NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

PREAMBLE

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

R9-22-730	New Section

2. **Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific), and the statute or session law authorizing the exemption:**

   Authorizing statute: A.R.S. §§ 36-2901.08
   Implementing statute: A.R.S. §§ 36-2901.08
   Statute or session law authorizing the exemption: A.R.S. § 41-1005 amended under Laws 2013, Ch. 10, § 10

3. **The effective date of the rule and the agency's reason it selected the effective date:**

   Effective upon filing with the Secretary of State, January 15, 2014.

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

   Notice of Proposed Exempt Rulemaking: 20 A.A.R. 28, January 3, 2014

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 An agency's justification and reason why a rule should be made, amended, repealed, or renumbered to include an explanation about the rulemaking: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. § 36-2901.01, adopted by Initiative Measure Proposition 204 in the 2000 general election, includes individuals with income up to 100% of the federal poverty level as part of the definition of persons eligible for health care coverage through AHCCCS. Due to the lack of available funding, effective July 8, 2011, the Administration closed the program to new enrollment for persons described by A.R.S. § 36-2901.01 who were not also described in the Arizona State Plan for Medicaid. Arizona Laws 2013, 1st Special Session, Chapter 10, Section 5, added A.R.S. § 36-2901.07, which expanded the definition of eligible persons to include individuals with income between 100% and 133% of the federal poverty level.

A.R.S. § 36-2901.08, also enacted in the same section of the 2013 law, authorizes the Administration to establish, administer and collect an assessment on hospital revenues, discharges or bed days for funding a portion of the nonfederal share of the costs incurred beginning January 1, 2014, associated with eligible persons added to the program by A.R.S. §§ 36-2901.01 and 36-2901.07. The Administration is proposing a new rule to describe the process for establishing, administering and collecting the assessment on hospitals. A.R.S. § 41-1005 (A)(32) exempts the Administration from Title 41, Chapter 6 of the Arizona Revised Statutes (the Arizona Administrative Procedure Act) for purposes of implementing and establishing the hospital assessment; however, that provision requires the Administration to provide public notice and an opportunity for public comment at least thirty days before doing so.

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

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

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 summary of the economic, small business, and consumer impact, if applicable:

The Administration estimates that, through the hospital assessment, the Administration will collect $75.3 million from Arizona hospitals for the State Fiscal Year ending June 30, 2014. The AHCCCS program is jointly funded by the State and the federal government through the Medicaid program. Depending on the eligibility category of the individual, the federal government provides approximately two-thirds, 83%, or 100% of the cost of care for persons described in A.R.S. § 36.2901.08(A). The Administration will use the amounts collected from the assessment combined with the federal financial participation to fund the cost of health care coverage for an estimated 300,000 persons described in A.R.S. § 36.2901.08(A) through direct payments to health care providers and capitation payments to managed care organizations that, in turn, make payments to health care providers that render care to AHCCCS members. Many of the providers of that medical care are considered small businesses located in Arizona. A.R.S. § 36-2901.08 prohibits the assessed hospitals from passing the cost of the assessment on to patients or third parties who pay for care in the hospital. In the aggregate, the Administration expects to return millions more in State Fiscal Year 2014 in incremental payments for hospital services than will be collected through the assessment.

10. A description of any changes between the proposed rulemaking, including any supplemental proposed rulemaking, and the final rulemaking package (if applicable):

None

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

Numb:	**Date/ Commentor:**	**Comment:**	**Response:**
1.	01/10/14 Jason Bezozo	R9-22-730 The proposed model unfairly excludes	The only comments received on the

