included within the data quality profile:
   i. Data source and data site information must be submitted on ADT transactions;
   ii. Patient demographic information must be submitted on ADT transactions;
   iii. Race must be submitted on ADT transactions;
   iv. Ethnicity must be submitted on ADT transactions; and
   v. Language must be submitted on ADT transactions.

e. No later than April 1, 2026, the hospital must complete a data quality improvement plan as defined by the HIE organization to improve the quality of data elements by 3.0% collectively over the March 1, 2026 data quality profile. The quality improvement plan is not required if the data quality profile results are greater than 90% for each measure, the quality Improvement plan is not required.

f. No later than September 1, 2026, a final data quality profile will be completed, based on July 2026 data to reassess data elements and performance improvement. Hospitals must have improved the quality of data elements by 3.0% collectively from its March 2026 data quality profile. This requirement does not apply if the data quality profile results are greater than 90% for each measure.

R9-22-712.61. DRG Payments: Exceptions

A. Notwithstanding section R9-22-712.60, claims for inpatient services from the following hospitals shall be paid on a per diem basis, including provisions for outlier payments, where rates and outlier thresholds are included in the capped fee schedule published by the Administration on its website and available for inspection during normal business hours at 801 E. Jefferson, Phoenix, Arizona. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The outlier CCR will be the sum of the urban or rural default operating CCR appropriate to the location of the hospital and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. The resulting amount will be the total reimbursement for the claim. There is no provision for outlier payments for hospitals described under subsection (A)(3).

1. Hospitals designated as type: hospital, subtype; rehabilitation in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website in March of each year;
2. Hospitals designated as type: hospital, subtype: long term in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
3. Hospitals designated as type: hospital, subtype; psychiatric in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;

B. Notwithstanding Section R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the principal diagnosis on the claim is a behavioral health diagnosis, shall be reimbursed as prescribed by a per diem rate described by a fee schedule established by the Administration; however, if the principal diagnosis is a physical health diagnosis, the claim shall be processed under the DRG methodology described in this section, even if behavioral health services are provided during the inpatient stay.

C. Notwithstanding Section R9-22-712.60, claims for services associated with transplant services shall be paid in accordance with the contract between the AHCCCS administration and the transplant facility.

D. Notwithstanding Section R9-22-712.60, claims from an IHS facility or 638 Tribal provider shall be paid the all-inclusive rate on a per visit basis in accordance with the rates published annually by IHS in the Federal Register.

E. For hospitals that have contracts with the Administration for the provision of transplant services, inpatient days associated with transplant services are paid in accordance with the terms of the contract.

~~**F.** For inpatient services with a date of admission from October 1, 2023 through September 30, 2024 (CYE 2024), provided by a hospital in subsection (A) that qualifies, the administration shall pay the hospital an Inpatient Differential Adjusted Payment equal to the sum of the payment otherwise provided for in subsection (A) plus the product of the amount otherwise provided for in subsection (A) and a percentage published on the Administration's public website as part of its fee schedule, subsequent to a public notice published no later than September 1, 2023. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype. If a hospital receives a DAP for CYE 2024 but fails to meet all of the requirements in subsection (G), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2024 through September 30, 2025 (CYE 2025), if a DAP would be available at that time.~~

~~1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c) or (d):~~

~~a. No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.~~

i. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system.

ii. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.

iii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

iv. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.

v. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.

b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.

i. For hospitals that have participated in DAP HIE requirements in CYE 2023:

(1) No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization.

(2) After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry.

ii. For hospitals that have not participated in DAP HIE requirements in CYE 2023:

(1) No later than November 1, 2023, complete the AzHDR Participant Agreement, and

(2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.

c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.

i. For hospitals that have participated in DAP SDOH requirements in CYE 2023:

(1) No later than September 30, 2023, initiate use of the Community Cares referral system operated by the HIE organization.

(2) No later than May 1, 2024: After all the onboarding requirements have been met and the provider has access to the system and through September 30, 2024, the hospital must regularly utilize the Community Cares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month per registered AHCCCS ID that resulted from utilizing the social needs screening tool in Community Cares. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024.

ii. For hospitals that have not participated in DAP SDOH requirements in CYE 2023:

(1) No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required, and

(2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.

d. No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.

i. No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.

ii. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facility's policy.

2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in subsection (2)(a), (b), (c) or (d):

a. No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
   i. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system.
   ii. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
   iii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
   iv. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.
   v. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.

b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
   i. For hospitals that have participated in DAP HIE requirements in CYE 2023:
      (1) No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization.
      (2) After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry.
   ii. For hospitals that have not participated in DAP HIE requirements in CYE 2023:
      (1) No later than November 1, 2023, complete the AzHDR Participant Agreement, and
      (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.

c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
   i. For hospitals that have participated in DAP SDOH requirements in CYE 2023:
      (1) No later than September 30, 2023, initiate use of the Community Cares referral system operated by the HIE organization.
      (2) No later than May 1, 2024: After all the onboarding requirements have been met and the provider has access to the system and through September 30, 2024, the hospital must regularly utilize the Community Cares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month per registered AHCCCS ID that resulted from utilizing the social needs screening tool in Community Cares. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024.
   ii. For hospitals that have not participated in DAP SDOH requirements in CYE 2023:
      (1) No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required, and
      (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.

d. No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
   i. No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.

~~ii. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.~~

~~G~~F. For ~~outpatient services with dates of service~~inpatient services with a date of admission from October 1, 2024 through September 30, 2025 (CYE 2025), ~~the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a~~provided by a hospital in subsection (A) that qualifies, the administration shall pay the hospital an Inpatient Differential Adjusted Payment equal to the sum of the payment otherwise provided for in subsection (A) plus the product of the amount otherwise provided for in subsection (A) and a percentage established by the administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2024. If a hospital receives a DAP for CYE 2025 but fails to meet all of the requirements in subsection (F), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2025 through September 30, 2026 (CYE 2026), if a DAP would be available at that time. A hospital can and will qualify for an increase if it meets the criteria specified below for any of the applicable hospital subtypes.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c), (d), (e) or (f):
   a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
      i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP. Hospitals must meet the following milestones in maintaining existing connections to the current HIE platform:
      ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the hospital's Electronic Health Record (EHR) system.
      iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
      iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
      v. No later than May 1, 2024, hospitals must complete their HIE Integration workbook in its entirety to connect data sender interfaces to ONE Platform.
      vi. No later than May 1, 2024, the hospital must submit a signed Picture Archiving and Communication System (PACS) Statement of Work (SOW) to participate in sharing images via the HIE.
      vii. No later than September 1, 2024, hospitals must launch the integration implementation project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
      viii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
      ix. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
         (1) HIE Participation Agreement for ONE Platform.
         (2) Statement of Work (SOW) to access the ONE Platform Portal.
         (3) Statement of Work (SOW) to send data to ONE Platform.
      x. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
      xi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform HIE portal.
   b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.
      i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.

iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.
iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
(1) HIE Participation Agreement for ONE Platform.
(2) Statement of Work (SOW) to access the ONE Platform Portal.
(3) Statement of Work (SOW) to send data to ONE Platform.
v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.
vii. No later than August 1, 2025, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
viii. No later than August 1, 2025, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
ix. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.

c. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI) that the hospital requests to participate in the DAP.
ii. Within 30 days of sending data into the test environment but no later than December 1, 2024, the hospital must review the results of up to 217 parameters from the HIE Data Quality Report with the HIE organization, identifying the high-risk (red) and moderate risk (orange) scores for each parameter.
iii. Within 60 days of sending data into the test environment, but no later than December 1, 2024, the hospital must achieve an HIE Data Quality Report with 0 high-risk (red) test parameters prior to sending data into the HIE production environment.
iv. No later than December 1, 2024, the hospital must submit a written resolution plan to Contexture along with an expected timeline and detailed action plan for resolution to correct the moderate risk (orange) parameters on the HIE Data Quality Report.

d. Hospitals who participated in the DAP SDOH program in CYE 2023 and/or CYE 2024.
i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.
iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screening/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater. This goal will be defined and discussed in the post-live meeting with the hospital's assigned SDOH Advisor.
iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).

e. Hospitals who have not participated in the DAP SDOH program in CYE 2023 or CYE 2024.
i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings/referrals within CommunityCares per facility location.
iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
iv. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
v. No later than November 30, 2024, the hospital must develop and submit a current facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
vi. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

f. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for an NDP.
iii. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
iv. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in (2)(a),(b), (c), (d), (e), (f), (g) or (h):
a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the facility's (EHR) system.
iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
v. No later than May 1, 2024, the hospital must complete their HIE Integration workbook in its entirety to connect data sender interfaces to ONE platform.
vi. No later than May 1, 2024, the hospital must submit a signed Picture Archiving and Communication System (PACS) Statement of Work (SOW) to participate in sharing images via the HIE.
vii. No later than September 1, 2024, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
viii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
ix. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).

