NOTICE OF FINAL 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	Amend

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

Authorizing statute: A.R.S. § 36-2901.08

Implementing statute: A.R.S. § 36-2901.08

Statute authorizing the exemption: A.R.S. § 41-1005(A)(31)

3. The effective date of the rule:

The Administration is proposing an effective date of July 10, 2018 so that the invoices for the new rates will be available on or before July 15, 2018 or upon approval by CMS, whichever is later.

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: N/A

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking: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. § 36-2901.08 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. It is the Agency's objective to assess only so much as is necessary to meet the estimated costs

associated with the projected populations referenced in the statute. As such, it is necessary for the Administration to adjust the assessment from time to time as the Administration updates its estimate of the number of eligible persons and projected cost associated with coverage for those persons. The Administration is proposing a new rule to update the figures to be used as of July 1, 2018 for collecting the assessment from hospitals.

At the assessment rates in the current rule, the Administration estimates that it would collect $290 million over the course of a state fiscal year. The amendments reflected in this proposed rule adjust the assessment rates such that the Administration anticipates the collection of $287 million for the State Fiscal Year ending June 30, 2019. This amount corresponds to the amount of non-federal funds estimated to be necessary to cover the cost of providing care to the estimated 414,000 eligible individuals described in A.R.S. §36-2901.08(A) for State Fiscal year ending June 30, 2019.

Additionally, the Administration is proposing to update the current reference of data from the 2011 Medicare Cost Reports and 2012 Uniform Accounting Reports and replacing it with references to the 2016 Medicare Cost Reports and 2016 Uniform Accounting Reports to more accurately reflect current hospital discharges.

The Administration is also proposing to modify the language of the rule so that a hospital will only be assessed if it was open on March 1 preceding the July assessment start date and require new hospitals to submit data to AHCCCS by April 15 of each year. Currently, a hospital is assessed if it was open on April 1 preceding the July assessment start date and data for new hospitals is due to AHCCCS by May 15 of each year. This change will allow a more reasonable timeframe from when the assessment needs to be finalized each year. The rulemaking also clarifies the assessment calculation for new hospitals.

As required by A.R.S. § 36-2901.08(B), the assessment has been established in a manner consistent with federal regulations at 42 C.F.R. Part 433 Subpart B so that the assessment does not cause a reduction in federal financial participation.

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:

No studies were conducted relevant to the rule.

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

Not applicable

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

The Administration estimates that $287 million will be necessary to be collected from Arizona hospitals to fund the cost required by statute for State Fiscal Year (SFY) 2019 ending June 30, 2019. The assessment amount currently in rule reflects the amount needed in SFY 2018 to cover the estimated cost of care, approximately $290 million. The amendment adjusts the rates downward to reflect the estimated need of $287 million for SFY 2019.

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 between two-thirds and 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 414,000 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 SFY 2019 in incremental payments for hospital services than will be collected through the assessment. Along with a copy of this proposed exempt rule making, the Administration has posted to its website information regarding the fiscal impact of this amendment to hospitals: https://azahcccs.gov/PlansProviders/CurrentProviders/State/proposedrules.html.

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

There were no changes between the proposed and final rulemaking.

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

No public comments were received.

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:

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:

The rule 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:

The rulemaking must be established consistent with 42 CFR Part 433 Subpart B. The rule is not more stringent than federal law.

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

No 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 rule:

No material is incorporated by reference.

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

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

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARD FOR PAYMENTS

Section

ARTICLE 7. STANDARD 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. "201~~1~~6 Medicare Cost Report" means:
   a. The Medicare Cost Report for the hospital fiscal year ending in calendar year 201~~1~~6 as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated ~~December 31, 2012; or~~July 21, 2017.
   ~~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. "201~~1~~6 Uniform Accounting Report" means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of ~~December 19, 2012~~August 16, 2017.
~~3. "2012 Uniform Accounting Report" means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of August 2, 2013.~~
~~4.~~3. "Quarter" means the three month period beginning January 1, April 1, July 1, and October 1 of each year.
4. A "new hospital" means a licensed hospital that did not hold a license from the Arizona Department of Health Services prior to January 1, 2018.

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). For the period beginning ~~July 1, 2017~~ July 1, 2018, the assessment shall be calculated by multiplying the number of discharges reported on the hospital's 201~~1~~6 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. ~~$483.00~~ $546.00 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. ~~$483.00~~ $546.00 per discharge for hospitals designated as type: hospital, subtype: critical access hospital.
3. ~~$120.75~~ $136.50 per discharge for hospitals designated as type: hospital, subtype: long term.
4. ~~$120.75~~ $136.50 per discharge for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 201~~1~~6 Medicare Cost Report.
5. ~~$386.50~~ $436.75 per discharge for hospitals designated as type: hospital, subtype: short- term with 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 201~~2~~6 Uniform Accounting Report.