	Banner Health	from the assessment a number of hospitals that benefit from the restoration and expansion of AHCCCS coverage while including some hospitals in the assessment that will not benefit from the restoration and expansion. Exclusion of one hospital because of its high percentage of Medicare discharges. applies only to one hospital located in Phoenix. The requirements for a qualifying hospital to be located in a city of one million and for 15 percent of its inpatient days ("on average", whatever that may mean) be attributed to out –of –state patients seem at best anachronistic when considering: (a) the long-term nature of the statewide assessment; and (b) the intended use of the resulting funds to support the wholesale restoration and expansion of a portion of the AHCCCS program. Banner believe the exclusion as drafted unjustly favors a single high-volume Medicare provider over other hospitals that serve significantly higher volumes of elderly patients. Particularly the requirement for a specified percentage of non-Arizona discharges, arbitrarily and capriciously exempts one high-volume Medicare provider. The current design results in an exclusion for one hospital in one city of the state that barely meets the Medicare volume threshold, resulting in a significant gain on the assessment for that hospital, and forcing at least three others with much higher percentages of Medicare volumes to pay the highest assessment rates, resulting in significant losses. Banner is requesting that AHCCCS modify the exclusion to (a) make it better suited for a statewide assessment design, and (b) avoid the disparate and inequitable treatment of other high-volume Medicare hospitals. Specifically (a) expand the location requirement to include hospitals in unincorporated areas; (b) eliminate the out-of-state requirement; (c) maintain the minimum qualifying threshold of 50 percent Medicare volume; and (d) require	proposed rule were received from Banner Health System which was a member of the stakeholder group that provided input on the design of the assessment. AHCCCS established a robust stakeholder participation process in which the workgroup was provided an opportunity to review and consider all suggested modifications to the assessment. On January 10, 2014, shortly before the close of the comment period, Banner submitted as comments on the proposed rules, a copy of comments that were provided in September of 2013, as part of that workgroup. Those comments were considered prior to publication of the proposed rule. AHCCCS understands the objection to be, in essense, that certain individual hospitals in the Banner Health System are not treated similar to other hospitals which Banner believes to be similarly situated. As part of its statutory requirements, the AHCCCS Administration was charged with designing an assessment that ensured that the costs of the assessment were not passed on to patients or other health care payors. As part of its efforts to do so, AHCCCS adopted as a guiding principle that it would make its best efforts to implement an assessment that minimized the negative impact to hospital systems – not individual hospitals. Banner Health Systems, viewed as a single entity rather than as individual hospitals, is not negatively impacted by the assessment. In addition, the statute requires AHCCCS to establish an assessment that meets federal requirements for the use of an assessment on providers as the basis for the funding of Medicaid services. AHCCCS was required to submit to the federal government an analysis of the sources and expected benefits of increased Medicaid payments. In summary, the assessment paid by hospitals and additional payments made by AHCCCS to hospitals must not be correlated beyond a degree set forth in federal regulations. Recently, AHCCCS received federal approval for the assessment described in this rule. Modification of the assessment at this point would require additional analysis by AHCCCS and further review and approval by the federal government. This would cause an unacceptable delay in the implementation of the assessment.

		an additional minimum qualifying threshold of 5,000 Medicare cases, in recognition of the burden borne by other high-volume Medicare hospitals.	AHCCCS has made a commitment to the stakeholder hospitals to review the assessment rates and the assessment methodologies on an on-going basis in order to ensure to the greatest extent possible that the amounts expected to be collected by the assessment are adequate to meet – but not exceed – the cost of the populations described in statute as funded by the assessment. Because the changes suggested in this comment would have significant impacts on other hospitals, AHCCCS believes it is most appropriate to address it through the stakeholder process as we develop the rates for the next rate period. While AHCCCS will consider the suggestions of Banner Health Systems and other stakeholders as part of future revisions to the assessment rule, AHCCCS has chosen to move forward with the proposed rule to achieve implementation consistent with statutory requirements.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules. When applicable, matters shall include, but not be limited to:

No other matters have been prescribed.

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

Not applicable

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

Not applicable

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

No analysis was submitted.

13. A list of any incorporated by reference material and its location in the rule:

None

14. Whether the rule was previously made, amended, repealed or renumbered as an emergency rule. If so, the agency shall state where the text changed between the emergency and the exempt rulemaking packages:

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

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-730 Hospital Assessment

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-730. **Hospital Assessment**

A. For purposes of this Section, the following terms are defined as provided below unless the context specifically requires another meaning:

1. "2011 Medicare Cost Report" means:
   a. The Medicare Cost Report for the hospital fiscal year ending in calendar year 2011 as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated December 31, 2012; or
   b. For hospitals not included in that CMS HCRIS report, the "as filed" Medicare Cost Report for the hospital fiscal year ending in calendar year 2011 submitted by the hospital to the Administration.
2. "2011 Uniform Accounting Report" means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of December 19, 2012.
3. "2012 Uniform Accounting Report" means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of August 2, 2013.
4. "Quarter" means the three month period beginning January 1, April 1, July 1, and October 1 of each year.

B. Beginning January 1, 2014, for each Arizona licensed hospital not excluded under subsection (I) shall be subject to an assessment payable on a quarterly basis. The assessment shall be levied against the legal owner of each hospital as of the first day of the quarter, and except as otherwise required by subsections (D), (E) and (F), shall be calculated by multiplying the number of discharges reported on the hospital's 2011 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as "Other Long Term Care Discharges" by the following rates based on the hospital's peer group:

1. $125.25 per discharge for hospitals located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.
2. $125.25 per discharge for hospitals designated as type: hospital, subtype: critical access hospital.
3. $31.25 per discharge for hospitals designated as type: hospital, subtype: long term.

