NOTICE OF FINAL 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 both 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 authorizing the exemption: A.R.S. § 41-1005(A)(31)

3. The proposed effective date of the rule and the agency's reason for selecting the effective date:

The Administration is proposing an effective date of October 1, 2022 so that the invoices for the new rates will be available on or before October 15, 2022 or upon approval by CMS, whichever is later.

4. A list of all notices published in the *Register* as specified in R1-1-409(A) that pertains to the record of the exempt rulemaking:

Not applicable.

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

Name: Nicole Fries

Address: AHCCCS
Office of Administrative Legal Services
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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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking: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 non-federal 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. This rulemaking will amend rates paid by hospitals under the Hospital Assessment authorized by A.R.S. § 36-2901.08 for the federal fiscal year (FFY) 2023, beginning October 1, 2022, and running through September 30, 2023. This assessment funds the cost of covered services to certain eligibility groups identified in the statute. As with prior rulemakings implementing the hospital assessment, it is the Administration's objective to assess only as 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 updates its estimate of the number of eligible persons and projected cost associated with coverage for those persons. The amendments proposed by the Administration use more recent data to update the figures of the assessment for the period beginning October 1, 2022. Currently, the model uses data from the 2019 Medicare Cost Reports and 2019 Uniform Accounting Reports. The proposed rule will continue to use the 2019 Medicare Cost Reports and 2019 Uniform Accounting Reports, due to volatility of data during the COVID-19 public health emergency. The amount of the assessment determined by the model will increase to $588 million. Additional date changes have been made to include hospitals in the assessment that opened during FFY 2022.

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:

No studies were conducted relevant to the rule.

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 because the rulemaking will not diminish a previous grant of authority to a political subdivision.

9. A preliminary summary of the economic, small business, and consumer impact:

The monies collected from the assessment currently in rule reflects the amount needed in FFY 2022 (October 1, 2021 – September 30, 2022) to cover the estimated cost of care, approximately $534 million. The estimated need is increasing to approximately $588 million for FFY 2023. The 2019 report data used to calculate these amounts are maintained in the rulemaking. The Administration does not intend to use 2020 or 2021 data to calculate the hospital assessment for FFY 2023 or going forward, due to the impact of the COVID-19 Public Health Emergency on the data. When available, the administration will also evaluate whether 2022 reports are appropriate to use in calculating the hospital assessment in later years.

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 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 over 600,000 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 on to patients or third parties who pay for care in the hospital.

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 to hospitals:
https://azahcccs.gov/PlansProviders/CurrentProviders/State/proposedrules.html

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

One change was made to address a type in the text of the proposed exempt rulemaking. In B(5) a % was added where one had been inadvertently left out.

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

Name and Position of Commenter	Date of Comment	Text of Comment	AHCCCS Response
Amy Upston, Director of Financial Policy and Reimbursement – Arizona Hospital and Healthcare Association	7/5/2022	Thank you for the opportunity to comment on the proposed Federal Fiscal Year (FFY) 2023 Hospital Assessment Fund (HAF) assessment rule. I am responding on behalf of the Arizona Hospital and Healthcare Association (AzHHA). AzHHA is a statewide association of more than 75 hospital, healthcare and affiliated health system members, representing short-term acute care, behavioral health, post-acute care and critical access hospitals, as well as their affiliated clinics and staff. AzHHA greatly appreciates AHCCCS's transparent approach with the hospital assessments and the ongoing opportunity for stakeholders to provide feedback. Overall, AzHHA supports the proposed rule and the methodology, but we would like to bring two items to your attention. First, while a HAF balance is necessary to pay for the first two months' worth of capitation rates associated with the hospital assessment populations, there have been times when AHCCCS has allowed a	Thank you for providing AzHHA's feedback on the draft FFY 23 HAF assessment rule. Please see AHCCCS' responses to portions of the letter and let us know if you have any questions. AHCCCS will monitor funding needs for the coverage payments and evaluate if a mid-CYE 23 adjustment in HAF assessments to hospitals is warranted. Numerous

