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
R9-22-731	New Section

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, A.R.S. § 36-2999.72

Implementing statute: A.R.S. § 36-2901.08, A.R.S. § 36-2999.72

Statute authorizing the exemption: A.R.S. § 41-1005(A)(31), Laws 2020, Chapter 46, Section 3

3. The effective date of the rule:

The Administration is proposing an effective date of October 1, 2020 so that the invoices for the new rates will be available on or before October 15, 2020 or upon approval by CMS, whichever is later.

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: N/A

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking: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. §§ 36-2999.72 and 36-2999.73 require AHCCCS to establish a second hospital assessment beginning October 1, 2020 and requires the Administration to deposit the monies into the Health Care Investment Fund (HCIF). Monies from the HCIF are to be used to 1) make directed payments to hospitals pursuant to 42 CFR §

438.6(c) that supplement the base reimbursement provided to hospitals for services provided to persons eligible for Title XIX services, 2) increase base reimbursement for services reimbursed under the dental fee schedule and physician fee schedule, and 3) to pay for the non-federal share of the costs for AHCCCS expenses to administer this program, not to exceed one percent of the total assessment monies collected.

The statute requires the Administration to adopt rules regarding the method for determining the assessment, the amount or rate of the assessment and modifications to or exemptions from the assessment. The Administration has structured the HCIF assessment similar to hospital assessment established under A.R.S. § 36-2901.08. Consistent with statute, both the existing assessment and the assessment proposed by this rule assess hospitals based on inpatient hospital discharges and total outpatient net patient revenue and uses the same peer groups as the original assessment.

In addition to establishing the HCIF assessment, the proposed rule makes modifications to the original assessment. 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.

This rulemaking, in part, will amend rates paid by hospitals under the hospital assessment authorized by A.R.S. § 36-2901.08 for the time period beginning October 1, 2020. 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 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 updates its estimate of the number of eligible persons and projected cost associated with coverage for those persons.

At the assessment rates in the current rule, the Administration estimates that it would collect $433 million over the course of a federal fiscal year. The amendments reflected in this proposed rule adjust the assessment rates such that the Administration anticipates the collection of $534 million for the Federal Fiscal Year ending September 30, 2021. This amount corresponds to the amount of non-federal funds estimated to be necessary to cover the cost of providing care to the estimated 490,000 eligible individuals described in A.R.S. §36-2901.08(A) for Federal Fiscal year ending September 30, 2021. Moving forward, it is the Administrations' intent to update both assessments at the beginning of each Federal Fiscal Year.

The rulemaking also renames the title of A.A.C. R9-22-730 "Hospital Assessment Fund" hospital assessment to distinguish it from the newly established HCIF hospital assessment. An additional amendment is proposed to assess freestanding children's hospitals effective October 1, 2020. Previously, freestanding children's hospitals were

exempt from the assessment. Finally, the rulemaking removes the threshold for the outpatient component of the assessment.

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

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

The Administration estimates that $534 million will be necessary to be collected from Arizona hospitals to fund the cost required by A.R.S § 36-2901.08 for Federal Fiscal Year (FFY) 2021, ending September 30, 2021. The assessment amount currently in rule reflects the amount needed in SFY 2021 to cover the estimated cost of care, approximately $433 million. The original SFY 2021 amount was determined earlier in the year and did not account for additional enrollment and costs associated with COVID-19. The amendment adjusts the rates upward to reflect the estimated need of $534 million for FFY 2021.

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 90% 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 490,000 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.

Additionally, the Health Care Investment Fund hospital assessment established in A.R.S. § 36-2999.72 will be matched by federal funds. The majority of the assessment funds and accompanying federal funds will be used to provide an increase for base reimbursement for services reimbursed under the dental fee schedule and physician fee schedule and for quarterly supplemental payments to Arizona hospitals. Many of the providers of that medical care are considered small businesses located in Arizona.

A.R.S. §§ 36-2901.08 and 36-2999.72 prohibit 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 FFY 2021 in incremental payments for medical 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 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:

There were no changes between the proposed and final rulemaking.

