NOTICE OF FINAL EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

PREAMBLE

1. **Permission to proceed with this final rulemaking was granted under A.R.S. § 41-1039 by the governor on:**

   October 30, 2026

2. **Article, Part, or Section Affected (as applicable)** **Rulemaking Action**

   R9-22-730 Amend

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

   Authorizing statute: A.R.S. § 36-2901.08

   Implementing statute: A.R.S. § 36-2901.08

   Statute or session law authorizing the exemption: A.R.S. § 41-1005(A)(31)

4. **The effective date of the rule:**

   The effective date of the rule is October 30, 2026. AHCCCS selected an immediate effective date upon filing of the Notice of Final Rulemaking with the Secretary of State's Office under A.R.S. § 41-1032(A) to comply with deadlines and amendments to the agency's governing statutes and federal programs, and to implement the rules in accordance with the contract year which begins October 1, 2026.

5. **Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the current record of the final exempt rule:**

   Notice of Docket Opening: 32 A.A.R. 2422, Issue Date: October 2, 2026, Issue Number: 40, File number: R

   Notice of Proposed Exempt Rulemaking: 32 A.A.R. 2400, Issue Date: October 2, 2026, Issue Number: 49, File number: R26-176.

6. **The agency's contact person who can answer questions about the rulemaking:**

   Name: Sam McCue

   Title: Senior Rules Analyst

   Division: AHCCCS Office of the General Counsel

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7. **An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**

Rulemaking for the Hospital Assessment was initially approved under Executive Order 2012-03, and this regulation was subsequently revised in April 2015 and each year thereafter. This rulemaking will continue the practice of modifying the regulation by adjusting the per-discharge assessments and net patient outpatient revenue contributions from various hospital types, effective with invoices issued on October 15, 2026. Under A.R.S. § 36-2901.08, the Administration is responsible for administering and collecting hospital assessments to fund the non-federal share of costs for eligible persons enrolled under A.R.S. § 36-2901.01 (Proposition 204 population) and A.R.S. § 36-2901.07 (adults with incomes between 106% and 138% of the Federal Poverty Level).

The rulemaking aligns with federal regulation 42 CFR 433.68, which includes a hold harmless provision. Under Arizona's current agreement with the federal government (the State Plan), the state is required to maintain this coverage unless the plan is amended. The Hospital Assessment serves as a funding mechanism for persons covered under Proposition 204, including those in federally mandated groups such as the elderly, blind, disabled, and certain parents. Without approval from the Centers for Medicare & Medicaid Services, Arizona would not receive federal funding to support healthcare coverage for these populations. Failure to secure funding could lead to a significant loss of health coverage for Arizona residents or require hospitals to contribute more than necessary to the assessment.

8. **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:**

AHCCCS did not review or rely on any study for this rulemaking.

9. **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

10. **A summary of the economic, small business, and consumer impact, if applicable to the exemption:**

The AHCCCS program is jointly funded by the state and the federal government through the Medicaid program. Depending on the eligibility category of the person, the federal government provides between two-thirds and 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 nearly 700,000 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 these providers are small businesses located in Arizona. A.R.S. § 36-2901.08

prohibits the assessed hospitals from passing the cost of the assessment to patients or third parties who pay for care in the hospital.

11. **A description of any change between the proposed exempt rulemaking, to include supplemental notices, and the final exempt rulemaking:**

    There were no changes between the proposed exempt rulemaking and the final exempt rulemaking.

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

    AHCCCS did not receive any public or stakeholder comments on this rulemaking.

13. **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:**

    There are no other matters prescribed by statute applicable specifically to the Administration or this specific rulemaking.

    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:**

       The rule does not require the issuance of a regulatory permit.

    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:**

       These rules are governed by the Code of Federal Regulations, Title 42, Chapter IV, Subchapter C. The rule is not more stringent than 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 analysis was submitted to the agency.

14. **A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:**

    Not applicable

15. **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 exempt rulemaking packages:**

    Not applicable

16. **The full text of the rules follows:**

    Rule text begins on the next page.

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-730. Hospital Assessment Fund - Hospital Assessment

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-730. Hospital Assessment Fund - Hospital Assessment

A. ~~For purposes of this Section, the following terms are defined as provided below.~~ In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Section have the following meanings unless the context ~~specifically~~ explicitly requires another meaning:

