NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

PREAMBLE

1. Articles, Parts, or Sections Affected | **Rulemaking Action:**

Articles, Parts, or Sections Affected	Rulemaking Action
R9-22-712.06	New

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

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

Implementing statute: A.R.S. § 36-2903.01

3. The effective date of the rule:

As specified in A.R.S. § 41-1032(A)(4), the agency requests an immediate effective date to provide a benefit to the public and a penalty is not associated with a violation of the rule.

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

Notice of Rulemaking Docket Opening: 27 A.A.R. 1030, July 9, 2021.

Notice of Proposed Rulemaking: 27 A.A.R. 1027, July 9, 2021.

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

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6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to

include an explanation about the rulemaking:

A.R.S. § 36-2903.01 requires the Administration to describe in rule how Graduate Medical Education (GME) funds are calculated and distributed. The intention of this rulemaking is to implement the appropriation made for two new GME pools established in Laws 2020, Chapter 58. Laws 2020, Chapter 58 established a separate rural pool (for GME hospitals outside of Maricopa and Pima counties) and an urban pool (for GME hospitals inside Maricopa and Pima counties). Monies are to be made for the direct and indirect costs of graduate medical education, are to supplement but not supplant voluntary payments made from political subdivisions for payments to hospitals to operate GME programs, and must prioritize distribution to programs at hospitals in counties with a higher percentage of persons residing in a health professional shortage area as defined in 42 Code of Federal Regulations Part 5.

Between July 2019 and December 2019, the AHCCCS Administration established a GME workgroup consisting of all Arizona GME hospitals, the Arizona Hospital and Healthcare Association, and the Health System Alliance of Arizona to discuss the two new pools and to come to a consensus on how the funding is prioritized. The hospitals recommended a number of items that would help them to establish new GME programs and prioritize funding based on the needs of Arizonans. These recommendations included the following:

- Once a resident starts a multi-year program, provide continued funding until they complete the program.
- Prioritize funding based on residency type in order to best meet the needs of Arizonans. This includes primary care (internal medicine, family medicine, general pediatrics, obstetrics and gynecology, and geriatrics), behavioral health, general surgery, and any other programs which AHCCCS determines is a high need.
- Create the following tiers for funding priority:
  - Returning residents and fellows.
  - Residents and fellows that are not returning but are in a GME program for primary care, behavioral health, general surgery, and any other programs which AHCCCS determines is high needs.
  - Residents or fellows that are not returning but for which the GME program received funding in the prior year.
  - All other residents and fellows.
- In order to meet the HPSA requirement, create the following subtiers:
  - Hospitals in a county designated by the Health Resource and Services Administration of the U.S. Department of Health & Human Services as a health professional shortage area (HPSA) with an 85-100% primary care shortage.
  - Hospitals in a county designated as a HPSA with an 50-84% primary care shortage.
  - Hospitals in a county designated as a HPSA with an 25-49% primary care shortage.

- Hospitals in a county designated as a HPSA with an 0-24% primary care shortage.

- Since establishing rural residencies is often more costly than establishing urban residencies, startup costs should be included for rural residencies.
- In order for hospitals to determine how many graduate medical resident slots they will offer in the upcoming academic year, make a preliminary allocation of funds prior to the beginning of the academic year.
- Allow payments only for programs which began on or after July 1, 2020 or expanded the number of slots on or after July 1, 2020 in order to ensure that payments are supplemented and not supplanted.
- For rural hospitals, allocate direct and indirect payments concurrently. For urban hospitals, first allocate all direct payments before indirect payments.

The Centers for Medicare and Medicaid Services (CMS) require the AHCCCS Administration to annually update the amount allocated to each hospital in the State Plan. Before AHCCCS may make GME payments, a State Plan Amendment (SPA) must be submitted and approved by CMS. Before AHCCCS may make GME payments, a State Plan Amendment (SPA) must be submitted and approved by CMS. Technical and conforming changes will also be made.

7. <u>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:</u>

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

8. <u>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:</u>

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

9. <u>A summary of the economic, small business, and consumer impact:</u>

The AHCCCS Administration estimates this will result in an allocation of up to $10 million in the first year and up to $20 million for the second year. No hospitals will negatively be impacted by this change, and none of the GME hospitals are small businesses. The AHCCCS program is jointly funded by the State and the federal government through the Medicaid program.

