NOTICE OF FINAL 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:**
R9-22-701	Amend
R9-22-712.35	Amend
R9-22-712.60	Amend
R9-22-712.61	Amend
R9-22-712.66	Amend
R9-22-712.67	Amend
R9-22-712.71	Amend
R9-22-712.75	Amend

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

Authorizing statute: A.R.S. § 36-2903.01(F)

Implementing statute: A.R.S. §§ 36-2903.01(G)(3) and 36-2903.01(G)(12)

3. The effective date of the rule:

The agency selected an effective date of October 1, 2016 as specified in A.R.S. § 41-1032(B) to coincide with the start of the contract year between the AHCCCS Administration and managed care contractors that make the majority of hospital payments. Thus good cause exists for this effective date and the effective date will not harm the public interest.

4. Citations to all related notices published in the Register to include the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 22 A.A.R. 784, April 8, 2016

Notice of Proposed Rulemaking: 22 A.A.R. 761, April 8, 2016

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The proposed rulemaking will amend and clarify rules regarding payments to hospitals for inpatient and outpatient services. Specifically, this rulemaking increases payments for inpatient and outpatient services provided during a one year period to hospitals that participate in a qualifying health information exchange and have been certified as having achieved "meaningful use stage 2" with respect to the hospital's use of the health information exchange. The payment adjustments reward hospitals that have made the investment necessary to implement an effective system of electronic health records retention and exchange which actions are expected to improve patient health outcomes and reduce of the cost of care. In addition, the proposed rulemaking refines the Service Policy Adjustor associated with claims for inpatient hospital services provided to certain high-acuity children; clarifies payments for inpatient hospital services after a patient is transferred to another hospital to receive sub-acute care; and clarifies reimbursement for inpatient hospital services designated as "administrative days" – that is, when a patient must be admitted or cannot be safely discharged due to the unavailability or an appropriate setting outside the hospital.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

A study was not referenced or relied upon when revising these regulations for.

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. The rulemaking will not diminish a previous grant of authority of a political subdivision.

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

The Administration anticipates a moderate economic impact on the implementing agency, small businesses and consumers for the rule changes:

- The Administration anticipates that the adjustments to payments for inpatient and outpatient hospital services due to Value Based Purchasing (VBP) will result in approximately $3.6 million of additional payments for the contract year October 1, 2016 through September 30, 2017 to about 19 qualifying hospitals that have met the criteria in the rule for implementation and use of electronic health records and health information exchange.
- The Administration amended rule to clarify the description of how DRG payments are made, including transplant services. The amended rule also clarifies how DRG payments are made for Administrative days and transfers. These changes are not expected to have an economic impact on any party since the changes are only for clarification and do not change a service or payment. The revisions to the rules will enhance the public's understanding.
- In addition, the Administration refined the high acuity pediatric policy adjustor for January 1, 2016 to recognize the higher cost of treating higher acuity pediatric patients. It is anticipated that the high acuity pediatric policy adjustor will result in annual additional payments of $19.4 million to 53 hospitals.

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

No changes were made between the proposed rulemaking and the final rulemaking, with exception of the technical change of removing the term "comprehensive" from the definition of subacute services as requested by a commenter.

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

The following comments were received as of the close of the comment period of May 9, 2016.

Item #	Rule Cite Line #	Comment From and Date rec'd.	Comment	Analysis/ Recommendation
1.	R9-22-701	William Timmons 05/04/16	The word "comprehensive" could mean different things to different individuals with their interpretation related to whether they work for a hospital or a health care plan. Thus, any attempt to define "comprehensive" would be difficult. For these reasons the word "comprehensive" adds no value to the definition and should be removed. The phrase "instead of" is key since it supports our pursuit of direct admissions to both hospitals so we don't have to rely just on transfers from tertiary care hospitals. The definition needs to include **what it is not, i**.e., it is not the type/level of care provided in a skilled nursing facility. The preferred definition is: **"Sub-acute services" means inpatient care for a patient with an acute illness, injury or exacerbation of a disease process when the patient does not require acute inpatient hospitalization but requires care at a level beyond that provided by a skilled nursing facility. Sub-acute care is rendered immediately after or instead of acute inpatient hospitalization.**	The Administration has agreed to remove the term "comprehensive", however, the Administration declines the suggestion to make other revisions to the definition of sub-acute services. Sub-acute services may include the level of services provided at a nursing facility, thus the recommendation to include care at a level beyond that provided by a skilled nursing facility will not be added. Nursing facilities are permitted to render sub-acute services. The federal description of nursing facility services in 42 CFR 440.155 provides that nursing facility services are services provided to persons who do not require hospital care but whose condition requires services above the level of room and board.
2.	R9-22-712.67 A	William Timmons 05/04/16	Add the following information from the payment policies manual that AHCCCS published on October 30, 2015, this would add clarity which is important since we want to make sure that tertiary care hospitals are incentivized to transfer patients to LNH and HCH. **"Clarification regarding transfers for sub-acute services: A recipient who no longer meets medical inpatient criteria may be discharged/transferred to another acute care facility without triggering a reduction to the transferring hospital via the 70 Discharge Status**	The Administration has noted your comment. Hospitals that participate in AHCCCS are required to sign provider participation agreements which agreement incorporates by reference several policy manuals. Those policy manuals provide clarification and detail regarding billing instructions. Billing instructions are generally delineated in policy. Therefore, additional language is not necessary.

