NOTICE OF PROPOSED 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

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

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

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

3. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the proposed rule:

Notice of Final Rulemaking: Notice of Rulemaking Docket Opening: [to be filled in by SOS editor]

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

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5. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking: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. § 36-2901.01, adopted by Initiative Measure Proposition 204 in the 2000 general election, includes individuals with income up to 100% of the federal poverty level as part of the definition of persons eligible for health care coverage through AHCCCS. Due to the lack of

available funding, effective July 8, 2011, the Administration closed the program to new enrollment for persons described by A.R.S. § 36-2901.01 who were not also described in the Arizona State Plan for Medicaid. Arizona Laws 2013, 1st Special Session, Chapter 10, Section 5, added A.R.S. § 36-2901.07, which expanded the definition of eligible persons to include individuals with income between 100% and 133% of the federal poverty level.

A.R.S. § 36-2901.08, also enacted in the same section of the 2013 law, authorizes the Administration to establish, administer and collect an assessment on hospital revenues, discharges or bed days for funding a portion of the nonfederal share of the costs incurred beginning January 1, 2014, associated with eligible persons added to the program by A.R.S. §§ 36-2901.01 and 36-2901.07. The Administration is proposing a new rule to describe the process for establishing, administering and collecting the assessment on hospitals. A.R.S. § 41-1005 (A)(32) exempts the Administration from Title 41, Chapter 6 of the Arizona Revised Statutes (the Arizona Administrative Procedure Act) for purposes of implementing and establishing the hospital assessment; however, that provision requires the Administration to provide public notice and an opportunity for public comment at least thirty days before doing so.

6. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to 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 the regulations.

7. 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.

8. The preliminary summary of the economic, small business, and consumer impact:

The Administration estimates that, through the hospital assessment, the Administration will collect $75.3 million for the State Fiscal Year ending June 30, 2014, from Arizona hospitals.

This is the estimated amount necessary to supplement the existing sources of funding for the eligible persons described in A.R.S. § 36.2901.08(A). AHCCCS administers the Medicaid program in Arizona, which is jointly funded by the State and the federal government. With respect to certain eligible persons covered by virtue of A.R.S. § 36-2901.01, the federal government will contribute approximately two-thirds of the cost of care. Effective January 1, 2014, the federal government will cover approximately 83% of the cost of certain other eligible persons covered under that State statute. For persons eligible under A.R.S. § 2901.07, the federal government will contribute 100% of the cost. Amounts collected as the result of the hospital assessment will be used as the State's contribution to the cost of care for the populations described above. Without these monies, the Administration would have insufficient resources available to cover the cost of these populations. The Administration will use the amounts collected from the assessment combined with the federal financial participation to administer the program, make direct payments to health care providers, and to make capitation payments to managed care organizations totaling about $777 million in State Fiscal Year 2014. These managed care organizations, in turn, make payments to health care providers that render care to AHCCCS members. Many of the providers of that medical care are considered small businesses located in Arizona. In addition to the substantial benefit to the approximately 300,000 additional eligible persons who will have health care coverage as a result of reopening and expanding the program, Arizona consumers will incur no cost associated with the assessment as 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. In the aggregate, the Administration expects to return $108 million more in State Fiscal Year 2014 in payments for hospital services than will be collected through the assessment.

9. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:

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10. The time, place, and nature of the proceedings to make, amend, repeal, or renumber the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Proposed rule language will be available on the AHCCCS website (www.azahcccs.gov) the week of XXXXX, 2013. Please send written or email comments to the above address by the close of the comment period, 5:00 p.m., XXXXXX, 2013.

11. 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:

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:

No analysis was submitted.

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

None

13. 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

R9-22-730 Hospital Assessment

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-730. Hospital Assessment

A. For purposes of this Section, the following terms are defined as provided below unless the context specifically requires another meaning:

1. "2011 Medicare Cost Report" means:
   a. the Medicare Cost Report for the hospital fiscal year ending in calendar year 2011 as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated December 31, 2012; or
   b. For hospitals not included in that CMS HCRIS report, the "as filed" Medicare Cost Report for the hospital fiscal year ending in calendar year 2011 submitted by the hospital to the Administration.
2. "Quarter" means the three month period beginning January 1, April 1, July 1, and October 1 of each year.

B. Beginning January 1, 2014, each Arizona licensed hospital not excluded under subsection (H) 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, subject to subsections (D) and (E), shall be calculated by multiplying the number of discharges reported on the hospital's 2011 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as "Other Long Term Care Discharges," or in the information provided under subsection (L) by the following rates based on the hospital's peer group:

1. $122.00 per discharge for hospitals located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.

2. $122.00 per discharge for hospitals designated as type: hospital, subtype: critical access hospital.
3. $30. 50 per discharge for hospitals designated as type: hospital, subtype: long term.
4. $30.50 per discharge for hospitals designated as type: hospital, subtype: psychiatric that reported 2,500 or more discharges on the 2011 Medicare Cost Report.
5. $97.50 per discharge for hospitals designated as type: hospital, subtype: short-term with more than 80 pediatric beds as reported in the hospital's 2012 Uniform Accounting Report.
6. $122.00 per discharge for hospitals designated as type: hospital, subtype: short-term not included in another peer group.

C. Peer groups 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 for March of each year.

D. Notwithstanding subsections (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2011 Medicare Cost Report, are assessed a rate of $30.50 for each discharge from the psychiatric sub-provider as reported in the 2011 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), for any hospital that reported more than 29,000 discharges on the hospital's 2011 Medicare Cost Report, discharges in excess of 29,000 are assessed a rate of $12.25 for each discharge in excess of 29,000 instead of the rate otherwise required by subsection (B).

F. Assessment notice. On or before the 15th day of the quarter, 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.

G. Assessment due date. Assessment must be received by the Administration by the 15th day of the second month of the quarter.

H. Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's 2011 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 March of each year:

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 2011 Medicare Cost Report.
4. Hospitals designated as type: hospital, subtype; rehabilitation.
5. Hospitals designated as type: hospital, subtype: childrens.
6. Hospitals designated as type: med-hospital, subtype: special hospitals.
7. 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 2011 Medicare Cost Report are reimbursed by Medicare.

I. New hospitals. For hospitals that did not file a 2011 Medicare Cost Report because of the date the hospital began operations, the hospital assessment will begin with the hospital's second quarter of operation but no sooner than January 1, 2014. The assessment will be based on the number of discharges reported by the hospital to AHCCCS for prior quarters until the hospital files its initial Medicare Cost Report. Thereafter, the assessment will be based on the discharges reported in the hospital's initial Medicare Cost Report.

J. 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. 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.

K. 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.

L. Required information. For any hospital that has not filed a 2011 Medicare Cost report, or if the 2011 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the assessment, the Administration shall use data reported on the

2011 Uniform Accounting Report filed by the hospital. If the 2011 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary to calculate the assessment.

M. 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.

N. 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.