1. "~~2023~~ 2024 Medicare Cost Report" means~~: The~~ the Medicare Hospital Provider Cost Report for ~~the hospital~~ a hospital's fiscal year ending in calendar year ~~2023~~ 2024 as reported in the CMS Healthcare ~~Provider~~ Cost Reporting Information System (HCRIS) release dated January ~~5, 2025.~~ 3, 2026.
2. "~~2023~~ 2024 Uniform Accounting Report" means the Uniform Accounting Report submitted to ~~the Arizona Department of Health Services~~ ADHS as of ~~December 15, 2024~~ November 19, 2025, for ~~the~~ a hospital's fiscal year ending in calendar year ~~2023.~~ 2024.
3. "Annualized" means divided by a ratio equal to the number of months of data divided by 12 months.
3. ~~"Quarter" means the a three-month period beginning January 1, April 1, July 1, and October 1each year.~~
4. ~~A "new~~ "New hospital" means a licensed hospital that did not hold a license from ~~the Arizona Department of Health Services~~ ADHS prior to January 1, ~~2025.~~ 2026.
5. "Outpatient ~~Net Patient Revenues"~~ net patient revenues" means an amount, calculated using data in ~~the~~ a hospital's ~~2023~~ 2024 Uniform Accounting Report or other data sources specified by subsection (N), that is equal to the hospital's ~~2023~~ 2024 total net patient revenue multiplied by the ratio of the hospital's ~~2023~~ 2024 gross outpatient revenue to the hospital's ~~2023~~ 2024 total gross patient revenue.
6. "Quarter" means ~~the~~ a three-month period beginning January 1, April 1, July 1, and October 1, each year.

B. Beginning January 1, 2014, ~~for each~~ an Arizona licensed hospital not excluded under subsection (L) shall be subject to an assessment payable on a quarterly basis. The assessment shall be levied against the legal owner of ~~each~~ the hospital as of the first day of the quarter, ~~and~~ except as otherwise required by subsections (D)~~, (E), (F), (G), (H) and~~ through (I). For the period beginning October 1, ~~2025,~~ 2026, the assessment for ~~each~~ the hospital shall be amount equal to the sum of: ~~(1) the~~

1. The number of discharges reported on the hospital's ~~2023~~ 2024 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as "Other Long Term Care Discharges," multiplied by the following rates appropriate to the hospital's peer group; and ~~(2) the~~

2. The amount of outpatient net patient revenues multiplied by the following rate appropriate to the hospital's peer group:

~~1.~~a. ~~$628.25~~ $801.75 per discharge and ~~1.0634%~~ 1.3548 percent of outpatient net patient revenues for a hospital located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.

~~2.~~b. ~~$628.25~~ $801.75 per discharge and ~~0.4431%~~ 0.5645 percent of outpatient net patient revenues for ~~hospitals~~ a hospital designated as type: hospital, subtype: critical access hospital.

~~3.~~c. ~~$157.25~~ $200.50 per discharge and ~~0.4431%~~ 0.5645 percent of outpatient net patient revenues for ~~hospitals~~ a hospital designated as type: hospital, subtype: long term.

~~4.~~d. ~~$157.25~~ $200.50 per discharge and ~~0.4431%~~ 0.5645 percent of outpatient net patient revenues for ~~hospitals~~ a hospital designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the ~~2023~~ 2024 Medicare Cost Report.

~~5.~~e. ~~$502.75~~ $641.50 per discharge and ~~1.1520%~~ 1.4677 percent of outpatient net patient revenues for ~~hospitals~~ a hospital designated as type: hospital, subtype: short-term with ~~20%~~ 20 percent of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's ~~2023~~ 2024 Uniform Accounting Report.

~~6.~~f. ~~$565.50~~ $721.50 per discharge and ~~1.3292%~~ 1.6935 percent of outpatient net patient revenues for ~~hospitals~~ a hospital designated as type: hospital, subtype: short-term with at least ~~10%~~ 10 percent but less than ~~20%~~ 20 percent of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's ~~2023~~ 2024 Uniform Accounting Report.

~~7.~~g. ~~$125.75~~ $160.50 per discharge and ~~0.3545%~~ 0.4516 percent of outpatient net patient revenues for ~~hospitals~~ a hospital designated as type: hospital, subtype: children's.

~~8.~~h. ~~$628.25~~ $801.75 per discharge and ~~1.7723%~~ 2.2580 percent of outpatient net patient revenues for ~~hospitals~~ a hospital designated as type: hospital, subtype: short-term not included in another peer group.

C. ~~Peer groups~~ A peer group for the four quarters beginning October 1 of each year ~~are~~ is established based on ~~hospitals~~ a hospital's license type and subtype designated in the Provider & Facility Database for Arizona Medical Facilities posted by ~~the Arizona Department of Health Services~~ ADHS Division of Licensing Services on its website on January 1, ~~2025.~~ 2026.