			Code (Discharge/transfer to another type of health care institution not defined elsewhere in the code list) for the provision of sub-acute services."	
3.	R9-22-712.75 A2	William Timmons 05/04/16	A2 use of the term "other" in this context would seem to imply that nursing facility provides sub-acute services as defined in R9-22-701. There is a difference between the levels of care provided by skilled nursing facilities and hospitals providing sub-acute services. To avoid possible confusion I suggest restating A2: **"Administrative days may also occur at the end of an acute care episode, for example, when a member is not discharged while awaiting placement in a post-acute care setting, such as a nursing facility or a hospital providing sub-acute services."**	The Administration declines to make the suggested change. Nursing facilities are not precluded from rendering sub-acute services. The federal description of nursing facility services in 42 CFR 440.155 provides that nursing facility services are services provided to persons who do not require hospital care but whose condition requires services above the level of room and board.
4.	R9-22-712.75E	William Timmons 05/04/16	For clarity purposes I suggest that R9-22-712.75E's example of "as nursing facility days" be **amended to include "as sub-acute facility days".** Also, I suggest that section E **include the phrase "Administrative days will be reimbursed using a negotiated per diem rate".** The reason is because a number of health plans have already established their own non-negotiated Administrative day rate for nursing facilities and want us to accept these much lower rates that are not commensurate with the sub-acute level of care we provide.	The rule specifies nursing facilities as an example and does not exclude days at other facilities offering sub-acute care. AHCCCS managed care organizations are permitted to establish their own rates through individually negotiated contracts with hospitals. Therefore, no changes will be made to the proposed language.
5.	General	William Timmons 05/04/16	This matter needs to be addressed: There is no financial incentive for hospitals to transfer patients to our hospitals either under the DRG system or the per diem system. Also there is no financial incentive for the health plans to authorize payment under the DRG system or the per diem system for patients transferred to our hospitals. **The result is that many infants, children and teens who no longer need care in a tertiary care hospital are not being transferred to our hospitals.**	The purpose of the rule is to establish an appropriate payment when patient is transferred from one hospital to another for sub-acute care. The rule is not intended to incentive such transfers or to incentives transfers to a particular hospital.
6.	VBP	Debbie Johnston 05/06/16	We also believe the second metric, participation in the state's health information exchange (HIE) network, will not be administratively burdensome for most hospital subtypes. However, it **will be cost-prohibitive for some hospitals.** This is particularly true for small hospitals that lack the capital resources to invest in connectivity at this time. While these facilities would like to participate in exchange, they are simply unable due to financial constraints.	The AHCCCS Administration is aware that some small hospital providers are already participating in the health information exchange. The purpose of this rulemaking is to recognize the improved health outcomes and health care costs savings expected from hospital participation in health information exchange. Alternate metrics for

				value based payments may be considered in future program years.
7.	VBP	Debbie Johnston 05/06/16	The proposal, however, falls short with respect to the principle that all hospitals should have an opportunity to qualify for the adjustment, regardless of subtype. As we mentioned in our December 30th letter, we are concerned that Psychiatric, Rehabilitation, and Long Term Acute Care (LTAC) hospitals will not be eligible for the differential adjustment because these hospital subtypes are currently excluded from federal MU Stage 2. We urged the Administration to adopt alternative metrics for these hospitals, which provide important transitional inpatient care to trauma and other medically complex patients on a post-acute care basis in order to restore medical and functional capacity that enable these patients to return to a community setting. Psychiatric hospitals are also critical in providing mental health and increasingly integrated services to the vast number of Medicaid recipients in need of inpatient behavioral health services**. We are disappointed that the Administration was unable to develop alternative metrics for these hospital subtypes for CYE 2017, and strongly urge their development for CYE 2018.**	Your suggestion has been noted. We will take it into consideration for CYE 2018.
8.	VBP	Debbie Johnston 05/06/16	Finally, we seek clarification on two issues related to the rulemaking. First, we would like to have a better understanding **of how the adjustment will be implemented within AHCCCS's managed care framework given rates are the product of provider-health plan negotiations.** The Preamble to the proposed rule states the differential adjustment will be made to hospitals that "satisfy specific criteria for receipt of VBP Differential Adjusted Payments by the AHCCCS Administration *as well as Managed Care Contractors*." (Emphasis added.) The Administration's criteria are set forth in the rulemaking. **Does the Administration also intend that AHCCCS health plans be permitted to set additional criteria as a prerequisite for "passing through" the payment adjustment?** We would strongly oppose such a proposal, as it could create uneven implementation of the VBP differential, increase confusion around the program, and reduce transparency. Second, we would like a better understanding of **how the adjustment is being funded.** Since the Legislature is not appropriating new funds for the adjustment, we assume funding is being reallocated from existing programs. In an effort to advance	This rule sets forth the fee-for-service payment methodology. MCO's are required by statute to use this payment methodology in the absence of a contract with a provider calling for a different methodology. This rule does not limit or restrict the ability of MCO's to contract for reimbursement on different terms. The AHCCCS Administration intends to address implementation of value-based purchasing incentives by managed care organizations through its contracts with the managed care organizations which is beyond the scope of this rule-making. The adjustment is supported by funds appropriated by the legislature. The AHCCCS Administration is not reducing payments to support the adjustment.

