NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ARIZONA LONG-TERM CARE SYSTEM

PREAMBLE

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

R9-28-702	Amend
R9-28-703	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. §§ 36-2903.01, 36-2903, 36-2932

Implementing statute: A.R.S. §§ 36-2999.52, 36-2999.54; Arizona Laws 2013, Chapter 37.

3. The effective date of the rule:

The agency selected an effective date of 60 days from the date of filing with the Secretary of State as specified in A.R.S. § 41-1032(A).

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 Final Rulemaking: 19 A.A.R. 137, February 1, 2013

Notice of Rulemaking Docket Opening: 19 A.A.R. 992, May 10, 2013

Notice of Proposed Rulemaking: 19 A.A.R. 983, May 10, 2013

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking: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. § 36-2999.52 authorizes the Administration to administer a provider assessment on health care items and services provided by nursing facilities and to make supplemental payments to nursing facilities for covered Medicaid expenditures. The Administration is proposing an amendment to rule to describe the process for estimating and distributing supplemental payments to contractors for enhanced payments to eligible nursing facilities based on bed days paid for through managed care. The rule amendments also describe the process for calculating and distributing the enhanced payments to eligible nursing facilities by the Administration for beddays paid by the Administration. In addition, the rules clarify general requirements applicable to nursing facilities in order for them to qualify for the supplemental payments. Finally, the amendment excludes the Arizona Veteran's Homes from the Assessment pursuant to Arizona Laws 2013, Chapter 37, which, pursuant to section 2 of that act is retroactively effective from and after September 30, 2013, and pursuant to section 3 of that act was adopted as an emergency measure and approved by the Governor April 3, 2013.

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

The Administration anticipates no economic impact on the implementing agency, small businesses and consumers. The clarification to rule does not change the estimated impact described under the previous rulemaking made effective January 8, 2013.

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

No significant changes were made between the proposed rulemaking and the final rulemaking, other than the addition of the definition of the "820 file" and a concise description of the calculation of the nursing facility assessment, and the due date to provide the assessment information to the Department of Revenue (DOR) was changed from September to December, This change in date has been confirmed with the DOR. In addition, technical and grammatical changes were made as a result of the Governors Regulatory Review Council's review, such as clarification of the verbiage under R9-28-703(A)(1) and (A)(2). In addition under R9-28-702, sections (D)(7), (D)(8) and (D)(9) are new text and should have been underlined.

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

Comment received from Kathleen Pagels, May 15, 2013. No other comments were received as of the close of the comment period of June 18, 2013.

Item #	Rule Cite Line #	Comment From	Comment	Analysis/ Recommendation
1.	R9-28-702 D4	Kathleen Pagel	If they change the number of days for those paying a lower rate, it will require a new waiver. The way it is structured, if they cannot adjust the $7.50 rate, any change in the lower tax rate for high MA days providers or any change in the MA patient day threshold will require a new waiver. A new waiver is not required when either the tax rate is increased (or decreased) equally or by the same percentage for all providers. I suggest the language indicate that the tax rates in D2 and D3 and/or the number of annual Medicaid days used in subsection (D)(3) will be modified each August 1, to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2). This language would at least provides a possible opportunity to modify the model for updated days without having to obtain a new waiver.	The Administration will not make any changes based on this comment. Any change in the tax rate for one or both classes of facilities (high and low Medicaid utilization) or any change in the number of bed days that will distinguish the classes of facilities will require review and approval by the federal government. As such, the proposed modification will not achieve the stated purpose (avoiding potential future review by the federal government) and reduces the transparency and clarity of the rule because it will not include the actual tax rates. If modified as proposed, the rule would merely reflect the method for calculating the rate rather than the actual rates. In addition, the suggested method of calculation could result in multiple outcomes that satisfy the test; therefore, the rule would not reflect

