

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

Amend

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: Laws 2013, 1st Special Session, Chapter 10

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

July 16, 2015

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: 21 A.A.R. 1041, July 10, 2015

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 An agency's justification and reason why a rule should be made, amended, repealed, or renumbered to include an explanation about the rulemaking: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 obtains new information to update estimations of the number of eligible persons and projections of the costs anticipated to provide coverage for those persons. The Administration is proposing a new rule to update the figures to be used as of July 1, 2015 for collecting the assessment on hospitals.

Laws 2013, 1st Special Session, Chapter 10 added an exemption to the Administrative Procedure Act for purposes of the administration and implementation of the hospital assessment:

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:

Not applicable.

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 \$250 million will be necessary to be collected from Arizona hospitals to fund the cost required by statute for State Fiscal Year (SFY) ending June 30, 2016. The assessment amount currently in rule reflects the amount needed in the last quarter of SFY 2015 and would generate approximately \$382 million over the course of SFY 2016 if left in place. The amendment adjusts the rates downward to reflect the actual need of \$250 million.

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, 85%, 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 360,000 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 2016 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.

<http://www.azahcccs.gov/reporting/state/proposedrules.aspx>

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

No changes were made between the proposed rulemaking and the final exempt rulemaking.

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

Item #	Rule Cite Line #	Comment From and Date rec’d.	Comment	Analysis/ Recommendation
1.	R9-22-730	Dennis Dahlen Banner Health (written comment rec’d 07/13/15)	<p>Since this is an iterative process with opportunities for improvements, Banner would like, once again, to bring attention to one of the exclusions that gives a market advantage to a single hospital because of its high percentage of Medicare discharges. This exclusion, provided in R9-22-730, Subsection I, Paragraph 7, of the proposed amendments to the Hospital Assessment Rule, applies to acute care hospitals <i>“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”</i>. According to the FY 2016 assessment modeling, this exclusion applies only to Mayo Clinic Hospital in Phoenix.</p> <p>We believe the methodology continues to unjustly favor a single high-volume Medicare provider, Mayo Clinic Hospital, over other hospitals that serve significantly higher volumes of elderly patients.</p>	<p>The Administration understands that the comments submitted are the same as those submitted during the rule development process in 2013, and submitted as a comment on the original proposed rule. The Administration understands the objection to be that certain individual hospitals in the Banner Health System are not treated similar to other hospitals which Banner believes to be similarly situated. The Administrations’ position has not changed.</p> <p>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.</p>
2.	R9-22-730	Dennis Dahlen Banner Health (written	Banner has consistently supported a broad-based, “all-in” model, especially for hospitals that benefit under the coverage restoration and expansion. The other proposed exclusion criteria, particularly the requirement for a specified percentage of non-Arizona discharges, arbitrarily and	

		comment rec'd 07/13/15)	capriciously exempts one high-volume Medicare provider, the Mayo Clinic Hospital, without any reasonable basis in policy or fact. If this exclusion remains as part of the methodology, it should treat similar hospitals equitably.	<p>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.</p> <p>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.</p>
3.	R9-22-730	Dennis Dahlen Banner Health (written comment rec'd 07/13/15)	The proposed model for FY 16 continues to exclude one hospital in one city of the state that barely meets the Medicare volume threshold, resulting in a significant gain on the assessment model for that hospital, while other hospitals that serve many more Medicare patients are still included in the assessment model with a significantly lower return. As such, Banner asks that AHCCCS revisit this policy and design an assessment methodology that is broad-based and treats all hospitals fairly.	

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:

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

R9-22-730 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). For the period beginning ~~April 1, 2015~~ July 1, 2015, the assessment 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. ~~\$635.00~~ \$416.00 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. ~~\$635.00~~ \$416.00 per discharge for hospitals designated as type: hospital, subtype: critical access hospital.

3. ~~\$158.75~~ \$104.00 per discharge for hospitals designated as type: hospital, subtype: long term.
4. ~~\$158.75~~ \$104.00 per discharge for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2011 Medicare Cost Report.
5. ~~\$508.50~~ \$332.75 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 2012 Uniform Accounting Report.
6. ~~\$571.25~~ \$374.50 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 2012 Uniform Accounting Report.
7. ~~\$635.00~~ \$416.00 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 ~~March 1, 2013~~ April 2, 2015.
- 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 ~~\$158.75~~ \$104.00 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~~ 28,900 discharges on the hospital's 2011 Medicare Cost Report, discharges in excess of ~~29,000~~ 28,900 are assessed a rate of ~~\$63.75~~ \$41.50 for each discharge in excess of ~~29,000~~ 28,900. The initial ~~29,000~~ 28,900 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 ~~Assessment~~ must be received by the Administration by no later than:

1. ~~the~~ 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 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 1, 2013~~ April 2, 2015:

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:

1. If the hospital was open on the April 1 preceding the July assessment start date, the hospital assessment will begin with the hospital's second quarter of operation but no sooner than January 1, 2014 on July 1 following the date the hospital began operating.
2. If the hospital began operating between April 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~~ 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. ~~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 first initial 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.

5. For hospitals providing self-reported data:

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

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 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.