(1) HIE Participation Agreement for ONE Platform.
(2) Statement of Work (SOW) to access the ONE Platform Portal.
(3) Statement of Work (SOW) to send data to ONE Platform.

x. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
xi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.

b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.
i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.
iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.
iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
(1) HIE Participation Agreement for ONE Platform.
(2) Statement of Work (SOW) to access the ONE Platform Portal.
(3) Statement of Work (SOW) to send data to ONE Platform.
v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.
vii. No later than August 1, 2025, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
viii. No later than August 1, 2025, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
ix. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.

c. Hospitals who participated in the DAP AzHDR program in CYE 2023 and/or CYE 2024.
i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 patient document uploads of advanced directives and 15 searches of advance directives per month per registered AHCCCS ID.

d. Hospitals who have not participated in the DAP AzHDR program in CYE 2023 or CYE 2024.
i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than November 1, 2024, the hospital must submit the AzHDR Subscription Agreement to the HIE organization.
iii. No later than April 1, 2025, the hospital must have onboarding completed by working with AzHDR to submit user information to gain credentials to access AzHDR and complete training.
iv. No later than May 1, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 searches/uploads of advance directives per month per AHCCCS ID.

e. Hospitals who participated in the DAP SDOH program in CYE 2023 and/or CYE 2024.
i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.
iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screening/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater. This goal will be defined and discussed in the post-live meeting with the hospital's assigned SDOH Advisor.
iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).

f. Hospitals who have not participated in the DAP SDOH program in CYE 2023 or CYE 2024.
i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP, and the total number of patient visits per year.
ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings and referrals within CommunityCares per facility location.
iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist hospitals in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).

g. Hospitals with an Emergency Department that participated in the NDP DAP in CYE 2024.
i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
iii. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

h. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
iii. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
iv. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

G. For inpatient services with a date of admission from October 1, 2024 through September 30, 2025 (CYE 2025), provided by a hospital in subsection (A) that qualifies, the administration shall pay the hospital an Inpatient Differential Adjusted Payment equal to the sum of the payment otherwise provided for in subsection (A) plus the product of the amount otherwise provided for in subsection (A) and a percentage established by the administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2024. If a hospital receives a DAP for CYE 2025 but fails to meet all of the requirements in subsection (F), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2025 through September 30, 2026 (CYE 2026), if a DAP would be available at that time. A hospital can and will qualify for an increase if it meets the criteria specified below for any of the applicable hospital subtypes.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c), (d), (e) and (f):
a. To be eligible for this DAP, hospitals must have participated in the DAP HIE program in CYE 2024 and/or CYE 2025.
b. No later than April 1, 2025, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI) that the hospital requests to participate in the DAP.
c. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: including standard Admission, Discharge, and Transfer (ADT) information; data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and proce-

dures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and have the implementation timeline approved to continue meeting DAP requirements.

d. No later than March 1, 2026, the hospital must complete the data quality profile, based on January 2026 data, with the HIE organization. Data elements in the following measure categories will be included within the data quality profile:
   i. Data source and data site information must be submitted on ADT transactions;
   ii. Patient demographic information must be submitted on ADT transactions;
   iii. Race must be submitted on ADT transactions;
   iv. Ethnicity must be submitted on ADT transactions; and
   v. Language must be submitted on ADT transactions.

e. No later than April 1, 2026, the hospital must complete a data quality improvement plan as defined by the HIE organization to improve the quality of data elements by 3.0% collectively over the March 1, 2026 data quality profile. The quality improvement plan is not required if the data quality profile results are greater than 90% for each measure.

f. No later than September 1, 2026, a final data quality profile will be completed, based on July 2026 data to reassess data elements and performance improvement. Hospitals must have improved the quality of data elements by 3.0% collectively from its March 2026 data quality profile. This requirement does not apply if the data quality profile results are greater than 90% for each measure.

2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets the criteria in subsection (2)(a) or (b):

a. Hospitals that participated in the DAP HIE program in CYE 2024 and/or CYE 2025.
   i. No later than April 1, 2025, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
   ii. No later than March 1, 2025, the hospital must launch the integration implementations project, have a Virtual Private Network (VPN) connection in place with the HIE, and electronically submit test patient information to the HIE test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
   iii. No later than May 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the facility's Electronic Health Record (EHR) system.
   iv. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.

b. Hospitals that have not participated in the DAP HIE program in CYE 2024 or CYE 2025.
   i. No later than April 1, 2025, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      (1) To request a HIE Participation Agreement and a DAP SOW, email DAP@contexture.org.
   ii. No later than March 1, 2026, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization portal.
   iii. No later than March 1, 2026, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
   iv. No later than March 1, 2026, the hospital must launch the integration implementations project, have a Virtual Private Network (VPN) connection in place with the HIE, and electronically submit test patient information to the HIE test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
   v. No later than August 1, 2026, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

R9-22-712.71. Final DRG Payment

A. The final DRG payment is the sum of the final DRG base payment, the final DRG outlier add-on payment, and the Differential Adjusted Payment.

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

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

D. The factor for each hospital and for each federal fiscal year is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS administration's website and is on file for public inspection at the AHCCCS administration located at 801 E. Jefferson Street, Phoenix, Arizona.

~~**E.** For inpatient services with a date of discharge from October 1, 2023 through September 30, 2024 (CYE 2024), the Inpatient Differential Adjusted Payment is the sum of the final DRG base payment and the final DRG outlier add-on payment multiplied by a percentage published on the Administration's public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2023. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype. If a hospital receives a DAP for CYE 2024 but fails to meet all of the requirements in subsection (F), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2024 through September 30, 2025 (CYE 2025), if a DAP would be available at that time.~~

~~1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c), or (d):~~

~~a. No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.~~

~~i. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's system.~~

~~ii. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.~~

~~iii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.~~

~~iv. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.~~

~~v. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. Which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.~~

~~b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.~~

~~i. For hospitals that have participated in DAP HIE requirements in CYE 2023:~~

~~(1) No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization.~~

~~(2) After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry.~~

~~ii. For hospitals that have not participated in DAP HIE requirements in CYE 2023:~~

~~(1) No later than November 1, 2023, complete the AzHDR Participant Agreement, and~~

~~(2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.~~

~~c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.~~

~~i. For hospitals that have participated in DAP SDOH requirements in CYE 2023:~~

~~(1) No later than September 30, 2023, initiate use of the Community Cares referral system operated by the HIE organization.~~

~~(2) No later than May 1, 2024: After all the onboarding requirements have been met and the provider has access to~~

~~the system and through September 30, 2024, the hospital must regularly utilize the Community Cares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month per registered AHCCCS ID that resulted from utilizing the social-needs screening tool in Community Cares. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024.~~

~~ii. For hospitals that have not participated in DAP SDOH requirements in CYE 2023:~~