D. ~~Notwithstanding~~ Except as provided in subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's ~~2023~~ 2024 Medicare Cost Report, are assessed a rate of ~~$157.25~~ $200.50 for each discharge from the psychiatric sub-provider as reported in the ~~2023~~ 2024 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~~ Except as provided in subsection (B), rehabilitative discharges from a hospital that reported having a rehabilitative sub-provider in the hospital's ~~2023~~ 2024 Medicare Cost Report, are assessed a rate of $0 for each discharge from the rehabilitative sub-provider as reported in the ~~2023~~ 2024 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~~ Except as provided in subsection (B), for ~~any~~ a hospital that reported more than 22,800 discharges on the hospital's ~~2023~~ 2024 Medicare Cost Report, discharges ~~in excess of~~ greater than 22,800 are assessed a rate of ~~$63.00~~ $80.25. ~~for each discharge in excess of 22,800.~~ The initial 22,800 discharges are assessed at the rate required by subsection (B).

G. ~~Notwithstanding~~ Except as provided in subsection (B), for ~~any~~ a hospital that reported pediatric outpatient net patient revenues greater than $375,000,000 on the hospital's ~~2023~~ 2024 Uniform Accounting Report, pediatric outpatient net patient revenues greater than $375,000,000 are assessed a rate of ~~.0354%~~ 0.0452 percent for pediatric outpatient net patient revenues greater than $375,000,000 from a hospital designated as subtype children's. The initial $375,000,000 ~~of~~ in pediatric outpatient net patient revenues are assessed at the rate required by subsection (B).

H. ~~Notwithstanding~~ Except as provided in subsection (B), for ~~any~~ a short-term hospital with at least ~~10%~~ 10 percent but less than ~~20%~~ 20 percent of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's ~~2023~~ 2024 Uniform Accounting Report that reported outpatient net patient revenues greater than $375,000,000 on the hospital's ~~2023~~ 2024 Uniform Accounting Report, outpatient net patient revenues greater than $375,000,000 are assessed a rate of ~~.0354%~~ 0.1693 percent for outpatient net patient revenues greater than $375,000,000 from a short-term hospital with at least ~~10%~~ 10 percent but less than ~~20%~~ 20 percent of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's ~~2023~~ 2024 Uniform Accounting Report. The initial $375,000,000 of outpatient net patient revenues are assessed at the rate required by subsection (B).

I. ~~Notwithstanding~~ Except as provided in subsection (B), for ~~any~~ a short-term hospital not included in another peer group that reported outpatient net patient revenues greater than $375,000,000 on the hospital's ~~2023~~ 2024 Uniform Accounting Report, outpatient net patient revenues greater than $375,000,000 are assessed a rate of ~~.1772%~~ 0.2258 percent for outpatient net patient revenues greater than $375,000,000 from a short-term hospital not included in another peer group. The initial $375,000,000 ~~of~~ in outpatient net patient revenues are assessed at the rate required by subsection (B).

J. 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~~ a hospital ~~a~~ notification that ~~the~~ a Hospital Assessment Fund 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.

K. Assessment due date. ~~The Hospital Assessment Fund assessment must be~~ A hospital shall ensure that the assessment is received by the Administration no later than:

1. The 15th day of the second month of the quarter~~.~~;
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.

L. Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's ~~2023~~ 2024 Medicare Cost Report and ~~Provider & Facility Database for Arizona Medical Facilities~~ ADHS Public Health Data Portal posted by the ~~Arizona Department of Health Services~~ ADHS Division of Licensing Services on ~~its~~ the ADHS website for January 1, ~~2025:~~ 2026:

1. ~~Hospitals~~ A hospital owned and operated by the state, the United States, or an Indian tribe.
2. ~~Hospitals~~ A hospital designated as type: hospital, subtype: short-term that ~~have~~ has a license number beginning ~~"SH".~~ "SH."
3. ~~Hospitals~~ A hospital designated as type: hospital, subtype: psychiatric that reported fewer than 2,500 discharges on the ~~2023~~ hospital's 2024 Medicare Cost Report.
4. ~~Hospitals~~ A hospital designated as type: hospital, subtype; rehabilitation.
5. ~~Hospitals~~ A hospital designated as type: hospital, subtype: special hospitals, not including subtype: children's.
6. ~~Hospitals~~ A hospital 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 ~~2023~~ 2024 Medicare Cost Report are reimbursed by Medicare.
7. ~~Hospitals~~ A hospital designated as type: hospital, subtype: short-term that ~~have~~ has at least 25 percent Medicare swing beds as percentage of total Medicare days, ~~per~~ according to the ~~2023~~ hospital's 2024 Medicare Cost Report.
8. ~~Hospitals~~ A hospital designated as type: hospital, subtype: short-term that ~~are~~ is an urban public acute care hospital.