			transparency, we believe it is important for the public and stakeholders to understand whether and how existing programs might be impacted.	
9.	R9-22-701	Debbie Johnston 05/06/16	We strongly support adding a definition of "sub-acute services" to the DRG regulations. We believe this definition will add much needed clarity, but recommend the following modifications: **1. The word "comprehensive" is subject to interpretation, and it is very likely providers and health plans will disagree over its meaning. Without further elaboration, we believe it adds little value to the definition. As such, we recommend eliminating the term.** **2. The definition should clarify that sub-acute services is a higher level of care than skilled nursing care provided by a SNF.** **3. We support the inclusion of the term "instead of" in the last sentence since patients may on occasion be directly admitted to these hospitals.**	The Administration has agreed to remove the term "comprehensive", however, no other revisions to the definition will be made. Sub-acute services may include the level of services provided at a nursing facility, thus the recommendation to include care at a level beyond that provided by a skilled nursing facility will not be added. Also see response to #3.
10.	R9-22-712.67	Debbie Johnston 05/06/16	**We support the definition of "transfer", but recommend the rules incorporate the following or substantially similar language from the October 30, 2015 Payment Policies Manual clarifying transfers for sub-acute services:** **"A recipient who no longer meets medical inpatient criteria may be discharged/transferred to another acute care facility without triggering a reduction to the transferring hospital via the 70 Discharge Status Code (Discharge/transfer to another type of health** **care institution not defined elsewhere in the code list) for the provision of sub-acute services."**	The Administration has noted your comment. Policy manual provisions incorporated by reference into the provider participation agreement between the hospital and the administration provide clarification and detail regarding billing instructions. Billing instructions are generally delineated in policy because details such as discharge status codes are subject to potential change by the professional organizations that establish those codes. Therefore, additional language will not be added to rule.
11.	R9-22-712.75 A2	Debbie Johnston 05/06/16	There is a difference between the levels of care provided by skilled nursing facilities and hospitals providing sub-acute or other post-acute care (e.g., rehabilitation). **To avoid possible confusion, we recommend restating R9-22-712(A)(2) as "Administrative days may also occur at the end of an acute care episode, for example, when a member is not discharged while awaiting placement in a post-acute care setting, such a nursing facility or hospital providing sub-acute services or other post-acute services."**	Please see the response to comment number 3.
12.	R9-22-712.75 A3	Debbie Johnston 05/06/16	**We recommend adding "or sub-acute facility days" after "nursing facility days" in subsection E. This would provide additional clarity by differentiating sub-acute services from skilled nursing services.**	The Administration has noted your comments. The rule specifies nursing facilities as an example.
13.	R9-22-712.75	Debbie Johnston	**In addition, we recommend adding the phrase "Administrative days will be reimbursed using a**	The rule sets forth the method by which the AHCCCS administration

	A3	05/06/16	**negotiated per diem rate."** Hospitals providing sub-acute care services report to us a number of AHCCCS health care plans have established non-negotiated Administrative day rates for nursing facilities and expect hospitals to accept these much lower rates, which are not commensurate with the sub-acute level of care hospitals provide. If the Administration chooses not to include this language in the rule, we urge such language be included in separate policy guidance.	will reimburse hospitals on a fee-for-services basis. AHCCCS managed care organizations are permitted to establish their own rates through individually negotiated contracts with hospitals. Therefore, no changes will be made to the proposed language.
14.	R9-22-712.66	Debbie Johnston 05/06/16	We do not question the high cost of treating high acuity pediatric patients. **However, we believe for the sake of transparency that the Administration should identify any data that it relied on in making this proposal.** While the Administration may not have relied on an external study, we would assume that Administration **staff reviewed internal or other data in making the policy determination** to establish and set a high acuity pediatric weight at 1.60. **We believe this data should be made available to the public**. In addition, we would like to have a better understanding of the funding source for this policy proposal, since the Administration is proposing and implementing it outside of the legislative appropriations process.	As the commenter noted, it is generally accepted that there is a higher cost to treating high acuity pediatric patients. No specific studies or data was reviewed to arrive at this conclusion.
15.	R9-22-712.35E 1	Steve Kaiser 05/09/16	Phoenix Children's Hospital has executed an agreement with a qualifying Health Information Exchange and currently is working through the process of exchanging data. Due to the complexity of the unique data flows in pediatrics, however, completing these processes may require more time than the proposed rule allows. Some of the challenges experienced in the pediatric context include obtaining appropriate parental consent when patients transfer in and out of foster care and the changing consent requirements as children get older. Furthermore, successful exchange of data requires all technology requirements be completed by both the Hospital and the HIE, and each Hospital is not in direct control of the timeline and priorities of a complex Health Information Exchange which must manage many clients. **We would propose that in the first year hospitals must have an executed agreement with a qualifying Health Information Exchange and be actively engaged with the on-boarding process with the HIE. By the second year hospitals should be electronically submitting admission,**	The purpose of this rulemaking is to recognize the improved health outcomes and health care costs savings expected from hospital that have already taken the necessary steps to participate in health information exchange. The rulemaking only impacts payments for hospital services during a one year period. Extension of an adjustment for participation in and health information exchange and/or alternate metrics for value based payments may be considered in future program years.