~~(1) No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required, and~~

~~(2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.~~

~~d. No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs. gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.~~

~~i. No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.~~

~~ii. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facility's policy.~~

~~2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in subsection (2)(a), (b), (c) or (d):~~

~~a. No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.~~

~~i. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's system.~~

~~ii. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.~~

~~iii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.~~

~~iv. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.~~

~~v. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. Which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.~~

~~b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.~~

~~i. For hospitals that have participated in DAP HIE requirements in CYE 2023:~~

~~(1) No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization.~~

~~(2) After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry.~~

~~ii. For hospitals that have not participated in DAP HIE requirements in CYE 2023:~~

~~(1) No later than November 1, 2023, complete the AzHDR Participant Agreement, and~~

~~(2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.~~

~~c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.~~

~~i. For hospitals that have participated in DAP SDOH requirements in CYE 2023:~~

~~(1) No later than September 30, 2023, initiate use of the Community Cares referral system operated by the HIE organization.~~

~~(2) No later than May 1, 2024: After all the onboarding requirements have been met and the provider has access to the system and through September 30, 2024, the hospital must regularly utilize the Community Cares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month per registered AHCCCS ID that resulted from utilizing the social-needs screening tool in Community Cares. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024.~~

~~ii. For hospitals that have not participated in DAP SDOH requirements in CYE 2023:~~

~~(1) No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required, and~~

~~(2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.~~

~~d. No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs. gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.~~

~~i. No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.~~

~~ii. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facility's policy.~~

~~F~~**E.** For ~~outpatient~~ inpatient services with a date ~~dates~~ of ~~service~~ discharge from October 1, 2024 through September 30, 2025 (CYE 2025), the ~~payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The~~ Inpatient Differential Adjusted Payment is the sum of the final DRG base payment and the final DRG outlier add on payment multiplied by a percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2024. If a hospital receives a DAP for CYE 2025 but fails to meet all of the requirements in subsection (F), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2025 through September 30, 2026 (CYE 2026), if a DAP would be available at that time. A hospital can and will qualify for an increase if it meets the criteria specified below for any of the applicable hospital subtypes.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c), (d), (e) or (f):
   a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
      i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the hospital's Electronic Health Record (EHR) system.
      iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
      iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
      v. No later than May 1, 2024, hospitals must complete their HIE Integration workbook in its entirety to connect data sender interfaces to ONE Platform.
      vi. No later than May 1, 2024, the hospital must submit a signed Picture Archiving and Communication System (PACS) Statement of Work (SOW) to participate in sharing images via the HIE.
      vii. No later than September 1, 2024, hospitals must launch the integration implementation project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
      viii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and

procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.

ix. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
   (1) HIE Participation Agreement for ONE Platform.
   (2) Statement of Work (SOW) to access the ONE Platform Portal.
   (3) Statement of Work (SOW) to send data to ONE Platform.

x. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.

xi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform HIE portal.

b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.

i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.

iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.

iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
   (1) HIE Participation Agreement for ONE Platform.
   (2) Statement of Work (SOW) to access the ONE Platform Portal.
   (3) Statement of Work (SOW) to send data to ONE Platform.

v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.

vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.

vii. No later than August 1, 2025, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.

viii. No later than August 1, 2025, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.

ix. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.

c. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.

i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI) that the hospital requests to participate in the DAP.

ii. Within 30 days of sending data into the test environment but no later than December 1, 2024, the hospital must review the results of up to 217 parameters from the HIE Data Quality Report with the HIE organization, identifying the high-risk (red) and moderate risk (orange) scores for each parameter.

iii. Within 60 days of sending data into the test environment, but no later than December 1, 2024, the hospital must achieve an HIE Data Quality Report with 0 high-risk (red) test parameters prior to sending data into the HIE production environment.

iv. No later than December 1, 2024, the hospital must submit a written resolution plan to Contexture along with an expected timeline and detailed action plan for resolution to correct the moderate risk (orange) parameters on the HIE Data Quality Report.

d. Hospitals who participated in the DAP SDOH program in CYE 2023 and/or CYE 2024.

i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.
iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screening/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater. This goal will be defined and discussed in the post-live meeting with the hospital's assigned SDOH Advisor.
iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).

e. Hospitals who have not participated in the DAP SDOH program in CYE 2023 or CYE 2024.
i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings/referrals within CommunityCares per facility location.
iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
iv. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
v. No later than November 30, 2024, the hospital must develop and submit a current facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
vi. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

f. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for an NDP.
iii. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
iv. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in (2)(a),(b), (c), (d), (e), (f), (g) or (h):
a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the facility's (EHR) system.
iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the

hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.

v. No later than May 1, 2024, the hospital must complete their HIE Integration workbook in its entirety to connect data sender interfaces to ONE platform.

vi. No later than May 1, 2024, the hospital must submit a signed Picture Archiving and Communication System (PACS) Statement of Work (SOW) to participate in sharing images via the HIE.

vii. No later than September 1, 2024, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.

viii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.

ix. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).

(1) HIE Participation Agreement for ONE Platform.
(2) Statement of Work (SOW) to access the ONE Platform Portal.
(3) Statement of Work (SOW) to send data to ONE Platform.

x. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.

xi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.

b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.

i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.

iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.

iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).

(1) HIE Participation Agreement for ONE Platform.
(2) Statement of Work (SOW) to access the ONE Platform Portal.
(3) Statement of Work (SOW) to send data to ONE Platform.

v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.

vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.

vii. No later than August 1, 2025, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.

viii. No later than August 1, 2025, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.

ix. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.

c. Hospitals who participated in the DAP AzHDR program in CYE 2023 and/or CYE 2024.

i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

ii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 patient document uploads of advanced directives and 15 searches of advance directives per month per registered AHCCCSID.

d. Hospitals who have not participated in the DAP AzHDR program in CYE 2023 or CYE 2024.
   i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
   ii. No later than November 1, 2024, the hospital must submit the AzHDR Subscription Agreement to the HIE organization.
   iii. No later than April 1, 2025, the hospital must have onboarding completed by working with AzHDR to submit user information to gain credentials to access AzHDR and complete training.
   iv. No later than May 1, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 searches/uploads of advance directives per month per AHCCCS ID.

e. Hospitals who participated in the DAP SDOH program in CYE 2023 and/or CYE 2024.
   i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
   ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.
   iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screening/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater. This goal will be defined and discussed in the post-live meeting with the hospital's assigned SDOH Advisor.
   iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).

f. Hospitals who have not participated in the DAP SDOH program in CYE 2023 or CYE 2024.
   i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP, and the total number of patient visits per year.
   ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings and referrals within CommunityCares per facility location.
   iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist hospitals in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).

g. Hospitals with an Emergency Department that participated in the NDP DAP in CYE 2024.
   i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
   ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
   iii. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

h. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
   i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
   ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
   iii. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
   iv. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