6. ~~$434.75~~ $491.50 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 201~~2~~6 Uniform Accounting Report.
7. ~~$483.00~~ $546.00 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 ~~April 1, 2017~~January 1, 2018.

D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 201~~1~~6 Medicare Cost Report, are assessed a rate of ~~$120.75~~ $136.50 for each discharge from the psychiatric sub-provider as reported in the 201~~1~~6 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 201~~1~~6 Medicare Cost Report, are assessed a rate of $0 for each discharge from the rehabilitative sub-provider as reported in the 201~~1~~6 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 ~~28,200~~ 23,500 discharges on the hospital's 201~~1~~6 Medicare Cost Report, discharges in excess of ~~28,200~~ 23,500 are assessed a rate of ~~$48.25~~ $54.50 for each discharge in excess of ~~28,200~~ 23,500. The initial ~~28,200~~ 23,500 discharges are assessed at the rate required by subsection (B).

G. Assessment notice. On or before the 15th day of the first month of the quarter or upon CMS approval, whichever is later, 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. The assessment must be received by the Administration no later than:

1. The 15th day of the second month of the quarter or
2. In the event CMS approves the assessment after the 15th day of the first month of the quarter, 30 days after notification by the Administration that the assessment invoice is available.

I. Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's 201~~1~~6 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 ~~April 1, 2017~~ January 1, 2018:

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 201~~1~~6 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 201~~1~~6 Medicare Cost Report are reimbursed by Medicare.
8. Hospitals designated as type: hospital, subtype: short-term that have at least 80 percent Medicare discharges, per the 2016 Medicare Cost Report.

J. New hospitals. For hospitals that did not file a 201~~1~~6 Medicare Cost Report because of the date the hospital began operations:

1. If the hospital was open on the ~~April~~March 1 preceding the July assessment start date, the hospital assessment will begin on July 1 following the date the hospital began operating.
2. If the hospital began operating between ~~April~~March 2 and June 30, the assessment will begin on July 1 of the following calendar year.
3. A hospital is not considered a new hospital based on a change in ownership.
4. ~~Until the first full year of data is available, the assessment will be based on the annualized number of discharges from the date hospital operations began through April 30 preceding the July assessment start date. The hospital shall submit the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the Administration no later than May 15 preceding the assessment start date for the new hospitals. Thereafter, the assessment will be based on the discharges reported in the hospital's first Medicare Cost Report and Uniform Accounting Report which includes 12 months worth of data; however, when a new hospital shares a Medicare Identification Number with an existing hospital, the assessment amount will be based on self reported data from the new hospital instead of the Medicare Cost Report. The data shall include the number of discharges and all other data requested by the Administration necessary to determine the appropriate assessment. No later than August 15, 2017, new hospitals shall also submit to the Administration discharge data and all other data requested by the Administration necessary to determine the appropriate assessment beginning July 1, 2018.~~
   The assessment will be based on the discharges reported in the hospital's first Medicare Cost Report and Uniform Accounting Report, which includes 12 months-worth of data, except when any of the following apply:
   a. If there is not a complete 12 months-worth of data available, the assessment will be based on the annualized number of discharges from the date hospital operations began through March 31 preceding the July assessment start date. The hospital shall self-report the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the

Administration no later than April 15 preceding the assessment start date for the new hospitals. "Annualized" means divided by a ratio equal to the number of months of data divided by 12 months.

b. If more than 12 months of data is available, the assessment will be based on the most recent 12 months of self-reported data, as of March 31;

5. For purposes of calculating subpart 4, if a new hospital shares a Medicare Identification Number with an existing hospital, the assessment amount will be based on self-reported data from the new hospital instead of the Medicare Cost Report. The data shall include the number of discharges and all other data requested by the Administration necessary to determine the appropriate assessment.

~~5~~6. For hospitals providing self-reported data, described in subpart 4 and 5:

a. Psychiatric discharges will be annualized to determine if subsections (B)(4) or (I)(3) apply to the assessment mount.

b. Discharges will be annualized to determine if subsection (F) applies to the assessment amount.

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. The assessed amount will continue at the same amount applied to the prior owner. 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 201~~1~~6 Medicare Cost report, or if the 201~~1~~6 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 201~~1~~6 Uniform Accounting Report filed by the hospital in place of the 201~~1~~6 Medicare Cost report to calculate the assessment. If the 201~~1~~6 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 201~~1~~6 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.