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 the authorizing statute (general) and the implementing statute (specific), and the statute or session law authorizing the exemption:

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

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

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

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

The Administration is proposing an effective date of October 1, 2023 so that the invoices for the new rates will be available on or before October 15, 2023 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 pertain to the record of the exempt rulemaking:

Notice of Rulemaking Docket Opening: 29 A.A.R.1636, July 21, 2023.

Notice of Proposed Rulemaking: 29 A.A.R.1630, July 21, 2023.

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

Name: Nicole Fries

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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 An agency's justification and reason why a rule should be made, amended, repealed, or renumbered to include an explanation about the rulemaking: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) 2024, beginning October 1, 2023, and running through September 30, 2024. 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, 2023. Currently, the model uses data from the 2019 Medicare Cost Reports and 2019 Uniform Accounting Reports. The proposed rule will use the 2021 Medicare Cost Reports and 2021 Uniform Accounting Reports. The amount of the assessment determined by the model will increase to $642 million. Additional date changes have been made to include hospitals in the assessment that opened in 2022. A technical change is included to enable AHCCCS to require additional data submissions from hospitals when data from Uniform Accounting Reports, Medicare Cost Reports, or Audited Financial Statements does not include the reliable information sufficient for AHCCCS to calculate 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. The summary of the economic, small business, and consumer impact, if applicable:

The monies collected from the assessment currently in rule reflects the amount needed in FFY 2023 (October 1, 2022 – September 30, 2023) to cover the estimated cost of care, approximately $588 million. The estimated cost of care is increasing to approximately $642 million for FFY 2024. The data used to calculate these amounts are updated in the rulemaking from 2019 reports to 2021 reports, to reflect more recent data. The Administration will not be using 2020 data to calculate the hospital assessment in any year, due to the impact of the COVID-19 Public Health Emergency on the data.

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 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 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, including any supplemental proposed rulemaking, and the final rulemaking package (if applicable):

Not applicable.

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

Not applicable.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules. When applicable, matters shall include, but not be limited to:

No other matters have been prescribed.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than the federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

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 and its location in the rule:

Not applicable.

14. Whether the rule was previously made, amended, repealed or renumbered as an emergency rule. If so, the agency shall state where the text changed between the emergency and the exempt rulemaking packages:

Not applicable.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

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~~2021 Medicare Cost Report" means:

   The Medicare Cost Report for the hospital fiscal year ending in calendar year ~~2019~~2021 as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated October ~~9~~18, ~~2020~~2022.

2. "~~2019~~2021 Uniform Accounting Report" means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of ~~December 10, 2020~~November 23, 2022 for the hospital's fiscal year ending in calendar year ~~2019~~2021.

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, ~~2022~~2023.

5. "Outpatient Net Patient Revenues" means an amount, calculated using data in the hospital's ~~2019~~2021 Uniform Accounting Report or other data sources specified by subsection (N), that is equal to the hospital's ~~2019~~2021 total net patient revenue multiplied by the ratio of the hospital's ~~2019~~2021 gross outpatient revenue to the hospital's ~~2019~~2021 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, ~~2022~~2023, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital's ~~2019~~2021 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. $~~829.50~~927.75 per discharge and ~~1.5314~~1.4726% 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. $~~829.50~~927.75 per discharge and ~~0.6381~~0.6136% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
3. $~~207.50~~232.00 per discharge and ~~0.6381~~0.6136% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
4. $~~207.50~~232.00 per discharge and ~~0.6381~~0.6136% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the ~~2019~~2021 Medicare Cost Report.
5. $~~663.50~~742.25 per discharge and ~~1.6590~~1.5953% 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~~2021 Uniform Accounting Report.
6. $~~746.50~~835.00 per discharge and ~~1.9142~~1.8408% 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~~2021 Uniform Accounting Report.
7. $~~166.00~~185.75 per discharge and ~~0.5105~~0.4909% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.
8. $~~829.50~~927.75 per discharge and ~~2.5523~~2.4544% 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~~, 2022~~ 2, 2023.

D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's ~~2019~~2021 Medicare Cost Report, are assessed a rate of $~~207.50~~232.00 for

each discharge from the psychiatric sub-provider as reported in the ~~2019~~2021 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~~2021 Medicare Cost Report, are assessed a rate of $0 for each discharge from the rehabilitative sub-provider as reported in the ~~2019~~2021 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~~23,000 discharges on the hospital's ~~2019~~2021 Medicare Cost Report, discharges in excess of ~~24,000~~23,000 are assessed a rate of $~~83.00~~93.00 for each discharge in excess of ~~24,000~~23,000. The initial ~~24,000~~23,000 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~~2021 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, ~~2022~~2023:

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~~2021 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~~2021 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~~2021 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~~2021 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~~2021 Medicare Cost report, or if the ~~2019~~2021 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~~2021 Uniform Accounting Report filed by the hospital in place of the ~~2019~~2021 Medicare Cost report to calculate the assessment. If the ~~2019~~2021 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~~2021 Medicare Cost report to calculate the assessment.

N. Required information for the outpatient assessment. For any hospital that has not filed a ~~2019~~2021 Uniform Accounting Report, if the 2021 Uniform Accounting Report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, or if the ~~2019~~2021 Uniform Accounting Report does not reconcile to ~~2019~~2021 Audited Financial Statements, the Administration shall use the data reported on ~~2019~~2021 Audited Financial Statements to calculate the outpatient assessment. If the ~~2019~~2021 Audited Financial Statements do not include the reliable information sufficient for the Administration to calculate the outpatient assessment, the Administration ~~all~~shall use data reported on the ~~2019~~2021 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~~2021Medicare 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.