		significant accumulation of the fund balance, much more than has been needed. With hospitals experiencing unprecedented inflation and their financial situation becoming less stable, we ask that AHCCCS continue to monitor the fund balance and any savings associated with the higher FMAP rate related to the public health emergency. If warranted, we ask that AHCCCS make a mid-year adjustment to decrease the hospital assessment rates. Second, AzHHA requests that in the upcoming year, AHCCCS takes a deeper look into the amount of assessment paid by each hospital and the hospital payment to cost ratio, as well as re-evaluate the "no losers" principle. As the hospital assessment has grown to more than $500 million annually, and soon be nearing $600 million, it has put a tremendous strain on hospitals despite hospitals not being the only beneficiaries of the Proposition 204 restoration and other funding sources being available. The current principle of "no losers" does not take into account the tremendous cost involved in caring for AHCCCS recipients. It also fails to take into consideration that it may exacerbate regional market disparities since some hospital systems pay a lot for the hospital assessment but do not reap the same benefits as other hospitals. These regional market disparities may be further exacerbated	factors will complicate that mid-year analysis though, such as the duration of the COVID public health emergency and maintenance of effort requirements. AHCCCS is open to working with interested hospitals to evaluate the appropriateness of assessment amounts and payments by hospital classes in preparation of the CYE 24 hospital assessment fund model.

		since not all health systems are eligible for certain supplemental payments. AzHHA requests AHCCCS to consider reviewing payment-to-cost or payment as a percentage of Medicare and include the cost of the assessment in this calculation. After doing so, we encourage AHCCCS to review the “no losers” principle and evaluate changing it so that there are no losing hospitals or consider reviewing it by region. We appreciate your consideration of this request. Please do not hesitate to contact me if you have any questions, or if I can provide additional information.	
Brittney Kaufmann, CEO – Health System Alliance of Arizona	7/5/2022	The Health System Alliance of Arizona (The Alliance) would like to again extend our gratitude to AHCCCS for its engagement with stakeholders on the proposed FFY 2023 hospital assessment and HEALTHII payment modeling. We greatly appreciate AHCCCS’ ongoing efforts to maintain transparency and incorporate stakeholder feedback into the continued development of these programs that provide critical funding to support safety-net services for the Medicaid population. The AHCCCS team are true professionals in facilitating the workgroups and engaging the necessary stakeholders to ensure the state’s programs best serve Arizona’s Medicaid populations. The Alliance serves the majority of the state’s Medicaid population and we take great pride in ensuring we provide critical top-quality care to these	Thank you for providing HSAA's feedback on the draft FFY 23 HAF assessment rule. Please see AHCCCS' response and let us know if you have any questions. AHCCCS thinks the HAF exemption for Valleywise is warranted given the unique role of this public safety net acute hospital and the support the

		patients. The Alliance hospitals also incur more than 70 percent of the hospital assessment costs that support all Medicaid providers. It is imperative that we continue to work together in partnership to provide the best patient care in a financially sustainable manner for all hospitals. Here are our comments regarding the draft rules for the FFY 2023 HAF assessment: As previously stated in the Alliance's feedback regarding the proposed HAF assessment changes, we believe Valleywise serves an important role as a safety-net hospital with unique circumstances and particular treatment as a public acute hospital. The Alliance supports Valleywise and its mission and it is important that the hospital succeeds. Given the great magnitude of Valleywise's benefit from Medicaid expansion, the Alliance does not believe it's appropriate to exempt Valleywise from paying its share of the HAF assessment costs—unless the state is willing to cover the resulting HAF shortfall with general revenue funds. DSH program limits have never adversely impacted the benefit Valleywise receives from Medicaid expansion coverage payments funded by the HAF assessment. From inception, Valleywise has benefited greatly from their participation. Preliminary FFY	exemption would provide. The agency intends to proceed with exemptions on both assessments for the public acute hospital class. The exemption for this class of public safety net acute care hospitals does not set a precedent to consider future exemption requests from other hospitals.

		2023 models demonstrate that Valleywise is projected to receive more expansion coverage payments than any other hospital in the state. The Alliance believes that exempting from the HAF assessment costs those hospitals that also benefit from Medicaid coverage may set a concerning precedent for hospital exemptions, and we would ask that there be no additional exemptions in the future. We appreciate AHCCCS' willingness to consider feedback regarding the HAF assessment. As indicated by AHCCCS on July 5, we will be looking for a revised HCIF assessment rule that reflects this year's budget and will submit comments at that time. We appreciate your consideration and continued partnership.	

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 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:

The rule does not require a 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:

The rulemaking must be established consistent with 42 CFR Part 433 Subpart B. 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.

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

No material is incorporated by reference.

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:

The rule was not made, amended or repealed as an emergency rule.

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

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 unless the context specifically requires another meaning:

1. "2019 Medicare Cost Report" means The Medicare Cost Report for the hospital fiscal year ending in calendar year 2019 as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated October 9, 2020.
2. "2019 Uniform Accounting Report" means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of December 10, 2020 for the hospital's fiscal year ending in calendar year 2019.
3. "Quarter" means the three month period beginning January 1, April 1, July 1, and October 1 of each year.
4. A "new hospital" means a licensed hospital that did not hold a license from the Arizona Department of Health Services prior to January 2, ~~2021~~2022.
5. "Outpatient Net Patient Revenues" means an amount, calculated using data in the hospital's 2019 Uniform Accounting Report, that is equal to the hospital's 2019 total net patient revenue multiplied by the ratio of the hospital's 2019 gross outpatient revenue to the hospital's 2019 total gross patient revenue.

