

**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

**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 Rulemaking Docket Opening: 20 A.A.R. 684, March 14, 2014

Notice of Proposed Rulemaking: 20 A.A.R. 671, March 14, 2014

**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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**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 revise the process for calculating the nursing facility assessment using Uniform Accounting Report data submitted to the Arizona Department of Health Services and amending the dollar amounts used to calculate the assessment. In addition, the proposed rules update terminology and clarify language in both the assessment and supplemental payment sections so that the methodology is more concise and understandable.

**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, since the increase assessments will equate to increased supplemental payments.

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

No changes were made between the proposed rulemaking and the final rulemaking. In addition, technical and grammatical changes were made as a result of the Governors Regulatory Review Council's review.

**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, April 14, 2014. No other comments were received as of the close of the comment period of April 21, 2014.

<b><u>Numb:</u></b>	<b><u>Date/ Commentor:</u></b>	<b><u>Comment:</u></b>	<b><u>Response:</u></b>
1.	04/14/14 Kathleen Pagels AZ Health Care Association	R9-28-702 Add to C2 “as of October 1 <sup>st</sup> of the assessment year”.	The Administration states in rule that information can be received by November 1 <sup>st</sup> under subsection D7. It is not necessary to repeat under this rule. November 1 <sup>st</sup> was selected to allow time to acquire and review information and determine if more information is necessary. The later date provides greater flexibility in time to amend or clarify information submitted.
2.	04/14/14 Kathleen Pagels AZ Health Care Association	R9-28-702 Add a C6 “out of state skilled nursing providers”.	R9-28-702 C provides the list of providers exempt from the assessment. The Administration does not have authority to assess out of state nursing facilities, therefore, it is not necessary to add this to rule.
3.	04/14/14 Kathleen Pagels AZ Health Care Association	R9-28-702 Comment to D5: We question whether CMS guidance indicates a new waiver is required for annual slope recalculation, but are ok with annual slope recalculation.	Whether CMS approval is required is outside the scope of this rulemaking.
4.	04/14/14 Kathleen Pagels AZ Health Care Association	R9-28-703 Add to A1: Dispute section- Suggested or Sample language  “Any facility whose AHCCCS utilization percentage (Medicaid Claims Paid divided by Total Claims Paid) varies from the UAR Utilization percentage (Reported Days divided by total Reported Days) from the UAR) by more than 1 standard deviation from the Mean is considered an outlier. The calculation for percentage variance is as follows:	The payment calculation uses a consistent set of data where every provider receives a proportional payment based on that single set of consistent data. To introduce supplemental data for a select number of providers unfairly disadvantages other providers who will receive a smaller proportional payment, and may lead to ongoing submission of data from other facilities and significant delays in the calculation of the payment.  In addition, the proposed process would make it difficult for

		<p>1. Absolute Value( [AHCCCS Medicaid Utilization %] - [UAR Medicaid Utilization %])</p> <p>2. Calculate +/- 1 Standard Deviations of part #1</p> <p>3. Identify each facility that falls outside of 1 standard deviation from the mean. These would be considered an outlier. If a facility has been deemed an outlier then they should be contacted by AHCCCS and given the opportunity (30 days from the date of contact to provide paid claims data to AHCCCS, supporting their Medicaid/ALTCS days. Support would be documentation such as Remittance Advice, EFT, Check etc... that can be directly tied to a specific patient. If the facility can prove their information is accurate then AHCCCS should allow the facility to use these proven days in the supplement calculation. Any days supported over and above the claims paid number should be included in the supplementation calculation. If the facility decides not to provide the data or cannot provide the data then AHCCCS will use the paid claims percentage. When AHCCCS receives the facility information they have (30 days from the date of receipt) to analyze and then contact the facility with their discrepancies. At that time the facility has (10 days from the date of contact) to either agree with the AHCCCS determination or provide additional data. “</p>	<p>the Administration to comply with the quarterly payment timeline.</p> <p>The State Plan approved by the federal government requires that we use adjudicated claims and encounters for the supplemental payment.</p> <p>A dispute resolution process is in place to address concerns.</p>
5.	04/14/14 Kathleen Pagels AZ Health Care Association	R9-28-703 Revise D2: strike D2 and add... "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 submitted to the Arizona Department of Health Services the report required by R9-11-204(A) covering a full year of operation"	A.R.S 36-2999.55 does not authorize limiting payments to nursing facilities that have filed a UAR for a full year.