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

AHCCCS made a couple of technical changes between the proposed rulemaking and the final rulemaking, for

clarity and to align the language of the rule with clarifying changes requested by the Center for Medicare and Medicaid Services in the Arizona State Plan Amendment that mirrors the change enacted in this rulemaking. These changes are not substantive under A.R.S. § 41-1025 and are listed below:

- In (B)(2) and (C)(2), the percentage ranges in the proposed rule were listed as 85-100%, 50-84%, 25-49%, and 0-24%, however for clarity and to prevent any decimated percentages to be missed by these tiers, the percentages were changed in the final rule to "greater than 85%", greater than 50 to 85%, 25-50%, and less than 25%;
- Subsection (B)(5) and (C)(6) were added to final rule to clarify that full time employees are counted once on a yearly basis to factor in the calculations of Graduate Medical Expenses.

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

Name and Position of Commenter	Date of Comment	Text of Comment	AHCCCS Response
Jennifer Carusetta, Vice President, Public Affairs & Advocacy, Phoenix Children's Hospital	8/9/2021	On behalf of Phoenix Children's Hospital (PCH), it is with great pleasure that I write to you today in support of the Proposed Rulemaking: Graduate Medical Education (GME). We extend our gratitude to you and your staff for the reinstatement of the state funded GME program in Arizona. Like all healthcare systems, we are acutely aware of the rapid growth taking place across our state, particularly amongst families in Maricopa County. As a system, we are eager to utilize every tool available to ensure that we can continue to offer Arizona children the quality-driven, innovative care that PCH is recognized for. GME plays a critical role in in this effort. We would also like to extend our appreciation to you for your leadership in developing the GME Workgroup, which was instrumental in facilitating a collaborative agreement amongst AHCCCS and hospitals as to how dollars in GME funding pools should be allocated. In keeping with these agreements, PCH will continue to work in partnership with policymakers to amend state law to remove the requirement that funds in the urban pool be prioritized to residency programs in counties with the highest physician shortage. We appreciate your continued partnership on this issue and your staff's agreement to amend the rule to reflect this change once it is enacted. I am happy to answer any questions or provide any additional information. Please do not hesitate	AHCCCS thanks Phoenix Children's Hospital for their support of this rulemaking.

		to contact me if I can offer any additional assistance.	
Eileen I. Klein, Consultant, Health System Alliance of Arizona (HSAA)	8/9/2021	On behalf of the Health System Alliance of Arizona (Alliance), we appreciate the opportunity to provide comments on the Graduate Medical Education (GME) proposed rule to implement the appropriation made for two new GME pools established in Laws 2020, Chapter 58. The Alliance is compromised of the largest health systems in Arizona representing 80% of the hospital care delivered to residents. Our member hospitals also sponsor the vast majority of local residency programs to grow a strong, sustainable health care workforce for the benefit of Arizona's health care economy and patients. The Alliance supports efforts to establish new GME programs focused on high need areas, which is a critical tool for recruiting and retaining qualified physicians in Arizona. The workgroup that was established by AHCCCS between July 2019 and December 2019, allowed for robust stakeholder engagement by all GME hospitals to come to a consensus on how the funding is prioritized. The Alliance and our member hospitals recommended a number of guiding principles to help establish new GME programs and prioritize funding which we are encouraged to see AHCCCS adopted in the proposed rulemaking. Specifically, the Alliance supports the following: • Prioritization of training programs where there are significant shortages and an opportunity to develop new GME slots in Arizona including General Surgery, Primary care programs that train physicians in Family Medicine, OB-GYN and Internal Medicine as well as Behavioral Health. • A commitment by AHCCCS to give precedence to funding residents for the entirety of their multi-year program. • Funding will be used for the expansion or creation of accredited programs. The Alliance appreciates that new dollars will supplement and not supplant existing funding for programs. Arizona's robust population growth, aging Baby Boomers and increasing healthcare professionals' shortages, continues to be a challenge to Arizona hospitals and healthcare systems. Continued investments in GME are crucial to the future of Arizona and the ability to provide quality, affordable healthcare. The Alliance	AHCCCS thanks the Health System Alliance of Arizona for their support of this rulemaking.

		appreciates AHCCCS' continued collaboration to implement GME appropriations with a focus on shortage areas. We especially want to acknowledge the work of Amy Upston in convening the stakeholder group and soliciting feedback throughout the process to best meet the needs of the Agency and hospitals.	