F. For inpatient services with a date of discharge service from October 1, 2025 through September 30, 2026 (CYE 2026), the Inpatient Differential Adjusted Payment is the sum of the final DRG base payment and the final DRG outlier add-on payment multiplied by a percentage established by the administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2025. If a hospital receives a DAP for CYE 2026 but fails to meet all of the requirements in subsection (F), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2026 through September 30, 2027 (CYE 2027), if a DAP would be available at that time. A hospital can and will qualify for an increase if it meets the criteria specified below for any of the applicable hospital subtypes.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c), (d), (e) and (f):
   a. To be eligible for this DAP, hospitals must have participated in the DAP HIE program in CYE 2024 and/or CYE 2025.
   b. No later than April 1, 2025, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI) that the hospital requests to participate in the DAP.
   c. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: including standard Admission, Discharge, and Transfer (ADT) information; data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and have the implementation timeline approved to continue meeting DAP requirements.
   d. No later than March 1, 2026, the hospital must complete the data quality profile, based on January 2026 data, with the HIE organization. Data elements in the following measure categories will be included within the data quality profile:
      i. Data source and data site information must be submitted on ADT transactions;
      ii. Patient demographic information must be submitted on ADT transactions;
      iii. Race must be submitted on ADT transactions;
      iv. Ethnicity must be submitted on ADT transactions; and
      v. Language must be submitted on ADT transactions.
   e. No later than April 1, 2026, the hospital must complete a data quality improvement plan as defined by the HIE organization to improve the quality of data elements by 3.0% collectively over the March 1, 2026 data quality profile. The quality improvement plan is not required if the data quality profile results are greater than 90% for each measure.
   f. No later than September 1, 2026, a final data quality profile will be completed, based on July 2026 data to reassess data elements and performance improvement. Hospitals must have improved the quality of data elements by 3.0% collectively from its March 2026 data quality profile. This requirement does not apply if the data quality profile results are greater than 90% for each measure.
2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets the criteria in subsection (a) or (b):
   a. Hospitals that participated in the DAP HIE program in CYE 2024 and/or CYE 2025.
      i. No later than April 1, 2025, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      ii. No later than March 1, 2025, the hospital must launch the integration implementations project, have a Virtual Private Network (VPN) connection in place with the HIE, and electronically submit test patient information to the HIE test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
      iii. No later than May 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the facility's Electronic Health Record (EHR) system.
      iv. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
   b. Hospitals that have not participated in the DAP HIE program in CYE 2024 or CYE 2025.
      i. No later than April 1, 2025, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP. To request a HIE Participation Agreement and a DAP SOW, email DAP@contexture.org.

ii. No later than March 1, 2026, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization portal.

iii. No later than March 1, 2026, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.

iv. No later than March 1, 2026, the hospital must launch the integration implementations project, have a Virtual Private Network (VPN) connection in place with the HIE, and electronically submit test patient information to the HIE test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.

v. No later than August 1, 2026, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

R9-22-712.90. Reimbursement of Hospital-based Freestanding Emergency Departments

A. "Hospital-based freestanding emergency department" (hospital-based FSED) means an outpatient treatment center, as defined in R9-10-101, that: (1) provides emergency room services under R9-10-1019, (2) is subject to the requirements of 42 C.F.R. 489.24, and (3) shares an ownership interest with a hospital, regardless of whether the outpatient treatment center operates under a hospital's single group license as described in A.R.S. § 36-422.

B. A hospital-based FSED shall register with the Administration separately from the hospital with which an ownership interest is shared and shall obtain a separate provider identification number. The Administration shall not charge a separate provider enrollment fee for registration of a hospital-based FSED. The Administration shall accept a hospital's compliance with the provider screening and enrollment requirements of 42 CFR Part 455 as compliance by the hospital-based FSED.

C. For dates of service on and after March 1, 2017, and except as provided in subsection (D), services provided by a hospital-based FSED for evaluation and management CPT codes 99281 through 99285 shall be reimbursed at the following percentages of the amounts otherwise reimbursable under R9-22-712.20 through R9-22-712.30. All other covered codes shall be reimbursed in accordance with R9-22-712.20 through R9- 22-712.30 without a percentage reduction.

1. 60 percent for a level 1 emergency department visit as indicated by CPT 99281.
2. 80 percent for a level 2 emergency department visit as indicated by CPT 99282.
3. 90 percent for a level 3 emergency department visit as indicated by CPT 99283.
4. 100 percent for a level 4 or 5 emergency department visit as indicated by CPT codes 99284 and 99285.

D. A hospital-based FSED located in a city or town in a county with less than 500,000 residents, where the only hospital in the city or town operating an emergency department closed on or after January 1, 2015, shall be reimbursed under R9-22-712.20 through R9-22-712.35 using the adjustment in R9-22-712.35 associated with the nearest hospital with which the freestanding emergency department shares an ownership interest.

E. Services provided by an outpatient treatment center that provides emergency room services under R9-10-1019 but does not otherwise meet the criteria in subsection A, shall be reimbursed based on the non-hospital AHCCCS capped fee-for- service schedule under R9-22-710.

F. The Administration shall not reimburse a hospital for services provided at a hospital-based FSED if the member is admitted directly from a hospital-based FSED to a hospital with an ownership interest in the hospital-based FSED. As provided in R9-22-712.60(B), payments made for the inpatient stay using the DRG methodology shall be the sole reimbursement.

~~**G.** For dates of service from October 1, 2023 through September 30, 2024 (CYE 2024), the payment otherwise required for hospital-based FSED services provided by qualifying hospital-based FSEDs shall be increased by a percentage established by the Administration and shall be applied to the payment methodology as described in subsection (C). The percentage is published on the Administration's public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2023. A hospital-based FSED will qualify for an increase if it meets the criteria specified below. If a hospital-based FSED receives a DAP for CYE 2024 but fails to meet all of the requirements in subsection (G), the hospital-based FSED shall be disqualified from participating in a DAP for dates of service October 1, 2024 through September 30, 2025 (CYE 2025), if a DAP would be available at that time.~~

~~**H.** An outpatient treatment center designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital-based freestanding emergency department will qualify for an increase if it meets the criteria in subsection (H)(1):~~

~~1. No later than April 30, 2023, the hospital-based FSED must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP).~~

~~2. The LOI must contain each hospital-based FSED, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.~~

~~a. No later than November 30, 2023, develop and submit a hospital-based FSED policy that meets AHCCCS/ADHS standards for a NDP.~~

~~b. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the hospital-based FSEDs' policy.~~

~~I~~**G.** For dates of service from October 1, 2024 through September 30, 2025 (CYE 2025), the payment otherwise required for hospital-based FSED services provided by qualifying hospital-based FSEDs shall be increased by a percentage established by the Administration and shall be applied to the payment methodology as described in subsection (C). The percentage is published on the Administration's public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2024. A hospital-based FSED can and will qualify for an increase if it meets the criteria specified below for any of the applicable hospital-based FSED subtypes. If a hospital-based FSED receives a DAP for CYE 2025 but fails to meet all of the requirements in subsection (G), the hos-

pital-based FSED shall be disqualified from participating in a DAP for dates of service October 1, 2025 through September 30, 2026 (CYE 2026), if a DAP would be available at that time.

~~J.~~ A outpatient treatment center designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital-based freestanding emergency department will qualify for an increase if it meets the criteria in subsection (1) or (2):

1. Hospitals with an Emergency Department that participated in the NDP DAP in CYE 2024.
   a. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
   b. No later than November 30, 2024, the hospital must develop and submit a facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
   c. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.
2. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
   a. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
   b. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
   c. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
   d. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.

H. For dates of service from October 1, 2025 through September 30, 2026 (CYE 2026), the payment otherwise required for hospital-based FSED services provided by qualifying hospital-based FSEDs shall be increased by a percentage established by the Administration and shall be applied to the payment methodology as described in subsection (C). The percentage is published on the Administration's public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2025. A hospital-based FSED can and will qualify for an increase if it meets the criteria specified below for any of the applicable hospital-based FSED subtypes. If a hospital-based FSED receives a DAP for CYE 2026 but fails to meet all of the requirements in subsection (G), the hospital-based FSED shall be disqualified from participating in a DAP for dates of service October 1, 2026 through September 30, 2027 (CYE 2027), if a DAP would be available at that time. An outpatient treatment center designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital-based freestanding emergency department will qualify for an increase if it meets the criteria in subsection (1) or (2):