				the Administration's determination of the actual future rate.
2.	R9-28-703	Kathleen Pagel	**A.** On an annual basis, AHCCCS shall determine the total funds available in the nursing facility assessment fund available for supplemental payments by: 3. Multiplying the appropriate federal matching assistance percentage (FMAP) by the difference of subsections (A)(1) and (A)(2). A 3 Change this to read: dividing the result of (A)(1) and (A)(2) by one minus the appropriate federal matching assistance percentage (FMAP) **A.** Payment by AHCCCS Contractors. 1. Before each payment year, AHCCCS the Administration shall estimate the Net Nursing Facility Assessment Fund by: a. Estimating the nursing facility assessments to be collected in the upcoming assessment year, b. Subtracting one percent of the total estimated assessments, and c. Multiplying the result of (A)(1)(a) and (A)(1)(b) by the appropriate federal matching assistance percentage (FMAP). 1.C Change this to read: dividing the result of (A)(1)(a) and (A)(1)(b) by one minus the appropriate federal matching assistance percentage (FMAP)	The Administration agrees to make changes to the formula to accurate reflect the total of the amounts collected by the assessment after the addition of federal financial participation.
3.	R9-28-702	Kathleen Pagel	**C.** All nursing facilities licensed in the state of Arizona shall be subject to the provider assessment except for: 1. A continuing care retirement community, 2. A facility with 58 or fewer beds, 3. A facility designated by the Arizona Department of Health Services as an Intermediate Care Facility for the Mentally Retarded, or	. The Administration agrees with the change of Universal to Uniform in the UAR reference.

			4. A tribally owned or operated facility located on a reservation. (STATE VETERANS HOMES??) **D.** The Administration shall calculate the prospective nursing facility provider assessment for qualifying nursing facilities as follows: 1. AHCCCS The Administration shall utilize each nursing facility's Universal Accounting Report (UAR) submitted to the Arizona Department of Health Services as of August 1st immediately preceding the assessment year. In addition, by August 1st each year, each nursing facility shall provide AHCCCS the Administration with any additional information necessary to determine the assessment. For any nursing facility that does not provide by August 1st the additional information requested by AHCCCS the Administration, AHCCCS the Administration shall determine the assessment based on the information available. 4. The number of annual Medicaid days used in subsection (D)(3) shall be recalculated each August 1, to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2). (if they change the number of days for those paying a lower rate, it will require a new waiver). The way it is structured, if they cannot adjust the $7.50 rate, any change in the lower tax rate for high MA days providers or any change in the MA patient day threshold will require a new waiver. A new waiver is not required when either the tax rate is increased (or decreased) equally or by the same percentage for all providers. I suggest the language indicate that the tax rates in D2 and D3 and/or the number of annual Medicaid days used in subsection (D)(3) will be modified each August 1, to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2).	The Administration has amended the rule to exclude the Arizona Veterans' Homes from the assessment and the supplemental payment pursuant to Arizona Laws 2013, Chapter 37 which excludes the Arizona Veterans' Homes from the definition of a nursing facility for purposes of Title 36, Chapter 29, Article 6 of the Arizona Revised Statutes.

			This language would at least provides a possible opportunity to modify the model for updated days without having to obtain a new waiver **B.** Each contractor must pay each facility the amount computed within 20 calendar days of receiving the nursing facility enhanced payment from the Administration. The contractors must confirm each payment and payment date to the Admin <u>(All timeframes should be 20 days)</u>	The Administration agrees that all timeframes should be 20 days, changes made accordingly.

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 are applicable.

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 federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

The rule must conform to the requirements of 42 U.S.C. § 1396b(w) and the implementing federal regulations found at 42 C.F.R. Part 433, Subpart B. An assessment or supplemental payments that do not meet federal requirements would result in a reduction in federal financial participation in the Medicaid program administered in Arizona. As indicated in the statute, federal approval for the assessment and the supplemental payments is required. As such, the rule will not exceed the parameters of 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 rule:

None

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency

shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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ARTICLE 7. STANDARDS FOR PAYMENTS

Section

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-28-702. Nursing Facility Assessment

A. For purposes of this Section, in addition to the definitions under A.R.S. 36-2999.51, the following terms have the following meaning unless the context specifically requires another meaning:

"820 transaction" means the standard health care premium payments transaction required by 45 CFR 162.1702.