			discharge, and transfer information.	
16.	R9-22-712.35E 2	Steve Kaiser 05/09/16	As an initial matter, there is currently no mechanism within AHCCCS to receive an attestation from an inpatient children's hospital, with the most recent direction from AHCCCS being that such a mechanism will be in place in May 2016 for submission of Program Year 2015 MU attestation. It also is unclear why attestation for program year 2015 would include data from January 2016 through April of 2016. The proposed rule also does not clarify whether a children's hospital must submit attestation of inpatient meaningful use or outpatient meaningful use. Phoenix Children's Hospital proposes that because of the lack of mechanism through which to submit an attestation for 2015, and since attestation for a program year cannot be filed until the following year, **that this rules criteria be based on successfully submitting a meaningful use attestation for Program Year 2015**	At the time of the proposed rule, April 30, 2016, was the deadline established by the federal government for the approval of an attestation to meaningful use. Since that time, CMS has announced that it will establish a new deadline, but, as of this date, has announced the new deadline. As a result, the Administration has modified the rule to reflect that the last date for an attestation for a children's hospital will be the date announced by CMS. In addition, the rule has been modified to clarify that the 2016 dates refer to the dates by which the attestation must be received and that the hospital must demonstrate implementation of Stage 2 Meaningful use during a reporting period in 2015.
17.	R9-22-712.66 (6)	Steve Kaiser 05/09/16	Phoenix Children's Hospital appreciates the support from AHCCCS in recognizing that higher acuity patients require more resources and care. This new ruling will allow Phoenix Children's Hospital to continue to provide the highest quality of care for patients with the most demanding needs.	Thank you for your support.
18.	R9-22-712.75 A	Steve Kaiser 05/09/16	Phoenix Children's Hospital supports the changes to R9-22-712.75 regarding DRG Reimbursement and Payment for Administrative Days.	Thank you for your support.
19.	General Prgh 2	Jennifer Carusetta 05/09/16	The Alliance would recommend that the Administration **utilize existing nationally recognized healthcare performance measures** when determining performance benchmarks and measuring hospital progress. As noted previously, hospitals already have systems in place to provide data in response to these measures.	Your suggestion has been noted. We will take it into consideration for CYE 2018.
20.	General Prgh 3	Jennifer Carusetta 05/09/16	It continues to be our understanding that the Value-Based Purchasing project is **intended to incentivize innovation and efficiency and shall not be used to penalize providers** who are unable to meet established benchmarks. The proposed framework establishes a good construct to continue to incentivize hospitals to transition from a payment system based on inputs, to a system based on outputs, without penalizing them for any of the infrastructure or implementation challenges they currently face.	Thank you for your support.

21.	General Prgh 4	Jennifer Carusetta 05/09/16	The proposed rules also clarify the circumstances under which hospitals may bill for Administrative Stays. We are actively engaged with Mercy Maricopa Integrated Care to identify collaborative solutions to address this issue, but very much appreciate the additional clarification on how systems may be reimbursed for these hospital stays.	Thank you for your support.
22.	General Prgh 5	Jennifer Carusetta 05/09/16	The proposed definition states that **sub-acute services** occur when the patient does not require acute inpatient hospitalization, but then goes on to state that sub-acute care shall take place immediately after an inpatient hospitalization. While we believe we understand the intent of this language, **it does appear to conflict and could lead to some confusion in its interpretation and application. For this reason, we would suggest additional clarification.**	The Administration has reviewed the definition and finds that where it states "does not require acute inpatient hospitalization" is sufficiently clear in addressing the present state of the patient's condition. Therefore no changes will be made.

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters are applicable.

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

Not applicable.

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

Not applicable.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

Not applicable.

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

None

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable.

15. The full text of the rules follows:

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-701. Standard for Payments Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:

"Accommodation" means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is semi-private except when the member must be isolated for medical reasons. Types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which room and board are provided.

"Aggregate" means the combined amount of hospital payments for covered services provided within and outside the GSA.

"AHCCCS inpatient hospital day or days of care" means each day of an inpatient stay for a member beginning with the day of admission and including the day of death, if applicable, but excluding the day of discharge, provided that all eligibility, medical necessity, and medical review requirements are met.

"Ancillary service" means all hospital services for patient care other than room and board and nursing services, including but not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).

"APC" means the Ambulatory Payment Classification system under 42 CFR 419.31 used by Medicare for grouping clinically and resource-similar procedures and services.

"Billed charges" means charges for services provided to a member that a hospital includes on a claim consistent with the rates and charges filed by the hospital with Arizona Department of Health Services (ADHS).