**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**

**CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

**ARIZONA LONG-TERM CARE SYSTEM**

**ARTICLE 7. STANDARDS FOR PAYMENTS**

Section

R9-28-702 Nursing Facility Assessment

R9-28-703 Nursing Facility Supplemental Payments

## ARTICLE 7. STANDARDS FOR PAYMENTS

### R9-28-702. Nursing Facility Assessment

- A. For purposes of ~~this Section~~ R9-28-702 and R9-28-703, 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 1<sup>st</sup> 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.~~

“Medicaid patient days” means patient days reported on the Nursing Care Institution Uniform Accounting Report (UAR) as attributable to AHCCCS and its contractors as the primary payor.

~~“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.~~

“Medicare patient days” means patient days reported on the Nursing Care Institution UAR as Skilled Medicare Patient Days or Part C/Advantage/Medicare Replacement Days.

"Nursing Care Institution UAR" means the Nursing Care Institution Uniform Accounting Report described by R9-11-204.

~~“Payment year” means the 12-month period beginning October 1<sup>st</sup> each year.~~

- B.** Subject to Centers for Medicare and Medicaid Services (CMS) approval, effective October 1, 2012, nursing facilities shall be subject to a provider assessment payable on a quarterly basis.
- 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, according to the Arizona Department of Health Services, Division of Licensing Services, Provider & Facility Database,
  3. A facility designated by the Arizona Department of Health Services as an Intermediate Care Facility for the ~~Mentally Retarded~~ Intellectually Disabled,
  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. The Administration shall utilize each nursing facility’s Uniform Accounting Report (UAR) submitted to the Arizona Department of Health Services as of August 1<sup>st</sup> immediately preceding the assessment year. In addition, by August 1<sup>st</sup> each year, each nursing facility shall provide the Administration with any additional information necessary to determine the assessment. For any nursing facility that does not provide by August 1<sup>st</sup> the additional information requested by the Administration, the Administration shall determine the assessment based on the information available.~~
  1. In September of each year, the Administration shall obtain from the Arizona Department of Health Services the most recently published Nursing Care Institution UAR and the information required in subsection (C)(2). At the request of the Administration, a nursing facility shall provide the Administration with any additional information necessary to determine the assessment.
  2. The Administration shall use the information obtained under subsection (D)(1) to determine:

- a. Each nursing facility's total annual Medicaid patient days,
- b. Each nursing facility's total annual Medicare patient days,
- c. Each nursing facility's total annual patient days,
- d. The aggregate net patient service revenue of all assessed providers, and
- e. The slope described under 42 CFR 433.68(e)(2).

~~2.3.~~ For each nursing facility, other than a nursing facility ~~noted~~ exempted in subsection ~~(D)(3)~~ (C) or described in subsection (D)(4), the provider assessment is calculated by multiplying the nursing facility's ~~non-Medicare resident day data for each assessment year by \$7.50~~ total annual patient days other than Medicare patient days by \$10.50.

~~3.4.~~ For a nursing facility, other than a nursing facility exempted in subsection (C), with ~~the~~ a number of total annual Medicaid patient days greater than or equal to the number required to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2), the provider assessment is calculated by multiplying the nursing facility's ~~non-Medicare resident day data for each assessment year by \$1.00~~ total annual patient days, other than Medicare patient days, by \$1.40.

~~4.5.~~ ~~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).~~

For each assessment year the slope described under 42 CFR 433.68(e)(2) shall be recalculated.

~~5.6.~~ The total annual assessment calculated under subsections ~~(D)(2), (D)(3) and (D)(4)~~ (D)(3), (D)(4) and (D)(5), shall not exceed 3.5 percent of the aggregate net patient service revenue of all assessed providers as reported on the Nursing Care Institution UAR obtained under subsection (D)(1).

7. All calculations and determinations necessary for the provider assessment shall be based on information possessed by the Administration on or before November 1 of the assessment year.

~~6.8.~~ The Administration ~~will~~ shall forward the provider assessments ~~by facility for all assessed facilities~~ to the Arizona Department of Revenue by no later than December 1 ~~of preceding~~ the assessment year.

~~7.9.~~ 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.

~~8.10.~~ In the event a nursing facility begins operation during the assessment year, that facility ~~would~~ will 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 submitted to the Arizona Department of Health Services the report required by R9-11-204(A) covering a full year of operation.~~

~~9.11.~~ 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. 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 contractor 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)~~ (A)(1) 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~~ its 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~~ amount available in the nursing facility assessment fund established by A.R.S. § 36-2999.53, plus the corresponding federal financial participation, ~~are~~ is 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) to make such payments in full.~~
6. Contractors shall not be required to make quarterly payments to a facility otherwise required by subsection ~~(A)(4)~~ (A)(3) until the Administration has made a retroactive adjustment to the capitation rates paid to contractors to correct the Nursing Facility Enhanced ~~payments~~ 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~~ 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)~~ subsections (A)(3) 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)~~ (A)(1) 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.