"Assessment year" means the 12 month period beginning October 1st each year

"Nursing Facility Assessment" means a tax paid by a qualifying nursing facility to the Department of Revenue on a quarterly basis established under A.R.S. § 36-2999.52.

"Medicaid days" means days of nursing facility services paid for by the Administration or its contractors as the primary payor and as reported in AHCCCS' claim and encounter data.

"Medicare days" means resident days where the Medicare program, a Medicare advantage or special needs plan, or the Medicare hospice program is the primary payor.

"Payment year" means the 12 month period beginning October 1st each year.

B. No Change

C. All nursing facilities licensed in the state of Arizona shall be subject to the provider assessment except for:

1. A continuing care retirement community,
2. A facility with 58 or fewer beds,
3. A facility designated by the Arizona Department of Health Services as an Intermediate Care Facility for the Mentally Retarded, ~~or~~
4. A tribally owned or operated facility located on a reservation~~.~~, or

5. Arizona Veteran's Homes

D. The Administration shall calculate the prospective nursing facility provider assessment for qualifying nursing facilities as follows:

1. ~~AHCCCS~~ The Administration shall utilize each nursing facility's ~~Universal~~ Uniform Accounting Report (UAR) submitted to the Arizona Department of Health Services as of August 1st immediately preceding the assessment year. In addition, by August 1st each year, each nursing facility shall provide ~~AHCCCS~~ the Administration with any additional information necessary to determine the assessment. For any nursing facility that does not provide by August 1st the additional information requested by ~~AHCCCS~~ the Administration, ~~AHCCCS~~ the Administration shall determine the assessment based on the information available.

2. No Change

3. No Change

4. No Change

5. No Change

6. ~~AHCCCS~~ The Administration will forward the provider assessment by facility to the Department of Revenue by ~~September 1st~~ no later than December preceding the assessment year.

7. In the event a nursing facility closes during the assessment year, the nursing facility shall cease to be responsible for the portion of the assessment applied to the dates the nursing facility is not operating.

8. In the event a nursing facility begins operation during the assessment year, that facility would have no responsibility for the assessment until such time as the facility has UAR data that falls within the collection period for the assessment calculation.

9. In the event a nursing facility has a change of ownership such that the facility remains open and the ownership of the facility changes, the assessment liability transfers with the change in ownership.

R9-28-703. Nursing Facility Supplemental Payments

~~**A.** On an annual basis, AHCCCS shall determine the total funds available in the nursing facility assessment fund available for supplemental payments by:~~

~~1. Estimating the nursing facility assessments to be collected in the upcoming assessment year,~~

~~2. Subtracting one percent of the total estimated assessments , and~~

~~3. Multiplying the appropriate federal matching assistance percentage (FMAP) by the difference of subsections (A)(1) and (A)(2).~~

~~**B.** AHCCCS shall calculate each year's quarterly supplemental payments to each nursing facility with Medicaid utilization, excluding ICFMRs, by:~~

~~1. Determining each facility's proportion of Medicaid resident bed days to total nursing facility Medicaid resident bed days by utilizing adjudicated claims and encounter data for the most recent 12 month period, including appropriate claims lag.~~

~~2. Multiplying subsections (B)(1) and (A)(3).~~

~~3. Dividing the payments determined under subsection (B)(2) by four.~~

~~**C.** AHCCCS and its contractors shall make quarterly supplemental payments to nursing facility providers.~~

~~**D.** Following the end of each assessment year, AHCCCS shall reconcile the supplemental nursing facility payments made during the assessment year to the annual deposits to the~~