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
Jennifer A. Carusetta, Executive Director – Health System Alliance of Arizona	9/28/20	On behalf of the Health System Alliance of Arizona (Alliance), it is with great pleasure that we extend our support for the Notice of Proposed Rulemaking: Hospital Assessment Fund and Health Care Investment Fund. The Alliance would like to thank AHCCCS for its dedication and partnership in the implementation of the HEALTHII Payments Program ("Program"). When this Program was first concepted more than two years ago, hospitals across Arizona were facing a $1 billion shortfall in Medicaid reimbursement. This shortfall limited hospital economic development and the industry's collective ability to grow to meet the needs of a booming population. Arizona hospitals and healthcare providers have since been devastated by lost patient volume and unprecedented outlays in the fight against the COVID-19 pandemic. What at one point was a fiscal shortfall has since become a financial crisis. The healthcare industry's recovery is contingent upon the successful implementation of this Program. It is for this reason that we are so very grateful for the efforts and foresight of our Agency partners. We recognize that the development of the Program is an iterative process and that in the coming years, adjustments will be necessary to ensure that it continues to meet federal statistical and regulatory requirements. As an Alliance, we are committed to continuing to lend our resources and support to ensure the long-term sustainability of the Program. Please do not hesitate to contact me if I can provide any additional information.	AHCCCS thanks Health System Alliance of Arizona for their support of this rulemaking. AHCCCS understands and recognizes that hospitals require time to plan for increases to the assessment and commits to continuing to engage with hospitals to provide this information as timely as possible.

Sean Murphy, Executive Director – Arizona Dental Association	9/24/20	The Arizona Dental Association is grateful for the work of fellow dentist and State Representative Dr. Regina Cobb for sponsoring HB 2668 (hospitals; unreimbursed costs; assessment; fund) also known as the Health Care Investment Act. The legislation, signed into law at the end of March 2020, will help make Arizona's healthcare system stronger by increasing AHCCCS payments so they can be slightly closer to the costs associated with providing care to these patients. The enactment of this legislation and the accompanying proposed rules will help provide financial feasibility to hospitals and will help support the network of providers to help hospitals and providers meet the needs of patients in their communities. AzDA would like to thank the legislators, and the Governor, who supported this important bill and appreciate the rules being crafted in a way to ensure that dental providers are brought back to their 2009/2010 rates. We appreciate the clarity of the legislation and the proposed rules that require insurance companies to pass through to the providers the entirety of the monies in these assessment Funds. As the summary of the proposed rules highlights: "the majority of the assessment funds will be used to provide an increase for base reimbursement for services reimbursed under the dental fee schedule." We recognize the need for appropriate oversight and auditing capability to ensure these monies are given to the providers in a timely manner, and that contractors are prohibited from reducing contracted rates as a result of these payments. With over a decade without such a rate increase, and during the existing public health crisis that has further exasperated healthcare issues, these increased reimbursement rates are crucial to dental providers caring for AHCCCS patients across Arizona.	AHCCCS thanks the Arizona Dental Association for their support of this rulemaking. AHCCCS understands and recognizes that dental providers require time to plan for increases to the assessment and commits to continuing to engage with dental providers to provide this information as timely as possible.

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. STANDARD FOR PAYMENTS

Section

ARTICLE 7. STANDARD 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. "2018 Medicare Cost Report" means:
   a. The Medicare Cost Report for the hospital fiscal year ending in calendar year 2018 as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated October 9, 2019.
2. "2018 Uniform Accounting Report" means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of November 6, 2019 for the hospital's fiscal year ending in calendar year 2018.
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, 2020.
5. "Outpatient Net Patient Revenues" means an amount, calculated using data in the hospital's 2018 Uniform Accounting Report, that is equal to the hospital's 2018 total net patient revenue multiplied by the ratio of the hospital's 2018 gross outpatient revenue to the hospital's 2018 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 ~~July 1, 2020~~October 1, 2020, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital's 2018 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. ~~$612.75~~$757.25 per discharge and ~~1.2078%~~1.4466% 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. ~~$612.75~~$757.25 per discharge and ~~0.5033%~~0.6028% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
3. ~~$153.25~~$189.50 per discharge and ~~0.5033%~~0.6028% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
4. ~~$153.25~~$189.50 per discharge and ~~0.5033%~~0.6028% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2018 Medicare Cost Report.
5. ~~$490.25~~$605.75 per discharge and ~~1.3085%~~1.5672% 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 2018 Uniform Accounting Report.

6. ~~$551.50~~$681.50 per discharge and ~~1.5098%~~1.8083% 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 2018 Uniform Accounting Report.

7. $151.50 per discharge and 0.4822% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.

~~7.~~ 8. ~~$612.75~~$757.25 per discharge and ~~2.0131%~~2.4111% 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 J~~uly~~ 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 2, 2020.

D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2018 Medicare Cost Report, are assessed a rate of ~~$153.25~~$189.50 for each discharge from the psychiatric sub-provider as reported in the 2018 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 2018 Medicare Cost Report, are assessed a rate of $0 for each discharge from the rehabilitative sub-provider as reported in the 2018 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 24,000 discharges on the hospital's 2018 Medicare Cost Report, discharges in excess of 24,000 are assessed a rate of ~~$61.50~~ $75.75 for each discharge in excess of 24,000. The initial 24,000 discharges are assessed at the rate required by subsection (B).