"Business agent" means a company such as a billing service or accounting firm that renders billing statements and receives payment in the name of a provider.

"Capital costs" means costs as reported by the hospital to CMS as required by ~~42 CFR 413.20.29~~42 CFR 413.20.

"Copayment" means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.

"Cost-to-charge ratio" (CCR) means a hospital's costs for providing covered services divided by the hospital's charges for the same services. The CCR is the percentage derived from the cost and charge data for each revenue code provided to AHCCCS by each hospital.

"Covered charges" means billed charges that represent medically necessary, reasonable, and customary items of expense for covered services that meet medical review criteria of AHCCCS or a contractor.

"CPT" means Current Procedural Terminology, published and updated by the American Medical Association. CPT is a nationally-accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians that provide a uniform language to accurately designate medical, surgical, and diagnostic services.

"Critical Access Hospital" is a hospital certified by Medicare under 42 CFR 485 Subpart F and 42 CFR 440.170(g).

"Direct graduate medical education costs" or "direct program costs" means the costs that are incurred by a hospital for the education activities of an approved graduate medical education program that are the proximate result of training medical residents in the hospital, including resident salaries and fringe benefits, the portion of teaching physician salaries and fringe benefits that are related to the time spent in teaching and supervision of residents, and other related GME overhead costs.

"DRI inflation factor" means Global Insights Prospective Hospital Market Basket.

"Eligibility posting" means the date a member's eligibility information is entered into the AHCCCS Pre-paid Medical Management Information System (PMMIS).

"Encounter" means a record of a medically-related service rendered by an AHCCCS-registered provider to a member enrolled with a contractor on the date of service.

"Existing outpatient service" means a service provided by a hospital before the hospital files an increase in its charge master as defined in R9-22-712(G), regardless of whether the service was explicitly described in the hospital charge master before filing the increase or how the service was described in the charge master before filing the increase.

"Expansion funds" means funds appropriated to support GME program expansions as described under A.R.S. § ~~36-2903.01(H)(9)(b) and (c)(i)~~ 36-2903.01(G)(9)(b) and (c)(i).

"Factor" means a person or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business agent.

"Fiscal intermediary" means an organization authorized by CMS to make determinations and payments for Part A and Part B provider services for a given region.

"Freestanding Children's Hospital" means a separately standing hospital with at least 120 pediatric beds that is dedicated to provide the majority of the hospital's services to children.

"GME program approved by the Administration" or "approved GME program" means a graduate medical education program that has been approved by a national organization as described in 42 CFR 415.152.

"Graduate medical education (GME) program" means an approved residency program that prepares a physician for independent practice of medicine by providing didactic and clinical education in a medical environment to a medical student who has completed a recognized undergraduate medical education program.

"HCAC" means a health care acquired condition described under ~~42 U.S.C. 1395ww(d)(4)(D)(iv)~~ 42 CFR 447.26 but does not include Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

"HCPCS" means the Health Care Procedure Coding System, published and updated by Center for Medicare and Medicaid Services (CMS). HCPCS is a listing of codes and descriptive terminology used for reporting the provision of physician services, other health care services, and substances, equipment, supplies or other items used in health care services.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as specified under 45 CFR 162, that establishes standards and requirements for the electronic transmission of certain health information by defining code sets used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

"ICU" means the intensive care unit of a hospital.

"Indirect program costs" means the marginal increase in operating costs that a hospital experiences as a result of having an approved graduate medical education program and that is not accounted for by the hospital's direct program costs.

"Intern and Resident Information System" means a software program used by teaching hospitals and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

"Medical education costs" means direct hospital costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, as described in the Medicare Provider Reimbursement Manual.

"Medical review" means a clinical evaluation of documentation conducted by AHCCCS or a contractor for purposes of prior authorization, concurrent review, post-payment review, or determining medical necessity. The criteria for medical review are established by AHCCCS or a contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

"Medicare Urban or Rural Cost-to-Charge Ratio (CCR)" means statewide average capital cost-to-charge ratio published annually by CMS added to the urban or rural statewide average operating cost-to-charge ratio published annually by CMS.

"National Standard code sets" means codes that are accepted nationally in accordance with federal requirements under 45 CFR 160 and 45 CFR 164.

"New hospital" means a hospital for which Medicare Cost Report claim and encounter data are not available for the fiscal year used for initial rate setting or rebasing.

"NICU" means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

"Non-IHS Acute Hospital" means a hospital that is not run by Indian Health Services, is not a free-standing psychiatric hospital, such as an IMD, and is paid under ADHS rates.

"Observation day" means a physician-ordered evaluation period of less than 24 hours to determine whether a person needs treatment or needs to be admitted as an inpatient. Each observation day consists of a period of 24 hours or less.

"Operating costs" means AHCCCS-allowable accommodation costs and ancillary department hospital costs excluding capital and medical education costs.

"OPPC" means an Other Provider Preventable Condition that is: (1) a wrong surgical or other invasive procedure performed on a patient, (2) a surgical or other invasive procedure performed on the wrong body part, or (3) a surgical or other invasive procedure performed on the wrong patient.