1. Hospital-based FSEDs that participated only in CYE 2025. Hospital-based FSEDs that participated in CYE 2024 and CYE 2025 will not be eligible.
   a. No later than April 1, 2025, the facility must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) NPI(s), that the facility requests to participate in the DAP.
   b. No later than November 30, 2025, the facility must develop and submit a facility policy that ensures facilities are purchasing Naloxone through standard routine pharmacy ordering.
   c. No later than February 28, 2026, the facility must submit a Naloxone Distribution Program Attestation regarding the implementation of the NDP, to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.
2. Hospital-based FSEDs that have not participated in the NDP DAP.
   a. No later than April 1, 2025, the facility must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the facility requests to participate in the DAP.
   b. No later than November 30, 2025, the facility must develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
   c. No later than January 1, 2026, the facility must begin distribution of Naloxone to individuals at risk of overdose as identified through the facility's policy.
   d. No later than February 28, 2026, the facility must submit a Naloxone Distribution Program Attestation regarding the implementation of the NDP, to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov.
   e. No later than April 1, 2025, the facility must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Maternal Syphilis Program. The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the facility requests to participate in the DAP.
   f. No later than November 30, 2025, develop and submit a facility policy that meets AHCCCS/ADHS standards for testing individuals for syphilis.
   g. No later than January 1, 2026, begin testing individuals for syphilis as identified through the facility's policy.
   h. No later than April 1, 2025, the facility must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Medications for Opioid Use Disorder (MOUD) Enhancement Program. The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the facility requests to participate in the DAP. The LOI must further attest to the following:

i. The facility will implement MOUD treatment quality improvement initiatives with internal tracking and review initiatives on at least a quarterly basis; and
ii. The facility will spend the preponderance of DAP funds to enhance, expand, and/or strengthen MOUD services.

i. No later than April 1, 2025, the facility agrees to participate in the Arizona Statewide Clinical Opioid Workgroup, which includes sharing metrics as determined by the Arizona Department of Health Services (ADHS) in a centralized, and timely manner, providing any best practices and nonsensitive data points for the use of state-driven publications, ensuring leadership attendance at quarterly meetings, and supporting relevant stakeholder participants (e.g., IT, quality improvement, addiction medicine, primary care, operational specialists).

j. No later than November 30, 2025, the facility must develop and submit a facility policy that meets AHCCCS/ADHS standards for a Hospital MOUD Enhancement Program that offers MOUD for eligible patients. The policy must be submitted to AHCCCS at the following email address: AHCCCSDAP@azahcccs.gov.

k. No later than April 1, 2026, the facility must submit a concise narrative summarizing the salient highlights of the progress of their MOUD treatment enhancement and utilization of DAP funds. The narrative must be submitted to AHCCCS at the following email address: AHCCCSDAP@azahcccs.gov.

NOTICES OF RULEMAKING DOCKET OPENING

This section of the *Arizona Administrative Register* contains Notices of Rulemaking Docket Opening under A.R.S. § 41-1021.

A docket opening is the first part of the administrative rulemaking process. It is an "announcement" that an agency intends to work on its rules.

When an agency opens a rulemaking docket to consider rulemaking, the Administrative Procedure Act (APA) requires publication of the Notice of Rulemaking Docket Opening in the Register.

Under the APA, effective January 1, 1995, agencies must submit a Notice of Rulemaking Docket Opening before beginning the formal rulemaking process. An agency may file the Notice of Rulemaking Docket Opening along with the Notice of Proposed Rulemaking.

The Office of the Secretary of State is the filing office and publisher of these notices. Questions about the interpretation of this information should be directed to the agency contact person listed in item #4 of this notice.

NOTICE OF RULEMAKING DOCKET OPENING

DEPARTMENT OF HEALTH SERVICES
FOOD, RECREATIONAL, AND INSTITUTIONAL SANITATION

[R25-211]

1. Permission to proceed with this docket was granted under A.R.S. § 41-1039 by the governor on:

September 7, 2023

2. Title and its heading:

9, Health Services

Chapter and its heading:

8, Department of Health Services – Food, Recreational, and Institutional Sanitation

Article and its heading:

1, Food Establishments and Article 9. Manufactured Food Regulatory Program

Section number:

R9-8-119, R9-8-901, R9-8-902, R9-8-903, R9-8-904, R9-8-905, R9-8-906, R9-8-907, R9-8-908, R9-8-909, R9-8-910, Table 9, R9-8-911, R9-8-912, R9-8-913, R9-8-914, and R9-8-915 (*Sections may be added, amended, repealed, or renumbered as necessary*)

3. The subject matter of the proposed rule:

The Arizona Department of Health Services (Department) entered into a cooperative agreement with the Food & Drug Administration to participate in the nationally integrated food safety system that governs *Current Good Manufactured Practices*. The Department established a Manufactured Food Regulatory Program to implement an integrated, risk-based, food safety system focused on protecting public health statewide, in compliance with Arizona Revised Statutes (A.R.S.) § 36-136(A)(4) and (7) and 36-132(A)(14). The Department plans to adopt rules in Arizona Administrative Code Title 9, Chapter 8, Article 9 to regulate facilities that provide manufactured foods to Arizonians. The new rules will provide minimum standards for measuring and improving the performance of prevention, intervention, and response activities of manufactured foods; and will regulate activities to reduce foodborne illness. The rules will include requirements for sanitary facilities and controls, equipment, personnel, operations, processes and controls, quality assurance, inspection, and incident investigation. The Department received rulemaking approval pursuant to A.R.S. § 41-1039 on September 7, 2023, and plans to adopt rules for manufactured foods through regular rulemaking. The new rules will conform to the rulemaking format and style requirements of the Governor's Regulatory Review Council and the Office of the Secretary of State.

4. A citation to all published notices relating to the current proceeding:

Notice of Rulemaking Docket Opening: 30 A.A.R. 2845; September 13, 2024; Issue Number: 37; File Number: R24-172
Notice of Proposed Rulemaking: 31 A.A.R. 1630; May 23, 2025; Issue Number: 21; File Number: R25-92
Notice of Supplemental Proposed Rulemaking: 31 A.A.R. 2444; July 25, 2025; Issue Number: 30; File Number: R25-165

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

Name:	Myrna Motta
Title:	Deputy Bureau Chief
	Bureau of Resiliency and the Environment
Division:	Public Health Resiliency, Environment, and Policy
Address:	Arizona Department of Health Services

Office of Food Safety and Environmental Services
150 N. 18th Ave., Suite 320
Phoenix, AZ 85007

Telephone: (602) 390-6307

Email: Myrna.Motta@azdhs.gov

or

Name: Stacie Gravito, Office Chief

Address: Arizona Department of Health Services
Office of Administrative Counsel and Rules
150 N. 18th Ave., Suite 200
Phoenix, AZ 85007

Telephone: (602) 542-1020

Fax: (602) 364-1150

Email: Stacie.Gravito@azdhs.gov

6. The time during which the agency will accept written comments and the time and place where oral comments may be made:

Written comments will be accepted at the addresses listed in item #4 until the close of record, which has not yet been determined. No oral proceedings have been scheduled at this time.

7. A timetable for agency decisions or other action on the current proceeding, if known:

To be announced in the Notice of Supplemental Proposed Rulemaking

NOTICE OF RULEMAKING DOCKET OPENING

DEPARTMENT OF ENVIRONMENTAL QUALITY
AIR POLLUTION CONTROL

[R25-212]

1. Permission to proceed with this docket was granted under A.R.S. § 41-1039 by the governor on:

August 19, 2025

2. Title and its heading:

18, Environmental Quality

Chapter and its heading:

2, Department of Environmental Quality – Air Pollution Control

Article and its heading:

13, State Implementation Plan Rules for Specific Locations

Part and its heading:

D, Arizona Regional Haze Class I Areas

Section number:

R18-2-D1301, R18-2-D1302, R18-2-D1303 (*Sections may be added, amended, repealed, or renumbered as necessary*)

3. The subject matter of the proposed rule:

Subject Matter: On January 10, 2017, the U.S. Environmental Protection Agency (EPA) finalized changes to the Regional Haze Rule, which requires each state to submit periodic state implementation plan (SIP) revisions addressing regional haze visibility impairment for each mandatory federal class I area (Class I Area) within the state and for each Class I Area outside the state that may be affected by emissions from the state. 82 FR 3078 (January 10, 2017). Pursuant to A.R.S. § 49-458.01(A), the Arizona Department of Environmental Quality (ADEQ) is required to "submit to the administrator state implementation plan revisions to address regional haze visibility impairment in mandatory federal class I areas." As such, ADEQ needs to amend Arizona Administrative Code Title 18, Chapter 2, Article 13, Part D to adopt rules containing enforceable emissions limits for nonpoint sources contributing to visibility impairment in Class I Areas, including appropriate monitoring, recordkeeping, and reporting provisions. ADEQ will submit the rule changes to EPA for approval in Arizona's SIP.

