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:**
R9-22-731	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. § 36-2999.72
Implementing statute:	A.R.S. § 36-2999.72
Statute authorizing the exemption:	Session Law 2022, Chapter 314 (House Bill 2863)

3. The proposed effective date of the rule and the agency's reason for selecting the effective date: The Administration is proposing an effective date of October 1, 2022 so that the invoices for the new rates will be available on or before October 15, 2022 or upon approval by CMS, whichever is later.

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

Notice of Termination:	28 A.A.R. 2024, August 12, 2022.
Notice of Docket Opening:	28 A.A.R 2027, August 12, 2022.

Notice of Proposed Exempt Rulemaking: 28 A.A.R. 2013, August 12, 2022.

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

Name: Nicole Fries

Address: AHCCCS
Office of Administrative Legal Services
801 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4232

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

Through this rulemaking, AHCCCS proposes to update the intended Health Care Investment Fund (HCIF) assessment amounts for FFY 2023. One of the main purposes of the HCIF is to make directed payments to hospitals, pursuant to 42 CFR § 438.6(c), that supplement the base reimbursement rate provided to hospitals for services provided to persons eligible for Title XIX Services. These directed payments have been named Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) payments. Additionally, the HCIF is used to increase base reimbursement for services reimbursed under the dental fee schedule and physician fee schedule.

Hospitals received their first HEALTHII directed payment in December 2020 and will continue receiving directed payments on a quarterly basis. Annually, HEALTHII payments represent a net increase of over $1.4 billion. To ensure adequate HCIF is available to provide the full State Match required to fund the physician and dental rate increases as required by Laws 2020, Chapter 46 and the HEALTHII directed payments, AHCCCS intends to amend the rates located in this rule.

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

No studies were conducted relevant to the rule.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state: Not applicable because the rulemaking will not diminish a previous grant of authority to a political subdivision.

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

The 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. §36-2999.72 prohibits 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 over $1.4 billion in FFY 2023 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 exempt rulemakings.

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

Name and Position of Commenter	Date of Comment	Text of Comment	AHCCCS Response
Amy Upston, Director of	9/12/2022	Thank you for the opportunity to comment on the proposed Federal Fiscal Year (FFY) 2023	Thank you for your comment

Financial Policy and Reimbursement – Arizona Hospital and Healthcare Association		Health Care Investment Fund (HCIF) assessment rule. I am responding on behalf of the Arizona Hospital and Healthcare Association (AzHHA). AzHHA is a statewide association of more than 75 hospital, healthcare and affiliated health system members, representing short-term acute care, behavioral health, post-acute care and critical access hospitals, as well as their affiliated clinics and staff. AzHHA greatly appreciates AHCCCS's transparent approach with the hospital assessments and the ongoing opportunity for stakeholders to provide feedback. Overall, AzHHA supports the proposed rule and the methodology, but would like to comment on a couple aspects of the rule. First, while AzHHA believes that public health hospitals should be treated similarly to other acute care facilities for HEALTHII payments, we greatly appreciate the exemption from the hospital assessments for public hospitals. We look forward to	on the R9-22-731 rulemaking. AHCCCS plans to review the appropriateness of HCIF and HAF assessment class categories and associated assessment rates and exemptions for the FFY 24 model and will consider specific proposals from stakeholders.

		continuing to work with AHCCCS to further eliminate this disparity. Second, when the HCIF assessment was added, due to a quick turnaround time, AHCCCS did not have time to ensure that the categories which were created for the HAF assessment continued to make sense for the HCIF assessment. Some of our members would appreciate it if AHCCCS would take the time to review these categories during the FFY 2024 process to ensure that lower rates or exemptions are not creating unfair market advantages. First, while a HAF balance is necessary to pay for the first two months' worth of capitation rates associated with the hospital assessment populations, there have been times when AHCCCS has allowed a significant accumulation of the fund balance, much more than has been needed. With hospitals experiencing unprecedented inflation and their financial situation becoming less stable, we ask that AHCCCS continue to monitor the fund balance and any	

		savings associated with the higher FMAP rate related to the public health emergency. If warranted, we ask that AHCCCS make a mid-year adjustment to decrease the hospital assessment rates. Second, AzHHA requests that in the upcoming year, AHCCCS takes a deeper look into the amount of assessment paid by each hospital and the hospital payment to cost ratio, as well as re-evaluate the "no losers" principle. As the hospital assessment has grown to more than $500 million annually, and soon be nearing $600 million, it has put a tremendous strain on hospitals despite hospitals not being the only beneficiaries of the Proposition 204 restoration and other funding sources being available. The current principle of "no losers" does not take into account the tremendous cost involved in caring for AHCCCS recipients. It also fails to take into consideration that it may exacerbate regional market disparities since some hospital systems pay a lot for the hospital	

		assessment but do not reap the same benefits as other hospitals. These regional market disparities may be further exacerbated since not all health systems are eligible for certain supplemental payments. AzHHA requests AHCCCS to consider reviewing payment-to-cost or payment as a percentage of Medicare and include the cost of the assessment in this calculation. After doing so, we encourage AHCCCS to review the "no losers" principle and evaluate changing it so that there are no losing hospitals or consider reviewing it by region.	