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

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

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

The rules do not require the provider to obtain a permit or a general permit.

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

The 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:

No such analysis was submitted.

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

The rules do not include any incorporation by reference of materials as specified in statute.

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

The rules were not previously made, amended or repealed as emergency rules.

15. The full text of the rules follow:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-712.06. Supplemental Graduate Medical Education Fund Allocation

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-712.06. Supplemental Graduate Medical Education Fund Allocation

A. Gradual Medical Education (GME) reimbursement as of July 1, 2020.

1. In addition to distributions pursuant to section R9-22-712.05, and subject to the availability of funds and approval by CMS, the Administration shall annually distribute monies appropriated for the GME programs approved by the Administration to hospitals for direct and indirect costs for graduate medical education programs which were established or expanded on or after July 1, 2020. The Administration shall estimate the distributions using information possessed by the Administration as of December 15 of each calendar year. The actual distributions will be made using information possessed by the Administration as of September first of the year in which the new residency or fellowship begins.
2. Eligible Hospitals. A hospital is eligible for distributions under this section if all of the following apply:
   a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona;
   b. It incurs direct costs for the training of residents in the GME programs, which costs are or will be reported on the hospital's Medicare Cost Report;
   c. It is not administered by or does not receive its primary funding from an agency of the federal government;
   d. It is established a new GME program or expanded the number of residents or fellows in an existing GME program on or after July 1, 2020.
3. Eligible positions. For purposes of determining distributions under this section the following resident and fellowship positions qualify to the extent that the training takes place in Arizona at an eligible health care facility:
   a. Filled resident or fellow positions in approved programs which began on or after July 1, 2020;
   b. Eligible positions do not include residents or fellows that receive payments for services under the Access to Professional Services Initiative (APSI) program stablished in the Contractors' prepaid capitation contracts with the Administration.
4. Annual Reporting
   a. By December 15 of each year, a GME program shall provide all of the following information for GME programs and positions which are expected to be eligible for funding under this section as of the upcoming academic ear (i.e., July 1 to June 30 of each year):
      i. The program name and number assigned by the accrediting organization if available;
      ii. The original date of accreditation if available;
      iii. The names of the sponsoring institution and all participating institutions expected as of the date of reporting:
      iv. The number of anticipated resident and fellowship positions eligible for funding as of the upcoming academic year'
      v. The number of months or partial months during the upcoming academic year that each resident or fellow is expected to work in each hospital or in a non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
      vi. The academic year of anticipated resident and fellowship positions;
      vii. The length of the program;
      viii. The names and other information requested by AHCCCS to ensure the total GME distributions for each eligible position are not greater than the costs for each eligible position in the Intern and Resident Information System (IRIS) file;

b. By December 15 of each year, a GME program located in a county with a population of less than five hundred thousand persons shall provide the estimated one-time and ongoing costs for each program which it expects to be eligible for funding.

c. By September 1 of each year, a GME program shall provide the actual name of residents and fellows hired in the current academic year and other information requested by AHCCCS to ensure that total GME distributions for the eligible position are not greater than the costs for each eligible position in the IRIS file.

B. Preliminary allocation of funds for urban hospitals. Annually by January 15, the Administration shall estimate the annual GME distributions under this section using the funds appropriated for hospitals in counties with a populations of five hundred thousand persons or more based on the number of new residents and fellows in graduate medical education programs in the following manner:

