NOTICE OF FINAL EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM– ADMINISTRATION

PREAMBLE

1. Article, Part, or Section Affected (as applicable)	**Rulemaking Action:**
R9-22-730	Amend

2. Citations to the agency's statutory rulemaking authority to include both 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

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

3. The effective date of the rule:

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

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

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

Name:	Nicole Fries
Address:	AHCCCS
	Office of Administrative Legal Services
	701 E. Jefferson, Mail Drop 6200
	Phoenix, AZ 85034
Telephone:	(602) 417-4232
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@azahcccs.gov
Web site:	www.azahcccs.gov

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

A.R.S. § 36-2901.08 authorizes the Administration to establish, administer and collect an assessment on hospital revenues, discharges or bed days for funding a portion of the nonfederal share of the costs incurred beginning January 1, 2014, associated with eligible persons added to the program by A.R.S. §§ 36-2901.01 and 36-2901.07.

This rulemaking, in part, will amend rates paid by hospitals under the Hospital Assessment authorized by A.R.S. § 36-2901.08 for the time period beginning July 1, 2020. However, several modifications to A.A.C. R9-22-730 are proposed in order to continue remain compliant with federal regulations, including expanding the assessment to include an outpatient component based on hospital outpatient revenues. Accordingly, this rulemaking establishes an outpatient component of the hospital assessment consistent with the hold harmless provision specified in federal regulation 42 CFR § 433.68 "Permissible Health Care-Related Taxes." Pursuant to 42 CFR 433.68(f), federal financing for the State Medicaid program potentially could be reduced if the amount collected under an assessment is greater than 6% of the provider revenue for the "class" of service subject to the assessment. Because inpatient hospital services and outpatient hospital services are considered separate classes of service under 42 CFR 433.56, taxing more than one class affords the State the ability to increase the amount of the total assessment without jeopardizing federal funding.

Additional amendments are proposed to update the figures for the assessment to be imposed on hospitals for the period beginning July 1, 2020. Moreover, the rulemaking will update the data sources and will modify the definition of one hospital peer type to ensure the continued exemption from the assessment.

As with prior rulemakings implementing the hospital assessment, it is the Agency's objective to assess only so much as is necessary to meet the estimated costs associated with the projected populations referenced in the statute. As such, it is necessary for the Administration to adjust the assessment from time to time as the Administration updates its estimate of the number of eligible persons and projected cost associated with coverage for those persons. .

At the assessment rates in the current rule, the Administration estimates that it would collect $331 million over the course of a state fiscal year. The amendments reflected in this proposed rule adjust the assessment rates such that the Administration anticipates the collection of $433 million for the State Fiscal Year ending June 30, 2021. This amount corresponds to the amount of non-federal funds estimated to be necessary to cover the cost of providing care to the estimated 538,000 eligible individuals described in A.R.S. §36-2901.08(A) for State Fiscal year ending June 30, 2021.

As required by A.R.S. § 36-2901.08(B), the assessment has been established in a manner consistent with federal regulations at 42 C.F.R. Part 433 Subpart B so that the assessment does not cause a reduction in federal financial participation. This rulemaking does not implement provisions specified in HB 2668 (Az. Laws Title 36 Ch. 29). However, future modifications are expected to implement HB 2668.

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

No studies were conducted relevant to the rule.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

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

The Administration estimates that $433 million will be necessary to be collected from Arizona hospitals to fund the cost required by statute for State Fiscal Year (SFY) 2021 ending June 30, 2021. The assessment amount currently in rule reflects the amount needed in SFY 2020 to cover the estimated cost of care, approximately $331 million. The amendment adjusts the rates upward to reflect the estimated need of $443 million for SFY 2021.

The AHCCCS program is jointly funded by the State and the federal government through the Medicaid program. Depending on the eligibility category of the individual, the federal government provides between two-thirds and 100% of the cost of care for persons described in A.R.S. § 36.2901.08(A). The Administration will use the amounts collected from the assessment combined with the federal financial participation to fund the cost of health care coverage for an estimated 538,000 persons described in A.R.S. § 36.2901.08(A) through direct payments to health care providers and capitation payments to managed care organizations that, in turn, make payments to health care providers that render care to AHCCCS members. Many of the providers of that medical care are considered small businesses located in Arizona.