4. A citation to all published notices relating to the current proceeding:

Not Applicable

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

Name:	Travis Korby
Title:	Environmental Science Specialist II
Division:	Air Quality Improvement Planning
Address:	Arizona Department of Environment Quality 1110 W. Washington St. Phoenix, AZ 85007
Telephone:	(602) 771-4612
Email:	airplanning@azdeq.gov

6. The time during which the agency will accept written comments and the time and place where oral comments may be made:

To be announced in the Notice of Proposed Rulemaking.

7. A timetable for agency decisions or other action on the current proceeding, if known:

To be announced in the Notice of Proposed Rulemaking.

NOTICE OF RULEMAKING DOCKET OPENING

DEPARTMENT OF CHILD SAFETY
ADMINISTRATION

[R25-213]

1. Permission to proceed with this docket was granted under A.R.S. § 41-1039 by the governor on:

May 19, 2025

2. Title and its heading:

21, Child Safety

Chapter and its heading:

1, Department of Child Safety - Administration

Article and its heading:

5, Substantiation of Report Findings

Section number:

R21-1-501, R-21-1-502, R-21-1-504, R-21-1-505, R21-1-506, R21-1-507, R21-1-508, R21-1-509, and R21-1-510
(Sections may be added, amended, repealed, or renumbered as necessary)

3. The subject matter of the proposed rule:

Title 21, Chapter 1, Article 5 pertains to substantiation of report findings and includes the process for appeals and hearings. The Department intends to conduct rulemaking to make necessary updates as follows:

• Updates to the rules as identified in the Five-Year-Review Report approved by the Governor's Regulatory Review Council on June 6, 2023; and

• Amend the definition of "Substantiated Finding" in R21-1-501(17) and amend R21-1-507 and R21-1-508 to permit the Director to place a perpetrator on the central registry; and

• Update the rules to align with Laws 2024, Chapter 127 which increased the standard of proof for findings of child abuse or neglect from probable cause to a preponderance of the evidence and required a tiered system for the placement and maintenance of persons on the central registry of child abuse and neglect.

These changes are necessary to align with current statutes, clarify the Final Administrative Decision and Review process and describe the establishment, maintenance and removal from the new tiered Central Registry system.

4. A citation to all published notices relating to the current proceeding:

Notice of Proposed Rulemaking: 31 A.A.R. 2900, September 12, 2025 (*in this issue)*; File Number: R25-209

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

Name:	Karen Wouters
Title:	Rule Development Specialist
Division:	Department of Child Safety
Address:	3003 N. Central Ave. Phoenix AZ 85012

Telephone: (602) 255-3461
Fax: (602) 255-3262
Email: Karen.Wouters@azdcs.gov
Website: dcs.az.gov/about/policy/rulemaking

6. The time during which the agency will accept written comments and the time and place where oral comments may be made:

Written comments should be directed to the person listed in #5, Monday through Friday from 8 a.m. to 5 p.m. except for state holidays. Comments will also be accepted via email at the email address provided under item #5. All comments must be received by 5:00pm on close of public record. Mailed written comments shall be postmarked within 30 days of this published notice. The Department has scheduled an oral proceeding for public comments:

Date: October 15, 2025
Time: 10 a.m. - Noon
Location: Virtual Oral Proceeding via Microsoft Teams
Meeting ID: 212 571 792 487
Passcode: 8uN6DR2m
or
Dial in by phone
+1 480-561-6122
Phone conference ID: 556 824 516#

7. A timetable for agency decisions or other action on the current proceeding, if known:

To be determined.

REGISTER INDEXES

The *Register* is published by volume in a calendar year (See "General Information" in the front of each issue for more information).

Abbreviations for rulemaking activity in this Index include:

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PM = Proposed amended Section
PR = Proposed repealed Section
P# = Proposed renumbered Section

SUPPLEMENTAL PROPOSED RULEMAKING
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SPR = Supplemental proposed repealed Section
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PE# = Proposed Expedited renumbered Section
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SPEM = Supplemental Proposed Expedited amended Section
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SPE# = Supplemental Proposed Expedited renumbered Section
FINAL EXPEDITED
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FEM = Final Expedited amended Section
FER = Final Expedited repealed Section
FE# = Final Expedited renumbered Section

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EXEMPT
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X# = Exempt renumbered Section
EXEMPT PROPOSED
PXN = Proposed Exempt new Section
PXM = Proposed Exempt amended Section
PXR = Proposed Exempt repealed Section
PX# = Proposed Exempt renumbered Section
EXEMPT SUPPLEMENTAL PROPOSED
SPXN = Supplemental Proposed Exempt new Section
SPXR = Supplemental Proposed Exempt repealed Section
SPXM = Supplemental Proposed Exempt amended Section
SPX# = Supplemental Proposed Exempt renumbered Section
FINAL EXEMPT RULEMAKING
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FX# = Final Exempt renumbered Section

EMERGENCY RULEMAKING
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E# = Emergency renumbered Section
EEXP = Emergency expired

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REJECTION OF RULES
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TM = Terminated proposed amended Section
TR = Terminated proposed repealed Section
T# = Terminated proposed renumbered Section

RULE EXPIRATIONS
EXP = Rules have expired
See also "emergency expired" under emergency rulemaking

CORRECTIONS
C = Corrections to Published Rules

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RULEMAKING ACTIVITY INDEX

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R9-6-203. PM-7; FM-1317
Table 2.2. PM-7; FM-1317

Health Services, Department of - Emergency Medical Services

Health Services, Department of - Food, Recreational, and Institutional Sanitation

