NOTICE OF FINAL 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:**
R9-22-712.01	Amend
R9-22-712.20	Amend
R9-22-712.30	Amend
R9-22-712.40	Amend

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

Authorizing statutes: A.R.S. § 36-2903.01(F);

Implementing statute: A.R.S. § 36-2903.01(G);

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), but no later than December 31, 2013.

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:

Hospital Rate notices:

Notice of Proposed Exempt Rulemaking: 18 A.A.R. 1644, July 6, 2012

Notice of Exempt Rulemaking: 18 A.A.R. 1914, August 10, 2012

Notice of Rulemaking Docket Opening: 19 A.A.R. 943, May 3, 2013

Notice of Proposed Rulemaking: 19 A.A.R. 912, May 3, 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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

This rule-making readopts amendments to rules regarding hospital reimbursement that were originally adopted as exempt rules under the authority provided by Arizona Laws 2011, Chapter 31, Section 34. Arizona Laws 2012, Chapter 299, Section 7, provided that rules adopted under that exempt authority expire December 31, 2013 but allows the agency to continue program changes reflected in those exempt rules if the agency has specific statutory authorization. As part of Arizona Laws 2013, Chapter 202, Section 3, the agency is authorized by statute to readopt the provisions originally adopted.

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.

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 aggregate expenses are driven by a various amount of factors, such as utilization and enrollment. This rule keeps in place reductions that were put in place beginning October 1, 2011; therefore, holding the entire variables constant, the estimated impact of this rulemaking relative to last year is $0. The estimated impacts of last year's change are a 5% reduction of Outpatient payments for FFY2010 estimated at $34.4 million and a 5% reduction of Inpatient payments for FFY2010 estimated at $78.6 million.

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.

The Administration has removed the repromulgation of exempt rules published:

Notice of Proposed Exempt Rulemaking: 17 A.A.R. 2456, December 9, 2011

Notice of Exempt Rulemaking: 18 A.A.R. 212, January 27, 2012

The change made between the proposed rulemaking and the final rulemaking was the removal of the copayment change. This removal was necessary since the Administration's waiver will expire December 31, 2013, and the Administration will not be able to enforce copayment on childless adults as described under R9-22-711 and R9-22-101.

In addition, where "No change" is listed, the subsection for each section was added indicating "No change" as well. The text of some subsections has been removed and replaced with "No Change" to simplify understanding where changes to the rules were made and to make the rulemaking more concise.

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

No comments were received as of the close of the comment period of June 3, 2013.

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:

A permit is not required as a result of this rulemaking.

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 USC 1396a(a)(30)(A) and 42 CFR 447.204. This rulemaking is not more stringent than the 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 one submitted an analysis to the agency comparing the rule's impact of competitiveness in this state to the impact on business in other states.

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

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-712.01. Inpatient Hospital Reimbursement

R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule

R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-for-service Schedule

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-712.01. Inpatient Hospital Reimbursement

Inpatient hospital reimbursement. The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons with admissions on and after October 1, 1998, on a prospective reimbursement basis. The prospective rates represent payment in full, excluding quick-pay discounts, slow-pay penalties, and third-party payments for both accommodation and ancillary department services. The rates include reimbursement for operating and capital costs. The Administration shall make reimbursement for direct graduate medical education as described in A.R.S. § 36-2903.01. For payment purposes, the Administration shall classify each AHCCCS inpatient hospital day of care into one of several tiers appropriate to the services rendered. The rate for a tier is referred to as the tiered per diem rate of reimbursement. The number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier claims, transplant claims, or payment to out-of-state hospitals, freestanding psychiatric hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.

1. No Change
    a. No Change
    b. No Change
        i. No Change
        ii. No Change
        iii. No Change
        iv. No Change
        v. No Change
2. No Change

a. No Change

i. No Change

ii. No Change

iii. No Change

iv. No Change

b. No Change

c. No Change

d. No Change

3. No Change

a. No Change

b. No Change

c. No Change

i. No Change

ii. No Change

iii. No Change

iv. No Change

v. No Change

vi. No Change

vii. No Change

4. Annual update. The Administration shall annually update the inpatient hospital tiered per diem rates through September 30, 2011.