"Organized health care delivery system" means a public or private organization that delivers health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

"Outlier" means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described under this Article and A.R.S. § ~~36-2903.01(H)~~ 36-2903.01(G).

"Outpatient hospital service" means a service provided in an outpatient hospital setting that does not result in an admission.

"Ownership change" means a change in a hospital's owner, lessor, or operator under 42 CFR 489.18(a).

"Participating institution" means an institution at which portions of a graduate medical education program are regularly conducted and to which residents rotate for an educational experience for at least one month.

"Peer group" means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services, including specialty hospitals that limit the provision of services to specific patient populations, such as rehabilitative patients or children.

"PPC" means prior period coverage. PPC is the period of time, prior to the member's enrollment, during which a member is eligible for covered services. The time-frame is the first day of the month of application or the first eligible month, whichever is later, until the day a member is enrolled with a contractor.

"PPS bed" means Medicare-approved Prospective Payment beds for inpatient services as reported in the Medicare cost reports for the most recent fiscal year for which the Administration has a complete set of Medicare cost reports for every rural hospital as determined as of the first of February of each year.

"Procedure code" means the numeric or alphanumeric code listed in the CPT or HCPCS manual by which a procedure or service is identified.

"Prospective rates" means inpatient or outpatient hospital rates set by AHCCCS in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-party payments regardless of billed charges or individual hospital costs.

"Public hospital" means a hospital that is owned and operated by county, state, or hospital health care district.

"Qualifying health information exchange organization" means a non-profit health information organization as defined in A.R.S. § 36-3801 that provides the statewide exchange of patient health information among disparate health care organizations and providers not owned, operated, or controlled by the health information exchange. A qualifying health information exchange organization must include representation by the administration on its board of directors, and have a significant number of health care participants, including hospitals, laboratories, payers, community physicians and Federally Qualified Health Centers.

"Rebase" means the process by which the most currently available and complete Medicare Cost Report data for a year and AHCCCS claim and encounter data for the same year are collected and analyzed to reset the Inpatient Hospital Tiered per diem rates, or the Outpatient Hospital Capped Fee-For-Service Schedule.

"Reinsurance" means a risk-sharing program provided by AHCCCS to contractors for the reimbursement of specified contract service costs incurred by a member beyond a certain monetary threshold.

"Remittance advice" means an electronic or paper document submitted to an AHCCCS-registered provider by AHCCCS to explain the disposition of a claim.

"Resident" means a physician engaged in postdoctoral training in an accredited graduate medical education program, including an intern and a physician who has completed the requirements for the physician's eligibility for board certification.

"Revenue code" means a numeric code, that identifies a specific accommodation, ancillary service, or billing calculation, as defined by the National Uniform Billing committee for UB-04 forms.

"Sub-acute services" means inpatient care for a patient with an acute illness, injury or exacerbation of a disease process when the patient does not require acute inpatient

hospitalization. Sub-acute care is rendered immediately after, or instead of, acute inpatient hospitalization.

"Specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.

"Sponsoring institution" means the institution or entity that is recognized by the GME accrediting organization and designated as having ultimate responsibility for the assurance of academic quality and compliance with the terms of accreditation.

"Tier" means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure, or revenue codes, peer group, NICU classification level, or any combination of these items.

"Tiered per diem" means an AHCCCS capped fee schedule in which payment is made on a per-day basis depending upon the tier (or tiers) into which an AHCCCS inpatient hospital day of care is assigned.

"Trip" means a one-way transport each time a taxi is called. If the taxi waits for the member then the transport continues to be part of the one-way trip. If the taxi leaves and is called to pick up the member, that is considered a new one-way trip.

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

A. For all claims with a begin date of service on or before September 30, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:

1. By 48 percent for public hospitals on July 1, 2005, and hospitals that were public anytime during the calendar year 2004;
2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;

4. By 115 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the criteria during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
5. By 113 percent for a Freestanding Children's Hospital with at least 110 pediatric beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective; or
6. By 14 percent for a University Affiliated Hospital which is a hospital that has a majority of the members of its board of directors appointed by the Board of Regents during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective.

B. For all claims with a begin date of service on or after October 1, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services) for the following hospitals. A hospital shall receive an increase from only one of the following categories:

1. By 73 percent for public hospitals;
2. By 31 percent for hospitals in counties other than Maricopa and Pima with more than 100 licensed beds as of October 1 of that contract year;
3. By 37 percent for hospitals in counties other than Maricopa and Pima with 100 or fewer licensed beds as of October 1 of that contract year;
4. By 100 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the critical access criteria;
5. By 78 percent for a Freestanding Children's Hospital with at least 110 pediatric beds as of October 1 of that contract year; or
6. By 41 percent for a University Affiliated Hospital, ~~which~~ this is a hospital that has a majority of the members of its board of directors appointed by the Arizona Board of Regents.

C. In addition to subsections (A) and (B), an Arizona Level 1 trauma center as defined by R9-22-2101 shall receive a 50 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services and out-of-state hospital services) for Level 2 and 3 emergency department procedures.

D. Hospitals with greater than 100 pediatric beds not receiving an increase under subsection (B) shall receive an 18 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services).

