

NOTICE OF PROPOSED RULEMAKING
TITLE 9. HEALTH SERVICES
CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ADMINISTRATION

PREAMBLE

<u>1. Sections Affected</u>	<u>Rulemaking Action</u>
R9-22-712.20	Amend
R9-22-712.25	Amend
R9-22-712.30	Amend
R9-22-712.35	Amend
R9-22-712.40	Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

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

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

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: (volume #) A.A.R. (page #), (date) (to be filled in by editor)

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4693
Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov

5. An explanation of the rule, including the agency's reasons for initiating the rule:

The current rule requires that the fee schedule and the state-wide cost-to-charge ratio be “rebased” using more current Medicare cost data every five years as described in A.A.C. R9-22-712.40.

In the five years since the original adoption of the current rule, AHCCCS has also identified the need to consider a number of refinements to the existing methodology to ensure proper cost containment and provide more equitable compensation among hospitals. Some of the issues that have been identified include, but are not limited to, adjustments to the peer group modifiers that are currently fixed in rule and their application to certain charges, adjustment or elimination of separate payment for

outpatient observation, grouping charges by dates of service as well as by procedure type, clarification of settings that qualify for payment as outpatient hospital settings.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on in its evaluation of or justification for the rule or proposes 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:

No study was relied upon.

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

Not applicable.

8. The preliminary summary of the economic, small business, and consumer impact:

The new rule is anticipated to bring outpatient hospital cost coverage into a more equitable arrangement for all Arizona hospitals. The goal of the proposed rule is to establish an outpatient reimbursement methodology that contributes to an overall hospital reimbursement methodology that is consistent with efficiency, economy, quality care and appropriate access to care. In aggregate, the total payment for hospital outpatient services is expected to remain the same.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4693
Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS website www.azahcccs.gov the week of January 31, 2011. Please send written comments by either mail, email, or fax to the above address by 5:00 p.m., March 22, 2011.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: March 22, 2011
Time: 10:00 a.m.
Location: AHCCCS

701 East Jefferson
Phoenix, AZ 85034

Nature: Public Hearing

Date: March 22, 2011

Time: 10:00 a.m.

Location: ALTCS: Arizona Long-Term Care System
1010 N. Finance Center Dr, Suite 201
Tucson, AZ 85710

Nature: Public Hearing

Date: March 22, 2011

Time: 10:00 a.m.

Location: DAHL /Office of Special Investigations
2721 N. 4th street, Suite 23
Flagstaff, AZ 86004

Nature: Public Hearing

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None.

12. Incorporations by reference and their location in the rules:

None.

13. 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

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

R9-22-712.25. Outpatient Hospital Fee Schedule Calculations: Associated Service Costs ~~for ER and Surgery Services~~

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

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

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

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

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

~~To establish the AHCCCS Outpatient Capped Fee For Service Schedule, AHCCCS shall:~~

A. To establish the AHCCCS Outpatient Capped Fee-For Service Schedule for all claims with a begin date of service on or before September 30, 2011, AHCCCS shall:

1. Define the dataset of claims and encounters that shall be used to establish the AHCCCS Outpatient Capped Fee-For-Service Schedule.
2. Identify all the claims and encounters from non-IHS acute hospitals located in Arizona for services that shall be paid under the AHCCCS Outpatient Capped Fee-For-Service Schedule.
3. Match the revenue code on each detail of each claim and encounter to the ancillary line item CCR as reported on hospital-specific mapping documents and hospital-specific Medicare Cost Report for those hospitals that have submitted Medicare Cost Reports FYE 2002.
4. Multiply the line item CCR from subsection (3) by the covered billed charge for that revenue code to establish the cost for the service.
5. Inflate the cost for the service from subsection (4) using Global Insight Health-Care Cost Review inflation factors from date of service month to the midpoint of the rate year in which the fees are initially effective.
6. Include associated costs under R9-22-712.25 to calculate the rates for emergency room and surgery services.
7. Combine data from all Arizona hospitals identified in subsection (3) for each procedure code to establish the statewide median cost for each procedure.
8. Group procedure codes according to the Ambulatory Payment Classification (APC) System groups as listed in 69 FR 65682, November 15, 2004, and establish a statewide median cost for each APC. Multiply each statewide median APC cost by 116 percent to establish the AHCCCS-based fee for each procedure in that specific APC group. AHCCCS shall assign each procedure in the group the same fee.
9. For those procedure codes that are not grouped into any APC, establish a procedure-specific fee using either:
 - a. The AHCCCS Non-hospital Capped Fee-For-Service Fee Schedule;
 - b. ~~116%~~ 116 percent of procedure-specific median cost AHCCCS-based fee; or
 - c. The Medicare Clinical Laboratory Fee Schedule for laboratory services.
10. Compare the AHCCCS-based fee established in subsections (8) and (9) against the comparable Medicare fee established for the Medicare APC group as listed in the 69 FR 65682, November 15,