A.R.S. § 36-2901.08 prohibits the assessed hospitals from passing the cost of the assessment on to patients or third parties who pay for care in the hospital. In the aggregate, the Administration expects to return millions more in SFY 2021 in incremental payments for hospital services than will be collected through the assessment. Along with a copy of this proposed exempt rule making, the Administration has posted to its website information regarding the fiscal impact of this amendment to hospitals:
https://azahcccs.gov/PlansProviders/CurrentProviders/State/proposedrules.html

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

There were no changes between the proposed and final rulemaking.

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

Name and Position of Commenter	Date of Comment	Text of Comment	AHCCCS Response
Jennifer A. Carusetta, Executive Director – Health System Alliance	06/30/20	On behalf of the Health System Alliance of Arizona (Alliance), we	AHCCCS thanks Health System Alliance of Arizona for their support

of Arizona		appreciate the opportunity to provide comment on the Notice of Proposed Rulemaking: SFY2021 Hospital Assessment. To begin, we would like to thank AHCCCS for its efforts to mitigate the impact of the projected growth in the Medicaid Restoration and Expansion populations on the hospital industry in Arizona. As you are aware, our facilities have been devastated by the financial impact of COVID-19. We appreciate the dedication you and your staff have demonstrated in trying to find ways to mitigate these losses and find creative solutions to counter the increased costs associated with this program. As discussed throughout the Workgroup process, the members of the Alliance will bear the majority of the impact of any increased costs associated with the hospital assessment program, so it is our continued request that the Agency identify ways to reconcile any reductions in the projected enrollment growth mid-year so our membership does not expend more in assessment costs than necessary. We understand that there is a commitment on the Agency's part to explore this possibility and we appreciate your partnership. We understand that your staff resources are limited and would pledge our own resources to making any	of this rulemaking. AHCCCS understands and recognizes that hospitals require time to plan for increases to the assessment and commits to continuing to engage with hospitals to provide this information as timely as possible.

		potential reconciliation a reality. We appreciate your leadership and consideration throughout this process.	

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

No other matters have been prescribed.

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

The rule does not require a permit.

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

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

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

No analysis was submitted.

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

No material is incorporated by reference.

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

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

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARD FOR PAYMENTS

Section

ARTICLE 7. STANDARD FOR PAYMENTS

R9-22-730. Hospital Assessment

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

1. "~~2016~~ 2018 Medicare Cost Report" means:
   a. The Medicare Cost Report for the hospital fiscal year ending in calendar year ~~2016~~ 2018 as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated ~~July 21, 2017~~ October 9, 2019.
2. "~~2016~~ 2018 Uniform Accounting Report" means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of ~~August 16, 2017~~ November 6, 2019 for the hospital's fiscal year ending in calendar year 2018.
3. "Quarter" means the three month period beginning January 1, April 1, July 1, and October 1 of each year.
4. A "new hospital" means a licensed hospital that did not hold a license from the Arizona Department of Health Services prior to January 2, 2020 ~~1, 2018~~.
5. "Outpatient Net Patient Revenues" means an amount, calculated using data in the hospital's 2018 Uniform Accounting Report, that is equal to the hospital's 2018 total net patient revenue multiplied by the ratio of the hospital's 2018 gross outpatient revenue to the hospital's 2018 total gross patient revenue.

B. Beginning January 1, 2014, for each Arizona licensed hospital not excluded under subsection (I) shall be subject to an assessment payable on a quarterly basis. The assessment shall be levied against the legal owner of each hospital as of the first day of the quarter, and except as otherwise required by subsections (D), (E) and (F). For the period beginning July 1, ~~2019~~ 2020, the assessment for each hospital shall be ~~calculated by multiplying~~an amount equal to the sum of: (1) the number of discharges reported on the hospital's ~~2016~~ 2018 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as "Other Long Term Care Discharges," multiplied by the following rates appropriate to ~~based on~~ 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. ~~$632.00~~$612.75 per discharge and 1.2078% 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. ~~$632.00~~$612.75 per discharge and 0.5033% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
3. ~~$158.00~~$153.25 per discharge and 0.5033% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
4. ~~$158.00~~$153.25 per discharge and 0.5033% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the ~~2016~~ 2018 Medicare Cost Report.
5. ~~$505.50~~$490.25 per discharge and 1.3085% 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 ~~2016~~ 2018 Uniform Accounting Report.
6. ~~$568.75~~$551.50 per discharge and 1.5098% 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 ~~2016~~ 2018 Uniform Accounting Report.

7. ~~$632.0~~$612.75 per discharge and 2.0131% 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 July 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 ~~April 1, 2019~~January 2, 2020.