E. For outpatient services with dates of service from October 1, 2016 through September 30, 2017, the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2016. To qualify, a hospital providing outpatient hospital services must meet the following criteria:

1. By June 1, 2016, the hospital must have executed an agreement with and electronically submitted admission, discharge, and transfer information, as well as data from the hospital emergency department, to a qualifying health information exchange organization, and
2. No sooner than January 4, 2016, and no later than February 29, 2016, CMS must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015; or, for a children's hospital that does not participate in the medicare electronic health record incentive program, no sooner than January 4, 2016, and no later than the date established by CMS, the administration must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015.

~~**E.**~~**F.** Fee adjustments made under subsection (A), (B), (C), ~~and~~ (D), and (E) are on file with AHCCCS and current adjustments are posted on AHCCCS' web site.

R9-22-712.60 Diagnosis Related Group Payments.

A. Inpatient hospital services with discharge dates on or after October 1, 2014, shall be reimbursed using the diagnosis related group (DRG) payment methodology described in this section and sections R9-22-712.61 through R9-22-712.81.

B. Payments made using the DRG methodology shall be the sole reimbursement to the hospital for all inpatient hospital services and related supplies provided by the hospital. Services provided in the emergency room, observation area, or other outpatient departments that are

directly followed by an inpatient admission to the same hospital are not reimbursed separately. Are reimbursed through the DRG methodology and not reimbursed separately.

C. Each claim for an inpatient hospital stay shall be assigned a DRG code and a DRG relative weight based on version 31 of the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. If version 31 of the APR-DRG classification system will no longer support assigning DRG codes and relative weights to claims, and 3M Health Information Systems issues a newer version of the APR-DRG classification system using updated DRG codes and/or updated relative weights, then ~~the more current version~~ an updated version established by 3M Health Information Systems will be used; however, if the ~~newer~~ version employs updated relative weights, those weights will be adjusted using a single adjustment factor applied to all relative weights to ensure that the statewide weighted average of the updated relative weights does not increase or decrease from the statewide weighted average of the relative weights used under version 31.

D. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to quick pay discounts and slow pay penalties under A.R.S. 36-2904.

E. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to the Urban Hospital Reimbursement Program under R9-22-718.

F. For purposes of this section and sections R9-22-712.61 through R9-22-712.81:

1. "DRG National Average length of stay" means the national arithmetic mean length of stay published in version 31 of the All Patient Refined Diagnosis Related Group (APR-DRG) classification established by 3M Health Information Systems.
2. "Length of stay" means the total number of calendar days of an inpatient stay beginning with the date of admission through discharge, but not including the date of discharge (including the date of a discharge to another hospital, i.e., a transfer) unless the member expires.
3. "Medicare" means Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq*.
4. "Medicare labor share" means a hospital's labor costs as a percentage of its total costs as determined by CMS for purposes of the Medicare Inpatient Prospective Payment System.

R9-22-712.61. DRG Payments: Exceptions.

A. Notwithstanding section R9-22-712.60, claims for inpatient services from the following hospitals shall be paid on a per diem basis, including provisions for outlier payments, where rates and outlier thresholds are included in the capped fee schedule published by the Administration on its website and available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The outlier CCR will be the sum of the urban or rural default operating CCR appropriate to the location of the hospital and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. The resulting amount will be the total reimbursement for the claim. There is no provision for outlier payments for hospitals described under subsection (A)(3).

1. Hospitals designated as type: hospital, subtype; rehabilitation in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website in March of each year;
2. Hospitals designated as type: hospital, subtype: long term in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
3. Hospitals designated as type: hospital, subtype; psychiatric in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
4. ~~Transplant facilities to the extent the inpatient days associated with the transplant exceed the terms of the contract.~~

B. Notwithstanding section R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the ~~primary~~ principal diagnosis on the claim is a behavioral health diagnosis, shall be reimbursed as prescribed by ~~ADHS~~ a per diem rate described by a fee schedule established by the Administration; however, if the ~~primary~~ principal diagnosis is a ~~medical~~ physical health diagnosis, the claim shall be processed under the DRG methodology described in this section, even if behavioral health services are provided during the inpatient stay.

C. Notwithstanding section R9-22-712.60, claims for services associated with transplant services shall be paid in accordance with the contract between the AHCCCS administration and the transplant facility.

D. Notwithstanding section R9-22-712.60, claims from an ~~IHS facility or from a hospital operated as a 638 facility~~ IHS facility or 638 Tribal provider shall be paid the all-inclusive rate on a per visit basis in accordance with the rates published annually by IHS in the federal register. ~~A 638 facility is a hospital operated by an Indian tribe or tribal organization, as defined in 25 USC 1603, funded, in whole or part, by the IHS as provided for in a contract or compact with IHS under 25 U.S.C. §§ 450 through 458aaa-18.~~

E. For hospitals that have contracts with the Administration for the provision of transplant services, inpatient days associated with transplant services are paid in accordance with the terms of the contract.