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 October 1, ~~2021~~2022, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital's 2019 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 amount of outpatient net patient revenues multiplied by the following rate appropriate to the hospital's peer group:

1. ~~$748.50~~$829.50 per discharge and ~~1.3700%~~1.5314% of outpatient net patient revenues for hospitals located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.
2. ~~$748.50~~$829.50 per discharge and ~~0.5708%~~0.6381% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
3. ~~$187.25~~$207.50 per discharge and ~~0.5708%~~0.6381% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
4. ~~$187.25~~$207.50 per discharge and ~~0.5708%~~0.6381% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2019 Medicare Cost Report.
5. ~~$598.75~~$663.50 per discharge and ~~1.4842%~~1.6590% of outpatient net patient revenues 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 2019 Uniform Accounting Report.
6. ~~$673.50~~$746.50 per discharge and ~~1.7125%~~1.9142% of outpatient net patient revenues 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 2019 Uniform Accounting Report.
7. ~~$149.75~~$166.00 per discharge and ~~0.4567%~~0.5105% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.
8. ~~$748.50~~$829.50 per discharge and ~~2.2834%~~2.5523% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short- term not included in another peer group.

C. Peer groups for the four quarters beginning October 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 January, ~~2021~~2022.

D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2019 Medicare Cost Report, are assessed a rate of ~~$187.25~~$207.50 for each

discharge from the psychiatric sub-provider as reported in the 2019 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 2019 Medicare Cost Report, are assessed a rate of $0 for each discharge from the rehabilitative sub-provider as reported in the 2019 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 ~~23,000~~24,000 discharges on the hospital's 2019 Medicare Cost Report, discharges in excess of ~~23,000~~24,000 are assessed a rate of ~~$75.00~~$83.00 for each discharge in excess of ~~23,000~~24,000. The initial ~~23,000~~24,000 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 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.

H. Assessment due date. The Hospital Assessment Fund assessment must be received by the Administration no later than:

1. 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 2019 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 January 2, ~~2021~~2022:

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 2019 Medicare Cost Report.

4. Hospitals designated as type: hospital, subtype; rehabilitation.

5. Hospitals designated as type: med-hospital, subtype: special hospitals.

6. 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 2019 Medicare Cost Report are reimbursed by Medicare.

7. Hospitals designated as type: hospital, subtype: short-term that have at least 25 percent Medicare swing beds as percentage of total Medicare days, per the 2019 Medicare Cost Report.

8. Hospitals designated as type: hospital, subtype: short-term that are an urban public acute care hospital.

J. New hospitals. For hospitals that did not file a 2019 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 begin on October 1 following the date the hospital began operating.

2. If the hospital began operating between January 3 and June 30, the assessment will 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 be based on the discharges reported in the hospital's first Medicare Cost Report and Uniform Accounting Report, which includes 12 months-worth of data, except when any of the following apply;

    a. If there is not a complete 12 months-worth of data available, the assessment will 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 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 new hospitals. "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 be based on the most recent 12 months of self-reported data, as of December 31;

5. For purposes of calculating subpart 4, if 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.

6. For hospitals providing self-reported data, described in subpart 4 and 5:

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 the inpatient assessment. For any hospital that has not filed a 2019 Medicare Cost report, or if the 2019 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the inpatient assessment, the Administration shall use data reported on the 2019 Uniform Accounting Report filed by the hospital in place of the 2019 Medicare Cost report to calculate the assessment. If the 2019 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the inpatient assessment amounts, the

hospital shall provide the Administration with data specified by the Administration necessary in place of the 2019 Medicare Cost report to calculate the assessment.

N. Required information for the outpatient assessment. For any hospital that has not filed a 2019 Uniform Accounting Report, or if the 2019 Uniform Accounting Report does not reconcile to 2019 Audited Financial Statements, the Administration shall use the data reported on 2019 Audited Financial Statements to calculate the outpatient assessment. If the 2019 Audited Financial Statements do not include the reliable information sufficient for the Administration to calculate the outpatient assessment, the Administration all use data reported on the 2019 Medicare Cost report. If the Medicare Cost 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 2019 Medicare Cost report to calculate the outpatient assessment.

O. 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.

P. 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.