Health Services, Department of - Health Care Institutions: Licensing

R9-10-112. PM-152; FM-2457
R9-10-113. PM-152; FM-2457
R9-10-115. PM-246; TM-2775
R9-10-118. PM-152; FM-2457
R9-10-120. PM-152; FM-2457
R9-10-121. PM-152; PM-703; FM-2085; FM-2457
R9-10-122. PN-703; FN-2085
R9-10-123. PN-703; FN-2085
R9-10-124. PN-703; FN-2085
R9-10-125. PN-703; FN-2085
R9-10-126. PN-703; FN-2085
Table 1.2. PM-703; FN-2085
R9-10-201. PM-152; FM-2457
R9-10-202. PM-152; FM-2457
R9-10-203. PM-152; FM-2457
R9-10-209. PM-152; FM-2457
R9-10-212. PM-152; FM-2457
R9-10-215. PM-152; FM-2457
R9-10-218. PM-152; FM-2457
R9-10-234. PM-152; FM-2457
R9-10-303. PM-152; FM-2457
R9-10-307. PM-152; FM-2457
R9-10-320. PM-152; FM-2457
R9-10-321. PM-152; FM-2457
R9-10-402. PM-152; FM-2457
R9-10-403. PM-152; FM-2457
R9-10-406. PM-152; FM-2457
R9-10-410. PM-152; FM-2457
R9-10-411. PM-152; FM-2457
R9-10-413. PM-152; FM-2457
R9-10-414. PM-152; FM-2457
R9-10-421. PM-152; FM-2457
R9-10-423. PM-152; FM-2457
R9-10-426. PM-152; FM-2457
R9-10-501. PEM-384; FEM-1263
R9-10-503. PEM-384; FEM-1263
R9-10-506. PEM-384; FEM-1263
R9-10-507. PEM-384; FEM-1263
R9-10-508. PEM-384; FEM-1263
R9-10-509. PEM-384; FEM-1263
R9-10-510. PEM-384; FEM-1263
R9-10-511. PEM-384; FEM-1263
R9-10-512. PEM-384; FEM-1263
R9-10-514. PEM-384; FEM-1263
R9-10-515. PEM-384; FEM-1263
R9-10-516. PEM-384; FEM-1263
R9-10-518. PEM-384; FEM-1263
R9-10-520. PEM-384; FEM-1263
R9-10-522. PEM-384; FEM-1263
R9-10-525. PEM-384; FEM-1263
R9-10-606. PM-152; FM-2457
R9-10-613. PM-152; FM-2457
R9-10-701. PM-246; TM-2775
R9-10-702. PM-246; TM-2775
R9-10-703. PM-246; TM-2775
R9-10-706. PM-246; TM-2775
R9-10-707. PM-246; TM-2775
R9-10-709. PM-246; TM-2775
R9-10-710. PM-246; TM-2775
R9-10-712. PM-246; TM-2775
R9-10-713. PM-246; TM-2775
R9-10-715. PM-246; TM-2775
R9-10-716. PM-246; TM-2775
R9-10-717. PM-246; TM-2775
R9-10-718. PM-246; TM-2775
R9-10-719. PM-246; TM-2775
R9-10-720. PM-246; TM-2775
R9-10-722. PM-246; TM-2775
R9-10-801. PM-703; FM-2085
R9-10-802. PM-246; TM-2775
R9-10-803. PM-246; PM-703; FM-2085; TM-2775
R9-10-806. PM-246; PM-703; FM-2085; TM-2775
R9-10-807. PM-246; TM-2775
R9-10-808. PM-703; FM-2085
R9-10-809. PM-246; TM-2775
R9-10-810. PM-246; TM-2775
R9-10-811. PM-246; PM-703; FM-2085; TM-2775
R9-10-815. PM-703; FM-2085
R9-10-816. PM-246; PR-703; PN-703; FR-2085; FN-2085
R9-10-817. PM-246; PN-703; FN-2085; TM-2775
R9-10-818. P#-703; F#-2085; TM-2775
R9-10-819. P#-703; PM-703; F#-2085; FM-2085
R9-10-820. PM-246; P#-703; F#-2085
R9-10-821. P#-703; F#-2085; TM-2775
R9-10-901. PM-152; FM-2457
R9-10-902. PM-152; FM-2457
R9-10-905. PM-152; FM-2457
R9-10-911. PM-152; FM-2457
R9-10-914. PM-152; FM-2457
R9-10-918. PM-152; FM-2457

R17-4-502.	PEM-2714	R17-4-702.	FM-1954
R17-4-504.	PEM-2714	R17-4-705.	FM-1954
R17-4-508.	FM-1954	R17-4-707.	FM-1954

OTHER NOTICES AND PUBLIC RECORDS INDEX

Other legal notices required to be published under the Administrative Procedure Act, such as Rulemaking Docket Openings, are included in this Index by volume page number. Notices of Agency Ombudsman, Substantive Policy Statements, Proposed Delegation Agreements, and other applicable public records as required by law are also listed in this Index by volume page number.

THIS INDEX INCLUDES OTHER NOTICE ACTIVITY THROUGH ISSUE 36 OF VOLUME 31.

Substantive Policy Statement, Notices of

2025 RULES EFFECTIVE DATES CALENDAR

A.R.S. § 41-1032(A), as amended by Laws 2002, Ch. 334, § 8 (effective August 22, 2002), states that a rule generally becomes effective 60 days after the day it is filed with the Secretary of State's Office. The following table lists filing dates and effective dates for rules that follow this provision. Please also check the rulemaking Preamble for effective dates.

January		**February**		**March**		**April**		**May**		**June**	
Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date
1/1	3/2	2/1	4/2	3/1	4/30	4/1	5/31	5/1	6/30	6/1	7/31
1/2	3/3	2/2	4/3	3/2	5/1	4/2	6/1	5/2	7/1	6/2	8/1
1/3	3/4	2/3	4/4	3/3	5/2	4/3	6/2	5/3	7/2	6/3	8/2
1/4	3/5	2/4	4/5	3/4	5/3	4/4	6/3	5/4	7/3	6/4	8/3
1/5	3/6	2/5	4/6	3/5	5/4	4/5	6/4	5/5	7/4	6/5	8/4
1/6	3/7	2/6	4/7	3/6	5/5	4/6	6/5	5/6	7/5	6/6	8/5
1/7	3/8	2/7	4/8	3/7	5/6	4/7	6/6	5/7	7/6	6/7	8/6
1/8	3/9	2/8	4/9	3/8	5/7	4/8	6/7	5/8	7/7	6/8	8/7
1/9	3/10	2/9	4/10	3/9	5/8	4/9	6/8	5/9	7/8	6/9	8/8
1/10	3/11	2/10	4/11	3/10	5/9	4/10	6/9	5/10	7/9	6/10	8/9
1/11	3/12	2/11	4/12	3/11	5/10	4/11	6/10	5/11	7/10	6/11	8/10
1/12	3/13	2/12	4/13	3/12	5/11	4/12	6/11	5/12	7/11	6/12	8/11
1/13	3/14	2/13	4/14	3/13	5/12	4/13	6/12	5/13	7/12	6/13	8/12
1/14	3/15	2/14	4/15	3/14	5/13	4/14	6/13	5/14	7/13	6/14	8/13
1/15	3/16	2/15	4/16	3/15	5/14	4/15	6/14	5/15	7/14	6/15	8/14
1/16	3/17	2/16	4/17	3/16	5/15	4/16	6/15	5/16	7/15	6/16	8/15
1/17	3/18	2/17	4/18	3/17	5/16	4/17	6/16	5/17	7/16	6/17	8/16
1/18	3/19	2/18	4/19	3/18	5/17	4/18	6/17	5/18	7/17	6/18	8/17
1/19	3/20	2/19	4/20	3/19	5/18	4/19	6/18	5/19	7/18	6/19	8/18
1/20	3/21	2/20	4/21	3/20	5/19	4/20	6/19	5/20	7/19	6/20	8/19
1/21	3/22	2/21	4/22	3/21	5/20	4/21	6/20	5/21	7/20	6/21	8/20
1/22	3/23	2/22	4/23	3/22	5/21	4/22	6/21	5/22	7/21	6/22	8/21
1/23	3/24	2/23	4/24	3/23	5/22	4/23	6/22	5/23	7/22	6/23	8/22
1/24	3/25	2/24	4/25	3/24	5/23	4/24	6/23	5/24	7/23	6/24	8/23
1/25	3/26	2/25	4/26	3/25	5/24	4/25	6/24	5/25	7/24	6/25	8/24
1/26	3/27	2/26	4/27	3/26	5/25	4/26	6/25	5/26	7/25	6/26	8/25
1/27	3/28	2/27	4/28	3/27	5/26	4/27	6/26	5/27	7/26	6/27	8/26
1/28	3/29	2/28	4/29	3/28	5/27	4/28	6/27	5/28	7/27	6/28	8/27
1/29	3/30			3/29	5/28	4/29	6/28	5/29	7/28	6/29	8/28
1/30	3/31			3/30	5/29	4/30	6/29	5/30	7/29	6/30	8/29
1/31	4/1			3/31	5/30			5/31	7/30		