5. New hospitals. For rates effective on and after October 1, 1998, the Administration shall pay new hospitals the statewide average rate for each tier, as appropriate. The Administration shall update new hospital tiered per diem rates annually through September 30, 2011.

6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers under this Section by multiplying the covered charges on a claim by the Medicare Urban or Rural Cost-to-Charge Ratio. The Urban cost-to-charge ratio will be used for hospitals located in a county of 500,000 residents or more. The Rural cost-to-charge ratio will be used for hospitals located in a county of fewer than 500,000 residents.

a. No Change

b. Update. The CCR is updated annually by the Administration for dates of service beginning October 1, using the most current Medicare cost-to-charge ratios published or placed on display by CMS by August 31 of that year. The Administration shall update the outlier cost thresholds for each hospital through September 30, 2011 as described under A.R.S. § 36-2903.01. For ~~the rate year effective~~ inpatient hospital admissions with begin dates of service on and after October 1, 2011 ~~to September 30, 2012~~, AHCCCS will increase the outlier cost thresholds by 5% of the thresholds that were effective on September 30, 2011.

c. No Change

i. No Change

ii. No Change

iii. No Change

d. Cost-to-Charge Ratio used for qualification and payment of outlier claims.

i. No Change

ii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011 ~~through September 30, 2012~~, the CCR will be equal to 90.25% of the most recent published Urban or Rural Medicare CCR as described in subsection (6)(b). ~~as of August 31, 2011~~.

iii. ~~In addition, for~~ For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011 through September 30, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after April 1, 2011 by an additional percentage equal to the total percent increase reported on the charge master.

iv. Subject to approval by CMS, for qualification and payment of outlier claims with begin dates of service on or after October 1, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after June 1, 2012 by an additional percentage equal to the total percent increase reported on the charge master.

7. No Change

8. No Change
9. No Change
10. No Change
11. No Change
<u>12.</u> <u>Reductions to tiered per diem payment for inpatient hospital services. Inpatient hospital admissions with begin dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the tiered per diem rates in effect on September 30, 2011.</u>

R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule

A. No Change

1. No Change
2. No Change
3. No Change
4. No Change
5. No Change
6. No Change
7. No Change
8. No Change
9. No Change
   a. No Change
   b. No Change
   c. No Change
10. No Change
11. No Change

B. For all claims with a begin date of service on or after October 1, 2011, the AHCCCS Outpatient Capped Fee-for-Service Schedule shall be derived from the CMS Medicare Outpatient Prospective Payment System (OPPS) fee schedule modified by an Arizona conversion factor determined annually ~~in accordance with R9-22-712.40(C)~~.

1. No Change
2. No Change

C. No Change

R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule

A. No Change

B. No Change

C. No Change

D. No Change

E. Reductions to payments for outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule. Outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rate published by CMS pursuant to subsection (C) of this section.

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

A. Procedure codes. When procedure codes are issued by CMS and added to the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add to the Outpatient Capped Fee-for-Service Schedule the new procedure codes for covered outpatient services and shall either assign the default CCR under ~~R9-22-712.40(E)(2)~~ R9-22-712.40(F)(2), the Medicare rate, or calculate an appropriate fee.

B. No Change

C. Annual update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, through September 30, 2011, AHCCCS shall adjust outpatient fee schedule rates:

1. No Change
2. No Change

D. Reductions to the Outpatient Capped Fee-For-Service Schedule.
Claims paid using the Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rates in effect on September 30, 2011, subject to the annual adjustments to procedure codes and APC's under this section.

~~**D.**~~**E.** Rebase. AHCCCS shall rebase the outpatient fees every five years.

~~**E.**~~**F.** Statewide CCR.:

1. No Change
2. No Change