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

No other matters have been prescribed.

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

The rule does not require a permit.

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

The rulemaking must be established consistent with 42 CFR Part 433 Subpart B. The rule is not more stringent than federal law.

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

No analysis was submitted.

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

No material is incorporated by reference.

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

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

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

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, ~~2021~~2022, for each Arizona licensed hospital not excluded under subsection (I) shall be subject to an assessment payable on a quarterly basis. The assessment shall be levied against the legal owner of each hospital as of the first day of the quarter, and except as otherwise required by subsections (D), (E) and (F). For the period beginning October 1, ~~2021~~2022, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital's 2019 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as "Other Long Term Care Discharges," multiplied by the following rates appropriate to the hospital's peer group; and (2) the amount of outpatient net patient revenues multiplied by the following rate appropriate to the hospital's peer group:

1. $~~204.75~~211.50 per discharge and ~~3.3723~~3.5149% 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. $~~204.75~~211.50 per discharge and ~~1.4051~~1.645% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
3. $~~51.25~~53.00 per discharge and ~~1.4051~~1.645% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
4. $~~51.25~~53.00 per discharge and ~~1.4051~~1.645% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2019 Medicare Cost Report.

5. $~~164.00~~169.25 per discharge and ~~3.6533~~3.8078% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 2019 Uniform Accounting Report.

6. $~~184.25~~190.50 per discharge and ~~4.2153~~4.3936% 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~~2019 Uniform Accounting Report.

7. $~~41.00~~42.50 per discharge and ~~1.1241~~1.1716% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.

8. $~~204.75~~211.50 per discharge and ~~5.6205~~5.8581% 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, ~~2021~~2022.

D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2019 Medicare Cost Report, are assessed a rate of $~~51.25~~53.00 for each discharge from the psychiatric sub-provider as reported in the 2019 Medicare Cost Report. All discharges other than those reported as discharges from the psychiatric sub-provider are assessed at the rate required by

subsection (B).

E. Notwithstanding subsection (B), rehabilitative discharges from a hospital that reported having a rehabilitative sub-provider in the hospital's 2019 Medicare Cost Report, are assessed a rate of $0 for each discharge from the rehabilitative sub-provider as reported in the 2019 Medicare Cost Report. All discharges other than those reported as discharges from the rehabilitative sub-provider are assessed at the rate required by subsection (B).

F. Notwithstanding subsection (B), for any hospital that reported more than 24,000~~23,000~~ discharges on the hospital's 2019 Medicare Cost Report, discharges in excess of 24,000~~23,000~~ are assessed a rate of $~~20.25~~21.25 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 10th 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 10th day of the second month of the quarter.

I. Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's 2019 Medicare Cost Report and Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for January 2, ~~2021~~2022:

1. Hospitals owned and operated by the state, the United States, or an Indian tribe.

2. Hospitals designated as type: hospital, subtype: short-term that have a license number beginning "SH".

3. Hospitals designated as type: hospital, subtype: psychiatric that reported fewer than 2,500 discharges on the ~~2018~~2019 Medicare Cost Report.

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

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

6. Hospitals designated as type: hospital, subtype: short-term located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2019 Medicare Cost Report are reimbursed by Medicare.

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

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

J. New hospitals. For hospitals that did not file a 2019 Medicare Cost Report because of the date the hospital began operations:

1. If the hospital was open on the January 2 preceding the October assessment start date, the hospital assessment will begin on October 1 following the date the hospital began operating.

2. If the hospital began operating between January 3 and June 30, the assessment

will begin on October 1 of the following calendar year.

3. A hospital is not considered a new hospital based on a change in ownership.

4. The assessment will be based on the discharges reported in the hospital's first Medicare Cost Report and Uniform Accounting Report, which includes 12 months-worth of data, except when any of the following apply;

   a. If there is not a complete 12 months-worth of data available, the assessment will be based on the annualized number of discharges from the date hospital operations began through December 31 preceding the October assessment start date. The hospital shall self-report the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the Administration no later than January preceding the assessment start date for the new hospitals. "Annualized" means divided by a ratio equal to the number of months of data divided by 12 months.

   b. If more than 12 months of data is available, the assessment will be based on the most recent 12 months of self-reported data, as of December 31;

5. For purposes of calculating subpart 4, if a new hospital shares a Medicare Identification Number with an existing hospital, the assessment amount will be based on self-reported data from the new hospital instead of the Medicare Cost Report. The data shall include the number of discharges and all other data requested by the Administration necessary to determine the appropriate assessment.

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

a. Psychiatric discharges will be annualized to determine if subsections (B)(4) or (I)(3) apply to the assessment amount.

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

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

assessment.

O. Required information for the outpatient assessment. For any hospital that has not filed a 2019 Uniform Accounting Report, or if the 2019 Uniform Accounting Report does not reconcile to 2019 Audited Financial Statements, the Administration shall use the data reported on ~~2018~~2019 Audited Financial Statements to calculate the outpatient assessment. If the 2019 Audited Financial Statements do not include the reliable information sufficient for the Administration to calculate the outpatient assessment, the Administration all use data reported on the 2019 Medicare Cost report. If the Medicare Cost report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2019 Medicare Cost report to calculate the outpatient assessment.

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.