~~**G.** Notwithstanding subsection (B), for any hospital with more than $300,000,000 in outpatient net patient revenues on the hospital's 2018 Uniform Account Report, outpatient revenues greater than $300,000,000 are assessed a rate of 0.2013% for revenue in excess of $300,000,000. Revenues at or below $300,000,000 are assessed at the rate required by subsection (B).~~

G~~H~~. Hospital Assessment Fund 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~~I~~. 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 Hospital Assessment Fund assessment invoice is available.

J. Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's 2018 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, 2020:

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 2018 Medicare Cost Report.
4. Hospitals designated as type: hospital, subtype; rehabilitation.
~~5. Hospitals designated as type: hospital, subtype: children's.~~
56. Hospitals designated as type: med-hospital, subtype: special hospitals.
67. 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 2018 Medicare Cost Report are reimbursed by Medicare.
78. 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 2018 Medicare Cost Report.

K. New hospitals. For hospitals that did not file a 2018 Medicare Cost Report because of the date the hospital began operations:

1. If the hospital was open on the January 2 preceding the ~~July~~ October assessment start date, the H~~h~~ospital Assessment Fund assessment will begin on ~~July~~ 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 ~~July~~ 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 ~~July~~ 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.

L. 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 Hospital Assessment Fund 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.

M. Hospital closures. Hospitals that close shall pay a proportion of the quarterly Hospital Assessment Fund assessment equal to that portion of the quarter during which the hospital operated.

N. Required information for the inpatient Hospital Assessment Fund assessment. For any hospital that has not filed a 2018 Medicare Cost report, or if the 2018 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 2018 Uniform Accounting Report filed by the hospital in place of the 2018 Medicare Cost report to calculate the assessment. If the 2018 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 2018 Medicare Cost report to calculate the assessment.

O. Required information for the outpatient Hospital Assessment Fund assessment. For any hospital that has not filed a 2018 Uniform Accounting Report, or if the 2018 Uniform Accounting Report does not reconcile to 2018 Audited Financial Statements, the Administration shall use the data reported on 2018 Audited Financial Statements to calculate the outpatient assessment. If the 2018 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 2018 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 2018 Medicare Cost report to calculate the outpatient assessment.

P. The Administration will review and update as necessary rates and peer groups periodically to ensure the Hospital Assessment Fund assessment is sufficient to fund the state match obligation to cover the cost of the populations as specified in 36-2901.08.

Q. 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.

R9-22-731. Health Care Investment Fund - Hospital Assessment

A. For purposes of this Section, terms are the same as defined in A.A.C. R9-22-730 as provided below unless the context specifically requires another meaning:

B. Beginning October 1, 2020, 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, 2020, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital's 2018 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. $151.50 per discharge and 2.5886% 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. $151.50 per discharge and 1.0786% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
3. $38.00 per discharge and 1.0786% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
4. $38.00 per discharge and 1.0786% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2018 Medicare Cost Report.
5. $121.25 per discharge and 2.8043% 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 2018 Uniform Accounting Report.
6. $136.50 per discharge and 3.2357% 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 2018 Uniform Accounting Report.
7. $30.50 per discharge and 0.8629% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.
8. $151.50 per discharge and 4.3143% 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 2, 2020.

D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2018 Medicare Cost Report, are assessed a rate of $38.00 for each

discharge from the psychiatric sub-provider as reported in the 2018 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 2018 Medicare Cost Report, are assessed a rate of $0 for each discharge from the rehabilitative sub-provider as reported in the 2018 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 24,000 discharges on the hospital's 2018 Medicare Cost Report, discharges in excess of 24,000 are assessed a rate of $15.25 for each discharge in excess of 24,000. The initial 24,000 discharges are assessed at the rate required by subsection (B).

G. Assessment notice. On or before the 20th 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 must be received by the Administration no later than the 20th day of the second month of the quarter.

I. Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's 2018 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, 2020:

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 2018 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 2018 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 2018 Medicare Cost Report.

J. New hospitals. For hospitals that did not file a 2018 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.

L. 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.

M. 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.

N. Required information for the inpatient assessment. For any hospital that has not filed a 2018 Medicare Cost report, or if the 2018 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

2018 Uniform Accounting Report filed by the hospital in place of the 2018 Medicare Cost report to calculate the assessment. If the 2018 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 2018 Medicare Cost report to calculate the assessment.

O. Required information for the outpatient assessment. For any hospital that has not filed a 2018 Uniform Accounting Report, or if the 2018 Uniform Accounting Report does not reconcile to 2018 Audited Financial Statements, the Administration shall use the data reported on 2018 Audited Financial Statements to calculate the outpatient assessment. If the 2018 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 2018 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 2018 Medicare Cost report to calculate the outpatient assessment.

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.