~~nursing facility assessment fund for the same year less one percent of the actual assessments deposited in the fund plus federal matching funds. The proportion of each nursing facility's Medicaid resident bed days shall be used to calculate the reconciliation amounts. AHCCCS and its contractors shall make additional payments to or recoupments from nursing facilities based on the reconciliation.~~

~~**E.** Aggregate supplemental payments to nursing facilities shall not exceed upper payment limits established under 42 CFR 447.272.~~

~~**F.** A facility must be open on the date the supplemental payment is made in order to receive a payment.~~

A. Nursing Facility Supplemental Payments

1. Using Medicaid resident bed day information from the most recent and complete twelve months of adjudicated claims and encounter data, for every combination of contactor and every facility eligible for a supplemental payment, the Administration shall determine annually a ratio equal to the number of bed days for the facility paid by each contractor divided by the total number of bed days paid to all facilities by all contractors and the Administration.
2. Using the same information as used in (A)(1), for every facility eligible for a supplemental payment, the Administration shall determine annually a ratio equal to the number of bed days for the facility paid by the Administration divided by the total number of bed days paid to all facilities by all contractors and the Administration.
3. Quarterly, each contractor shall make payments to each facility in an amount equal to 98% of the amounts identified as Nursing Facility Enhanced Payments in the 820 transaction sent from AHCCCS to the contractor for the quarter multiplied by the percentage determined in subsection (A)(2) applicable to the contractor and to each facility.

4. Quarterly, the Administration shall make payments to each facility in an amount equal to 99% of the amounts collected during the preceding quarter under R9-28-702, less amounts collected and used to fund the Nursing Facility Enhanced Payments included in the capitation paid to contractors and the corresponding federal financial participation, multiplied by the percentage determined in subsection (A)(2) applicable to the Administration and to each facility. The Administration shall make the supplemental payments to the nursing facilities within 20 calendar days of the determination of the quarterly supplemental payment.
5. Neither the Administration nor the Contractors shall be required to make quarterly payments to facilities otherwise required by subsections (A)(3) or (A)(4) until the assessment collected and actually available in the nursing facility assessment fund, plus the corresponding federal financial participation, are equal to or greater than 101% of the amount necessary for contractors to make the payments to facilities described in subsections (A)(4) and (A)(5).
6. Contractors shall not be required to make quarterly payments to facility otherwise required by subsection (A)(4) until the Administration has made a retroactive adjustment to the capitation rates paid to contractors to correct the Nursing Facility Enhanced payments based on actual member months for the specified quarter.

B. Each contractor must pay each facility the amount computed within 20 calendar days of receiving the nursing facility enhanced payment from the Administration. The contractors must confirm each payment and payment date to the Administration within 20 calendar days from receipt of the funds.

C. After each assessment year, the Administration shall reconcile the payments made by contractors under subsection (A) and (B) to the portion of the annual collections under R9-28-702 attributable to Medicaid resident bed days paid for by contractors for the same year, less one percent, plus available federal financial participation. The proportion of each nursing facility's Medicaid resident bed days as described in subsection (A)(2)(ii) shall be used to calculate the reconciliation amounts. Contractors shall make additional

payments to or recoup payments from nursing facilities based on the reconciliation in compliance with the requirements of subsection (B).

D. General requirements for all payments.

1. A facility must be open on the date the supplemental payment is made in order to receive a payment. In the event a nursing facility closes during the assessment year, the nursing facility shall cease to be eligible for supplemental payments.

2. In the event a nursing facility begins operation during the assessment year, that facility shall not receive a supplemental payment until such time as the facility has claims and encounter data that falls within the collection period for the payment calculation.

3. In the event a nursing facility has a change of ownership, payments shall be made to the owner of the facility as of the date of the supplemental payment.

4. Subsection (E)(3) shall not be interpreted to prohibit the current and prior owner from agreeing to a transfer of the payment from the current owner to the prior owner.

E. The Arizona Veterans' Homes are not eligible for supplemental payments.