1. Each eligible resident and fellow is placed into tiers with the following priority:
   a. Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this section for the previous academic year and who is continuing in the same GME program.
   b. Residents and fellows that are not a returning resident or fellow but are in a GME program for Family Medicine, Internal Medicine, General Pediatrics, Obstetrics and Gynecology, Psychiatry including Subspecialties, General Surgery, and any other program determined as high needs by the AHCCCS Administration.
   c. Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this section in a prior year.
   d. All other residents and fellows.
2. Residents and fellows in each tier are further divided into 4 sub-tiers with the following priority based on the location of the sponsoring or participating hospital:
   a. Hospitals in a county designated by the Health Resource and Services Administration of the U.S. Department of Health & Human Services as a health professional shortage area (HPSA) with a greater than 85% primary care shortage.
   b. Hospitals in a county designated as a HPSA with a greater than 50% to 85% primary care shortage.
   c. Hospitals in a county designated as a HPSA with a 25-50% primary care shortage.
   d. Hospitals in a county designated as a HPSA with a less than 25% primary care shortage.
3. The amount of the distribution for each GME program for direct costs is calculated as the product of:
   a. The number of eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospitals;
   b. The Arizona Medicaid utilization as determined by R9-22-712.05(B)(4)(c)(i) in the previous calendar year; and,
   c. The average direct cost per resident determined under R9-22-712.05(b)(4)(d) in the previous calendar year.
4. If monies are still remaining after direct funding has been allocated, indirect funding shall be allocated based on the priority of each tier and sub-tier. The amount of the distribution for each GME program for indirect costs is calculated as the product of:
   a. The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
   b. The indirect cost per resident per month calculated in R9-22-712.05(D)(4)(b)(vi) in the previous calendar year; and
   c. Twelve months.
   d. Funds shall be allocated based on the priority of each tier and sub-tier. Distributions for eligible positions in a tier or sub-tier with a lower priority will not receive a distribution

until distributions are allocated for the costs of all positions in a higher tier or sub-tier. If funding is insufficient to fully fund a tier or sub-tier, the remainder of funds will be prorated for eligible positions in that tier or sub-tier.

5. Payments are made to participating hospitals based on the FTE's who worked at their hospitals per year.

C. Preliminary allocation of funds for rural hospitals. Annually by January 15, the Administration shall estimate the annual GME distributions under this section using the funds appropriated for rural hospitals based on the number of eligible resident and fellow positions in graduate medical education programs located in a county with a population of less than five hundred thousand persons in the following manner:

1. Each resident and fellow will then be placed into a tier with the following priority:
   a. Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this section for the previous academic year and who is continuing in the same GME program.
   b. Residents and fellows that are not a returning resident or fellow but are in a GME program for Family Medicine, Internal Medicine, General Pediatrics, Obstetrics and Gynecology, Psychiatry including Subspecialties, General Surgery, and any other program determined as high needs by the AHCCCS Administration.
   c. Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this section in a prior year.
   d. All other residents and fellows.
2. Residents and fellows in each tier are further divided into 4 sub-tiers with the following priority based on the location of the sponsoring or participating hospital:
   a. Hospitals in a county designated by the Health Resource and Services Administration of the U.S. Department of Health & Human Services as a HPSA with a greater than 85% primary care shortage.
   b. Hospitals in a county designated as a HPSA with a greater than 50% to 85% primary care shortage.
   c. Hospitals in a county designated as a HPSA with a 25-50% primary care shortage.
   d. Hospitals in a county designated as a HPSA with a less than 25% primary care shortage.
3. Funds shall first be allocated for direct and indirect costs based in order of priority of each tier. If not enough funding is available to fully fund a tier or sub-tier, the remainder of funds will be prorated in a tier or sub-tier.
4. The amount of the distribution for each GME program for direct costs is calculated as the product of:
   a. The number of eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospitals;
   b. The Arizona Medicaid utilization determined under R9-22-712.05(B)(4)(c)(i); and,
   c. The actual direct cost per resident per year.
5. The amount of the distribution for each GME program for indirect costs is calculated as the product of:
   a. The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
   b. The indirect cost per resident per month calculated in R9-22-712.05(D)(4)(b)(vi) in the previous calendar year; and
   c. Twelve months.
6. Payments are made to participating hospitals based on the FTE's who worked at their hospitals per year.

D. Final allocation of funds. Annually no sooner than September 1 following the start of the academic year, the Administration will recalculate the allocation for urban and rural hospitals using the same methodology

used to estimate distributions, but using the actual residents and fellows as reported in R9-22-712.06(B)(3)(c).

F. Exclusions. To ensure that residents and fellows are not double counted residents/fellows which receive funding through R9-22-712.06 shall not receive funding through R9-22-712.05.