M. New hospitals. For ~~hospitals~~ a hospital that did not file a ~~2023~~ 2024 Medicare Cost Report because of the date the hospital began operations:

1. If the hospital was open on the January 2 preceding the October assessment start date, the hospital assessment ~~will~~ shall begin on October 1 following the date the hospital began operating.
2. If the hospital began operating between January 3 and September 30, the assessment ~~will~~ shall begin on October 1 of the following calendar year.
3. A hospital is not considered a new hospital based on a change in ownership.
4. The assessment ~~will~~ shall be based on the discharges reported in the hospital's first Medicare Cost Report and Uniform Accounting Report, which includes 12 ~~months-worth~~ months of data, except when any of the following apply~~;~~:
   a. If there is not a complete 12 ~~months-worth~~ months of data available, the assessment ~~will~~ shall be based on the annualized number of discharges from the date hospital operations began through December 31 preceding the October assessment start date. The hospital shall ~~self-report~~ report the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the Administration no later than January preceding the assessment start date for ~~the~~ a new ~~hospitals.~~ hospital. ~~"Annualized" means divided by a ratio equal to the number of months of data divided by 12 months.~~
   b. If more than 12 months of data is available, the assessment ~~will~~ shall be based on the most recent 12 months of ~~self-reported~~ data reported by the hospital, as of December 31~~;~~.
5. ~~For purposes of~~ In calculating ~~subpart 4,~~ subsection (M)(4), if a new hospital shares a Medicare Identification Number with an existing hospital, the Administration shall base an assessment amount ~~will be based~~ on ~~self-reported~~ the reported data from the new hospital instead of the Medicare Cost Report. The ~~data~~ new hospital shall include the number of discharges and all other

data requested by the Administration necessary to determine the appropriate assessment.

6. For ~~hospitals providing self-reported~~ a hospital reporting data~~,~~ described in ~~subpart 4 and 5:~~ subsections (M)(4) and (5):

   a. Psychiatric discharges ~~will~~ shall be annualized to determine if subsections ~~(B)(4)~~ (B)(2)(d) or (L)(3) apply to the assessment amount.

   b. Discharges ~~will~~ shall be annualized to determine if subsection (F) applies to the assessment amount.

N. Changes ~~of~~ in ownership. ~~The parties~~ Parties to a change ~~of~~ in ownership shall promptly provide written notice to the Administration of a change ~~of~~ in ownership and any agreement regarding ~~the~~ payment of ~~the~~ an assessment. The assessed amount ~~will~~ shall continue at the same amount applied to the prior owner. ~~Assessments are~~ The assessment is the responsibility of the owner of record as of the first day of the quarter.~~; however, this~~ This Section is not intended to prohibit the parties to a change ~~of~~ in 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.

O. Hospital closures. ~~Hospitals~~ A hospital that ~~close~~ closes shall pay a proportion of ~~the~~ a quarterly assessment equal to that portion of the quarter during which the hospital operated.

P. Required information for ~~the~~ an inpatient assessment. For ~~any~~ a hospital that has not filed a ~~2023~~ 2024 Medicare Cost ~~report,~~ Report, or if the ~~2023~~ 2024 Medicare Cost ~~report~~ Report does not include ~~the~~ reliable information sufficient for the Administration to calculate ~~the~~ an inpatient assessment, the Administration shall use data reported on the ~~2023~~ 2024 Uniform Accounting Report filed by the hospital in place of the ~~2023~~ 2024 Medicare Cost ~~report~~ Report to calculate the assessment. If the ~~2023~~ 2024 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the inpatient assessment ~~amounts,~~ amount, the hospital shall provide the Administration with data specified by the Administration ~~necessary~~ in place of the ~~2023~~ 2024 Medicare Cost ~~report~~ Report to calculate the assessment.

Q. Required information for ~~the~~ an outpatient assessment. For ~~any~~ a hospital that has not filed a~~-2023~~ 2024 Uniform Accounting Report, if the ~~2023~~ 2024 Uniform Accounting Report does not include reliable information sufficient for the Administration to calculate ~~the~~ an outpatient assessment ~~amounts,~~ amount, or if the ~~2023~~ 2024 Uniform Accounting Report does not reconcile to ~~2023~~ 2024 Audited Financial Statements, the Administration shall use the data reported on ~~2023~~ 2024 Audited Financial Statements to calculate the outpatient assessment. If the ~~2023~~ 2024 Audited Financial Statements do not include ~~the~~ reliable information sufficient for the Administration to calculate the outpatient assessment, the Administration shall use data reported on the ~~2023~~ 2024 Medicare Cost ~~report.~~ Report. If the Medicare Cost ~~report~~ Report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration ~~necessary~~ in place of the ~~2023~~ 2024 Medicare Cost ~~report~~ Report to calculate the outpatient assessment.

R. 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 A.R.S. § 36-2901.08.

S. Enforcement. If a hospital does not comply with this Section, the ~~director~~ 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~~ Director shall notify the director of ~~the Department of Health Services who shall~~ ADHS to suspend or revoke the hospital's license.