2004. The fee for each procedure shall be the greater of the AHCCCS-based fee or the Medicare fee but no more than 150 percent of the AHCCCS-based fee; however, for those laboratory services for which a limit is established in the Medicare Clinical Laboratory Fee Schedule, the fee shall not exceed that limit.

11. Assign the 2005 Medicare fee in the AHCCCS Outpatient Capped Fee-For-Service Schedule for those procedures for which there are fewer than 20 occurrences of the procedure code in the dataset, either independently, or, if applicable, for all procedure codes within an APC Group.

B. For all claims with a begin date of service on and after October 1, 2011, the AHCCCS outpatient fee schedule shall be based upon the CMS Medicare Outpatient Perspective Payment System (OPPS) fee schedule modified by an Arizona conversion factor published annually in accordance with R9-22-712.40 (C).

1. When clinic services are billed using 51X revenue codes, the reimbursement is the difference between the facility and non-facility rates for the procedures listed in the Administration's Capped Fee for Service Schedule under R9-22-710.

2. Observation services, when not billed in conjunction with a service for which a single payment is made under R9-22-712.25, are reimbursed at an hourly rate published in the Outpatient fee schedule. This hourly rate includes reimbursement for associated services.

R9-22-712.25. Outpatient Hospital Fee Schedule Calculations: Associated Service Costs for ER and Surgery Services

A. AHCCCS shall include the costs of associated services, as defined by revenue codes and procedure codes, when determining the specific fees for the outpatient hospital procedures for emergency department and surgery services.

B. Payment made under subsection (A) or R9-22-712.20 (B)(2) is inclusive of all services on the claim regardless of whether the services are provided on one or more days.

~~B.C.~~ A complete listing of the revenue codes and procedure codes for associated costs included in the payment for emergency and surgery services is available with the AHCCCS Outpatient Capped Fee-For-Service Schedule on file and online with AHCCCS.

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

A. AHCCCS shall calculate a statewide CCR for a service where a specific fee cannot be determined under R9-22-712.20.

B. ~~The~~ For claims with a begin date of service on or before September 30, 2011, the statewide CCR shall be calculated based on the costs and covered charges associated with a service under subsection (A) for all Arizona hospitals, using the costing method defined in ~~R9-22-712.20(3)~~ R9-22-712.20 (A)(3).

C. For all claims with a begin date of service on and after October 1, 2011, the statewide CCR calculation shall equal either the CMS Medicare Outpatient Urban or the CMS Medicare Outpatient Rural Cost to Charge Ratio for Arizona. The urban cost-to-charge ratio will be used for hospitals located in a county of 500,000 residents or more and for out-of-state hospitals. The rural cost-to-charge ratio will be used

for hospitals located in a county of fewer than 500,000 residents. On October first of each year, urban and rural CCRs will be adjusted to the CCRs as published by CMS in the federal register on or before August first of that year.

~~C.D.~~ To determine the payment amount for procedures where a specific fee is not determined under R9-22-712.20, the statewide CCR is multiplied times the covered charges.