R9-22-712.66. DRG Service Policy Adjustor

In addition to subsection R9-22-712.65, for claims with DRG codes in the following categories, the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code, and the DRG provider policy adjustor shall be multiplied by the following service policy adjustors:

1. Normal newborn DRG codes: 1.55
2. Neonates DRG codes: 1.10
3. Obstetrics DRG codes: 1.55
4. Psychiatric DRG codes: 1.65
5. Rehabilitation DRG codes: 1.65
6. ~~Claims for members under age 19 assigned DRG codes other than listed above: 1.25~~ Claims for members under age 19 assigned DRG codes other than listed above:
   a. 1.25 for dates of discharge occurring on or after October 1, 2014 and ending no later than December 31, 2015 regardless of severity of illness level,
   b. 1.25 for dates of discharge on or after January 1, 2016 for severity of illness levels 1 and 2,
   c. 1.60 for dates of discharge on or after January 1, 2016 for severity of illness levels 3 and 4.

R9-22-712.67. DRG Reimbursement: Transfers.

A. For purposes of this ~~subsection~~ Section a "transfer" means the transfer of a member from a hospital to a short-term general hospital for inpatient care, ~~to~~ a designated cancer center, ~~or~~ children's hospital, or a critical access hospital except when a member is moved for the purpose of receiving sub-acute services.

B. Designated cancer center or children's hospitals are those hospitals identified as such in the UB-04 billing manual published by the National Uniform Billing Committee.

C. The hospital the member is transferred from shall be reimbursed either the initial DRG base payment or the transfer DRG base payment, whichever is less.

D. The transfer DRG base payment is an amount equal to the initial DRG base payment, as determined after making any provider or service policy adjustors, divided by the DRG National Average length of stay for the DRG code multiplied by the sum of one plus the length of stay.

E. The hospital the member is transferred to shall be reimbursed under the DRG payment methodology without a reduction due to the transfer.

F. Unadjusted DRG base payment. The unadjusted DRG base payment is either the initial DRG base payment, as determined after making any provider or service policy adjustors, or the transfer DRG base payment, whichever is less.

R9-22-712.71. Final DRG Payment.

The final DRG payment is the sum of the final DRG base payment, ~~and~~ the final DRG outlier add-on payment, and the Inpatient Value Based Purchasing (VBP) Differential Adjusted Payment.

~~**A.**~~ 1. The final DRG base payment is an amount equal to the product of the covered day adjusted DRG base payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

~~**B.**~~ 2. The final DRG outlier add-on payment is an amount equal to the product of the covered day adjusted DRG outlier add-on payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment

methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

~~C.~~ 3. The factor for each hospital and for each federal fiscal year is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS administration's website and is on file for public inspection at the AHCCCS administration located at 701 E Jefferson Street, Phoenix, Arizona.

4. For inpatient services with a date of discharge from October 1, 2016 through September 30, 2017, the Inpatient VBP Differential Adjusted Payment is the sum of the final DRG base payment and the final DRG outlier add-on payment multiplied by a percentage published on the Administration's public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2016. To qualify for the Inpatient VBP Differential Adjusted Payment, a hospital providing inpatient hospital services must meet the following criteria:

   a. By June 1, 2016, the hospital must have executed an agreement with and electronically submitted admission, discharge, and transfer information, as well as data from the hospital emergency department, to a qualifying health information exchange organization, and

   b. No sooner than January 4, 2016, and no later than February 29, 2016, CMS must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015; or, for a children's hospital that does not participate in the medicare electronic health record incentive program, no sooner than January 4, 2016, and no later than the date established by CMS, the administration must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015.

R9-22-712.75. DRG Reimbursement: Payment for Administrative Days.

~~A. Administrative days are days of a hospital stay in which a member does not meet criteria for an acute inpatient stay, but is not discharged because an appropriate placement outside the hospital is not available, the Administration or the contractor fail to provide for the~~

~~appropriate placement outside the hospital in a timely manner, or the member cannot be safely discharged or transferred.~~

A. Administrative days are days in which a member is admitted as an inpatient to an acute care hospital, does not meet the criteria for an acute inpatient stay, but is admitted or not discharged because (1) an appropriate placement outside the hospital is not available, (2) the member cannot be safely discharged or transferred, or (3) the Administration or the contractor failed to provide for the appropriate placement outside the hospital in a timely manner.

1. Administrative days may occur prior to an acute care episode, for example, when a woman with a high-risk pregnancy is admitted to a hospital while awaiting delivery.
2. Administrative days may also occur at the end of an acute care episode, for example, when a member is not discharged while awaiting placement in a nursing facility or other sub-acute or post-acute setting.
3. Administrative days may also include days in a receiving hospital when the member has been discharged from one acute care hospital for the purpose of receiving sub-acute services at the receiving hospital.

B. Administrative days do not include days when the member is awaiting appropriate placement or services that are currently available but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays.

C. Prior authorization is required for administrative days.

D. A hospital shall submit a claim for administrative days separate from any claim for reimbursement for the inpatient stay otherwise reimbursable under the DRG payment methodology.

E. Administrative days are reimbursed at the rate the claim would have paid had the services not been provided in an inpatient hospital setting but had been provided at the appropriate level of care (e.g., as nursing facility days).