D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's ~~2016~~ 2018 Medicare Cost Report, are assessed a rate of ~~$158.00~~$153.25 for each discharge from the psychiatric sub-provider as reported in the ~~2016~~ 2018 Medicare Cost Report. All discharges other than those reported as discharges from the psychiatric sub-provider are assessed at the rate required by subsection (B).

E. Notwithstanding subsection (B), rehabilitative discharges from a hospital that reported having a rehabilitative sub-provider in the hospital's ~~2016~~ 2018 Medicare Cost Report, are assessed a rate of $0 for each discharge from the rehabilitative sub-provider as reported in the ~~2016~~ 2018 Medicare Cost Report. All discharges other than those reported as discharges from the rehabilitative sub-provider are assessed at the rate required by subsection (B).

F. Notwithstanding subsection (B), for any hospital that reported more than 24,000~~23,400~~ discharges on the hospital's ~~2016~~ 2018 Medicare Cost Report, discharges in excess of 24,000~~23,400~~ are assessed a rate of ~~$63.25~~$61.50 for each discharge in excess of 24,000~~23,400~~ . The initial 24,000~~23,400~~ discharges are assessed at the rate required by subsection (B).

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

~~G.~~**H.** Assessment notice. On or before the 15th day of the first month of the quarter or upon CMS approval, whichever is later, the Administration shall send to each hospital a notification that the assessment invoice is available to be viewed on a secure website. The invoice shall include the hospital's peer group assignment and the assessment due for the quarter.

~~H.~~**I.** Assessment due date. The assessment must be received by the Administration no later than:

1. The 15th day of the second month of the quarter or
2. In the event CMS approves the assessment after the 15th day of the first month of the quarter, 30 days after notification by the Administration that the assessment invoice is available.

~~I.~~**J.** Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's ~~2016~~ 2018 Medicare Cost Report and Provider & Facility Database for Arizona Medical Facilities posted by the

Arizona Department of Health Services Division of Licensing Services on its website for ~~April 1, 2019~~January 2, 2020:

1. Hospitals owned and operated by the state, the United States, or an Indian tribe.
2. Hospitals designated as type: hospital, subtype: short-term that have a license number beginning "SH".
3. Hospitals designated as type: hospital, subtype: psychiatric that reported fewer than 2,500 discharges on the ~~2016~~ 2018 Medicare Cost Report.
4. Hospitals designated as type: hospital, subtype; rehabilitation.
5. Hospitals designated as type: hospital, subtype: children's.
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 ~~2016~~ 2018 Medicare Cost Report are reimbursed by Medicare.
8. Hospitals designated as type: hospital, subtype: short-term that have at least 25 percent Medicare swing beds as percentage of total Medicare days~~80 percent Medicare discharges~~, per the ~~2016~~ 2018 Medicare Cost Report.

~~J.~~**K.** New hospitals. For hospitals that did not file a ~~2016~~ 2018 Medicare Cost Report because of the date the hospital began operations:

1. If the hospital was open on the January 2~~March 1~~ preceding the July assessment start date, the hospital assessment will begin on July 1 following the date the hospital began operating.
2. If the hospital began operating between January 3~~March 2~~ and June 30, the assessment will begin on July 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~~March~~ 31 preceding the July 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~~April~~ 15 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~~March~~ 31;
5. For purposes of calculating subpart 4, if a new hospital shares a Medicare Identification Number with an existing hospital, the assessment amount will be based on self-reported data from the new hospital instead of the Medicare Cost Report. The data shall include the number of discharges and all other data requested

by the Administration necessary to determine the appropriate assessment.

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

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

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

~~K.~~**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.

~~L.~~**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.

~~M.~~**N.** Required information for the inpatient assessment. For any hospital that has not filed a ~~2016~~ 2018 Medicare Cost report, or if the ~~2016~~ 2018 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the inpatient assessment, the Administration shall use data reported on the ~~2016~~ 2018 Uniform Accounting Report filed by the hospital in place of the ~~2016~~ 2018 Medicare Cost report to calculate the assessment. If the ~~2016~~ 2018 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the inpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the ~~2016~~ 2018 Medicare Cost report to calculate the assessment.

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

~~N.~~**P.** 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.

~~O.~~**Q.** Enforcement. If a hospital does not comply with this section, the director may suspend or revoke the hospital's provider agreement. If the hospital does not comply within 180 days after the hospital's provider agreement is suspended or revoked, the director shall notify the director of the Department of Health Services who shall suspend or revoke the hospital's license.