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

- A. For all claims with a begin date of service through September 30, 2011, AHCCCS shall increase the outpatient capped-fee-schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:
1. By 48 percent for public hospitals on July 1, 2005, as well as hospitals that were public anytime during the calendar year 2004;
 2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the outpatient capped-fee-schedule rates are effective;
 3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the outpatient capped-fee-schedule rates are effective;
 4. By 115 percent for hospitals designated as Critical Access Hospitals, or for hospitals that have not been designated as Critical Access Hospitals, but meet the criteria during the contract year in which the outpatient capped-fee-schedule rates are effective;
 5. By 113 percent for a freestanding children's hospital with at least 110 pediatric beds during the contract year in which the outpatient capped-fee-schedule rates are effective; or
 6. By 14 percent for a University Affiliated Hospital, which is a hospital that has a majority of the members of its board of directors appointed by the Board of Regents during the contract year in which the outpatient capped-fee-schedule rates are effective.
- B. For all claims with a begin date of service on or after October 1, 2011, AHCCCS shall increase the outpatient capped-fee-schedule established under R9-22-712.20 (except for laboratory services, and out-of-state hospital services) for the following hospitals. A hospital shall receive an increase from only one of the following categories:
1. By 73 percent for public hospitals.
 2. By 31 percent for hospitals in counties other than Maricopa and Pima with more than 100 licensed beds as of October 1 of that rate year.
 3. By 37 percent for hospitals in counties other than Maricopa and Pima with 100 or fewer licensed beds as of October 1 of that rate year;

4. By 100 percent for hospitals designated as Critical Access Hospitals, or for hospitals that have not been designated as Critical Access Hospitals, but meet the criteria during the contract year in which the outpatient capped-fee-schedule rates are effective;
 5. By 78 percent for a freestanding children's hospital with at least 110 pediatric beds during the contract year in which the outpatient capped-fee-schedule rates are effective; or
 6. By 41 percent for a University Affiliated Hospital, which is a hospital that has a majority of the members of its board of directors appointed by the Arizona Board of Regents during the contract year in which the outpatient capped-fee-schedule rates are effective.
- ~~B. In addition to subsection (A), the following outpatient capped fee schedule rate increase shall be established: A 50 percent adjustment for a Level 2 and 3 emergency department procedures billed by a Level 1 trauma center as defined by R9-22-2101.~~
- C. In addition to subsection A and B, an Arizona Level 1 trauma center as defined by R9-22-2101 will receive a 50 percent increase to the outpatient capped-fee-schedule established under R9-22-712.20 (except for laboratory services, and out-of-state hospital services) for Level 2 and 3 emergency department procedures.
- D. Hospitals with greater than 100 pediatric beds not receiving an increase under subsection (B) will receive a 18 percent increase to the outpatient capped-fee-schedule established under R9-22-712.20 (except for laboratory services, and out-of-state hospital services).
- ~~E.~~ E. Fee adjustments made under subsection (A) ~~and (B)~~, (C) and (D) are available with the AHCCCS Outpatient Capped Fee-For Service Schedule, which is on file with AHCCCS ~~and posted on AHCCCS' web site.~~ Current adjustments are posted on AHCCCS' web site.

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 the new procedure codes for covered outpatient services and shall either assign the default CCR, the Medicare rate, or calculate an appropriate fee.
- B. APC changes. AHCCCS may reassign procedure codes to new or different APC groups when APC groups are revised by CMS. AHCCCS may reassign procedure codes to a different APC group than Medicare. If AHCCCS determines that utilization of a procedure code within the Medicare program is substantially different from utilization of the procedure code in the AHCCCS program, AHCCCS may choose not to assign the procedure code to any APC group. For procedure codes not grouped into an APC by Medicare, AHCCCS may assign the code to an APC group when AHCCCS determines that

the cost and resources associated with the non-assigned code are substantially similar to those in the APC group.

- C. Annual update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, AHCCCS shall adjust outpatient fee schedule rates:
 - 1. Annually by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or
 - 2. In a particular year the director may substitute the increases in subsection (C)(1) by calculating the dollar value associated with the inflation index in subsection (C)(1), and applying the dollar value to adjust rates at varying levels.
- D. Rebase. AHCCCS shall rebase the outpatient fees every five years.
- E. Statewide CCR:
 - 1. For begin dates of service on or before September 30, 2011, The the statewide CCR calculated in R9-22-712.30 shall be recalculated at the time of rebasing. When rebasing, AHCCCS may consider recalculating the statewide CCR based on the costs and charges for services excluded from the outpatient hospital fee schedule.
 - 2. For begin dates of service on or after October 1, 2011, the statewide CCR shall be set under R9-22-712.30 (D).