4. $31.25 per discharge for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2011 Medicare Cost Report.
5. $100.25 per discharge for hospitals designated as type: hospital, subtype: short-term with 20% or more of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 2012 Uniform Accounting Report.
6. $112.75 per discharge for hospitals designated as type: hospital, subtype: short-term with at least 10% but less than 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 2012 Uniform Accounting Report.
7. $125.25 per discharge for hospitals designated as type: hospital, subtype: short-term not included in another peer group.

C. Peer groups for the four quarters beginning July 1 of each year are established based on hospital license type and subtype designated 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 preceding March of each year.

D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2011 Medicare Cost Report, are assessed a rate of $31.25 for each discharge from the psychiatric sub-provider as reported in the 2011 Medicare Cost Report. All discharges other than those reported as discharges from the psychiatric sub-provider are assessed at the rate required by subsection (B).

E. Notwithstanding subsection (B), rehabilitative discharges from a hospital that reported having a rehabilitative sub-provider in the hospital's 2011 Medicare Cost Report, are assessed a rate of $0 for each discharge from the rehabilitative sub-provider as reported in the 2011 Medicare Cost Report. All discharges other than those reported as discharges from the rehabilitative sub-provider are assessed at the rate required by subsection (B).

F. Notwithstanding subsection (B), for any hospital that reported more than 29,000 discharges on the hospital's 2011 Medicare Cost Report, discharges in excess of 29,000 are assessed a rate of $12.50 for each discharge in excess of 29,000. The initial 29,000 discharges are assessed at the rate required by subsection (B).

G. Assessment notice. On or before the 15th day of the quarter, the Administration shall send to each hospital a notification that the assessment invoice is available to be viewed on a secure website. The invoice shall include the hospital's peer group assignment and the assessment due for the quarter.

H. Assessment due date. Assessment must be received by the Administration by the 15th day of the second month of the quarter.

I. Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's 2011 Medicare Cost Report and 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:

1. Hospitals owned and operated by the state, the United States, or an Indian tribe.
2. Hospitals designated as type: hospital, subtype: short-term that have a license number beginning "SH".
3. Hospitals designated as type: hospital, subtype: psychiatric that reported fewer than 2,500 discharges on the 2011 Medicare Cost Report.
4. Hospitals designated as type: hospital, subtype; rehabilitation.
5. Hospitals designated as type: hospital, subtype: children's.
6. Hospitals designated as type: med-hospital, subtype: special hospitals.
7. Hospitals designated as type: hospital, subtype: short-term located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2011 Medicare Cost Report are reimbursed by Medicare.

J. New hospitals. For hospitals that did not file a 2011 Medicare Cost Report because of the date the hospital began operations, the hospital assessment will begin with the hospital's second quarter of operation but no sooner than January 1, 2014. The assessment will be based on the number of discharges reported by the hospital to AHCCCS for prior quarters until the hospital files its initial Medicare Cost Report. Thereafter, the assessment will be based on the discharges reported in the hospital's initial Medicare Cost Report.

K. Changes of ownership. The parties to a change of ownership shall promptly provide written notice to the Administration of a change of ownership and any agreement regarding the payment of the assessment. Assessments are the responsibility of the owner of record as of the first day of the quarter; however, this rule is not intended to prohibit the parties to a change of ownership from entering into an agreement for a new owner to assume the assessment responsibility of the owner of record as of the first day of the prior quarter.

L. Hospital closures. Hospitals that close shall pay a proportion of the quarterly assessment equal to that portion of the quarter during which the hospital operated.

M. Required information. For any hospital that has not filed a 2011 Medicare Cost report, or if the 2011 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the assessment, the Administration shall use data reported on the 2011 Uniform Accounting Report filed by the hospital in place of the 2011 Medicare Cost report to calculate the assessment. If the 2011 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2011 Medicare Cost report to calculate the assessment.

N. The Administration will review and update as necessary rates and peer groups periodically to ensure the assessment is sufficient to fund the state match obligation to cover the cost of the populations as specified in 36-2901.08.

O. Enforcement. If a hospital does not comply with this section, the director may suspend or revoke the hospital's provider agreement. If the hospital does not comply within 180 days after the hospital's provider agreement is suspended or revoked, the director shall notify the director of the Department of Health Services who shall suspend or revoke the hospital's license.