July		**August**		**September**		**October**		**November**		**December**	
Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date
7/1	8/30	8/1	9/30	9/1	10/31	10/1	11/30	11/1	12/31	12/1	1/30
7/2	8/31	8/2	10/1	9/2	11/1	10/2	12/1	11/2	1/1	12/2	1/31
7/3	9/1	8/3	10/2	9/3	11/2	10/3	12/2	11/3	1/2	12/3	2/1
7/4	9/2	8/4	10/3	9/4	11/3	10/4	12/3	11/4	1/3	12/4	2/2
7/5	9/3	8/5	10/4	9/5	11/4	10/5	12/4	11/5	1/4	12/5	2/3
7/6	9/4	8/6	10/5	9/6	11/5	10/6	12/5	11/6	1/5	12/6	2/4
7/7	9/5	8/7	10/6	9/7	11/6	10/7	12/6	11/7	1/6	12/7	2/5
7/8	9/6	8/8	10/7	9/8	11/7	10/8	12/7	11/8	1/7	12/8	2/6
7/9	9/7	8/9	10/8	9/9	11/8	10/9	12/8	11/9	1/8	12/9	2/7
7/10	9/8	8/10	10/9	9/10	11/9	10/10	12/9	11/10	1/9	12/10	2/8
7/11	9/9	8/11	10/10	9/11	11/10	10/11	12/10	11/11	1/10	12/11	2/9
7/12	9/10	8/12	10/11	9/12	11/11	10/12	12/11	11/12	1/11	12/12	2/10
7/13	9/11	8/13	10/12	9/13	11/12	10/13	12/12	11/13	1/12	12/13	2/11
7/14	9/12	8/14	10/13	9/14	11/13	10/14	12/13	11/14	1/13	12/14	2/12
7/15	9/13	8/15	10/14	9/15	11/14	10/15	12/14	11/15	1/14	12/15	2/13
7/16	9/14	8/16	10/15	9/16	11/15	10/16	12/15	11/16	1/15	12/16	2/14
7/17	9/15	8/17	10/16	9/17	11/16	10/17	12/16	11/17	1/16	12/17	2/15
7/18	9/16	8/18	10/17	9/18	11/17	10/18	12/17	11/18	1/17	12/18	2/16
7/19	9/17	8/19	10/18	9/19	11/18	10/19	12/18	11/19	1/18	12/19	2/17
7/20	9/18	8/20	10/19	9/20	11/19	10/20	12/19	11/20	1/19	12/20	2/18
7/21	9/19	8/21	10/20	9/21	11/20	10/21	12/20	11/21	1/20	12/21	2/19
7/22	9/20	8/22	10/21	9/22	11/21	10/22	12/21	11/22	1/21	12/22	2/20
7/23	9/21	8/23	10/22	9/23	11/22	10/23	12/22	11/23	1/22	12/23	2/21
7/24	9/22	8/24	10/23	9/24	11/23	10/24	12/23	11/24	1/23	12/24	2/22
7/25	9/23	8/25	10/24	9/25	11/24	10/25	12/24	11/25	1/24	12/25	2/23
7/26	9/24	8/26	10/25	9/26	11/25	10/26	12/25	11/26	1/25	12/26	2/24
7/27	9/25	8/27	10/26	9/27	11/26	10/27	12/26	11/27	1/26	12/27	2/25
7/28	9/26	8/28	10/27	9/28	11/27	10/28	12/27	11/28	1/27	12/28	2/26
7/29	9/27	8/29	10/28	9/29	11/28	10/29	12/28	11/29	1/28	12/29	2/27
7/30	9/28	8/30	10/29	9/30	11/29	10/30	12/29	11/30	1/29	12/30	2/28
7/31	9/29	8/31	10/30			10/31	12/30			12/31	3/1

REGISTER PUBLISHING DEADLINES

The Secretary of State's Office publishes the *Register* weekly. There is a three-week delay between the deadline date and the *Register* publication date. The weekly deadline dates (*first column*) and issue dates (*second column*) are shown below. Council meetings and *Register* deadlines do not correlate. Also listed are the earliest dates on which an oral proceeding can be held on proposed rulemakings or proposed delegation agreements, following publication of the notice in the *Register*.

Deadline Date Friday, 5:00 p.m. *(**early submission date due to holiday)*	***Register* Publication Date**	**Oral Proceeding may be scheduled on or after** *(*later date due to holiday)*
May 16, 2025	June 6, 2025	July 7, 2025
May 23, 2025	June 13, 2025	July 14, 2025
May 30, 2025	June 20, 2025	July 21, 2025
June 6, 2025	June 27, 2025	July 28, 2025
June 13, 2025	July 4, 2025	August 4, 2025
June 20, 2025	July 11, 2025	August 11, 2025
June 27, 2025	July 18, 2025	August 18, 2025
**July 3, 2025	July 25, 2025	August 25, 2025
July 11, 2025	August 1, 2025	*September 2, 2025
July 18, 2025	August 8, 2025	September 8, 2025
July 25, 2025	August 15, 2025	September 15, 2025
August 1, 2025	August 22, 2025	September 22, 2025
August 8, 2025	August 29, 2025	September 29, 2025
August 15, 2025	September 5, 2025	October 6, 2025
August 22, 2025	September 12, 2025	*October 14, 2025
August 29, 2025	September 19, 2025	October 20, 2025
September 5, 2025	September 26, 2025	October 22, 2025
September 12, 2025	October 3, 2025	November 3, 2025
September 19, 2025	October 10, 2025	November 10, 2025
September 26, 2025	October 17, 2025	November 17, 2025
October 3, 2025	October 24, 2025	November 24, 2025
October 10, 2025	October 31, 2025	December 1, 2025
October 17, 2025	November 7, 2025	December 8, 2025
October 24, 2025	November 14, 2025	December 15, 2025
October 31, 2025	November 21, 2025	December 22, 2025
November 7, 2025	November 28, 2025	December 29, 2025
November 14, 2025	December 5, 2025	January 5, 2026
November 21, 2025	December 12, 2025	January 12, 2026
November 28, 2025	December 19, 2025	January 19, 2026

GOVERNOR'S REGULATORY REVIEW COUNCIL DEADLINES

The following deadlines apply to all Five-Year Review Reports and any adopted rule submitted to the Governor's Regulatory Review Council. Council meetings and *Register* deadlines do not correlate. We publish these deadlines under A.R.S. § 41-1013(B)(15).

All rules and Five-Year Review Reports are due in the Council office by 5 p.m. of the deadline date. The Council's office is located at 100 N. 15th Ave., Suite 305, Phoenix, AZ 85007. For more information, call (602) 542-2058 or visit https://grrc.az.gov.

GOVERNOR'S REGULATORY REVIEW COUNCIL DEADLINES FOR 2024/2025

(MEETING DATES ARE SUBJECT TO CHANGE)

[M24-54]

*Materials must be submitted by **5 P.M.** on dates listed as a deadline for placement on a particular agenda. Placement on a particular agenda is not guaranteed.

DEADLINE FOR PLACEMENT ON AGENDA*	FINAL MATERIALS SUBMITTED TO COUNCIL	DATE OF COUNCIL STUDY SESSION	DATE OF COUNCIL MEETING
Tuesday April 22, 2025	*Tuesday* May 20, 2025	***Wednesday*** May 28, 2025	*Tuesday* June 3, 2025
Tuesday May 20, 2025	*Tuesday* June 17, 2025	*Tuesday* June 24, 2025	*Tuesday* July 1, 2025
Tuesday June 17, 2025	*Tuesday* July 22, 2025	*Tuesday* July 29, 2025	*Tuesday* August 5, 2025
Tuesday July 22, 2025	*Tuesday* August 19, 2025	*Tuesday* August 26, 2025	***Wednesday*** September 3, 2025
Tuesday August 19, 2025	*Tuesday* September 23, 2025	*Tuesday* September 30, 2025	*Tuesday* October 7, 2025
Tuesday September 23, 2025	*Tuesday* October 21, 2025	*Tuesday* October 28, 2025	*Tuesday* November 4, 2025
Tuesday October 21, 2025	*Tuesday* November 18, 2025	*Tuesday* November 25, 2025	*Tuesday* December 2, 2025
Tuesday December 23, 2025	***Wednesday*** January 21, 2026	*Tuesday* January 27, 2026	*Tuesday* February 3, 2026