NOTICE OF PROPOSED EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

PREAMBLE

1. Permission to proceed with this final rulemaking was granted under A.R.S. § 41-1039 by the governor on:

May 16, 2025

2. Article, Part, or Section Affected (as applicable) **Rulemaking Action**

R9-22-730 Amend

3. 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

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

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

Not applicable

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

Name: Sladjana Kuzmanovic

Title: Sr. Rules Analyst

Division: AHCCCS Office of the General Counsel

Address: 150 N. 18th Avenue

Phoenix, AZ 85007

Telephone: (602) 417-4116

Fax: (602) 253-9115

Email: AHCCCSRules@azahcccs.gov

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

Rulemaking for the Hospital Assessment was initially approved under Executive Order 2012-03, and this regulation was subsequently revised in April 2015 and each year thereafter. This rulemaking will continue the practice of modifying the regulation by adjusting the per-discharge assessments and net patient outpatient revenue contributions from various hospital types, effective with invoices issued on October 15, 2025. Under A.R.S. § 36-2901.08, the Administration is responsible for administering and collecting hospital assessments to fund the non-federal share of costs for eligible individuals enrolled under A.R.S. § 36-2901.01 (Proposition 204 population) and A.R.S. § 36-2901.07 (adults with incomes between 106% and 138% of the Federal Poverty Level).

The proposed rulemaking aligns with federal regulation 42 C.F.R. 433.68, which includes a hold harmless provision. Under Arizona's current agreement with the federal government (the State Plan), the state is required to maintain this coverage unless the plan is amended. The Hospital Assessment serves as a funding mechanism for individuals covered under Proposition 204, including those in federally mandated groups such as the elderly, blind, disabled, and certain parents. Without approval from the Centers for Medicare & Medicaid Services, Arizona would not receive federal funding to support healthcare coverage for these populations. Failure to secure funding could lead to a significant loss of health coverage for Arizona residents or require hospitals to contribute more than necessary to the assessment.

7. 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:

Administration did not review or rely on any study for this rulemaking.

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

Not applicable

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

The AHCCCS program is jointly funded by the state and the federal government through the Medicaid program. Depending on the eligibility category of the individual, the federal government provides between two-thirds and 100% of the cost of care for persons described in A.R.S. § 36.2901.08(A). The Administration will use the amounts collected from the assessment combined with the federal financial participation to fund the cost of health care coverage for nearly 700,000 persons described in A.R.S. § 36.2901.08(A) through direct payments to health care providers and capitation payments to managed care organizations that, in turn, make payments to health care providers that render care to AHCCCS members. Many of these providers are small businesses located in Arizona. A.R.S. § 36-2901.08 prohibits the assessed hospitals from passing the cost of the assessment on to patients or third parties who pay for care in the hospital.

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

Name:	Sladjana Kuzmanovic
Title:	Sr. Rules Analyst
Division:	AHCCCS Office of the General Counsel
Address:	150 N. 18th Avenue
	Phoenix, AZ 85007
Telephone:	(602) 417-4116
Fax:	(602) 253-9115
Email:	AHCCCSRules@azahcccs.gov
Website:	www.azahcccs.gov

11. 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:

Per A.R.S. § 41-1013(4), this notice is being published in the *Register* for public review.

A person shall send comments to the person listed under Item #5.

A public hearing is scheduled on this proposed exempt rulemaking.

Date: September 15, 2025

Time: 2:00 p.m.

Location: Virtual - Teams Meeting

Meeting ID: 290 858 355 625 0

Passcode: 5kP6d366

or

Dial in by phone - (480) 561-5941

Conf. ID: 531677604#

Nature: Public Hearing

Public comment period ends: September 15, 2025 at 5:00 p.m.

Close of record: September 15, 2025 at 5:00 p.m.

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:

There are no other matters prescribed by statute applicable specifically to the Administration or this specific rulemaking.

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 the issuance of a regulatory permit. Therefore, a general permit is 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:

The rules are 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:

Not applicable

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

Not applicable

14. 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. Health Assessment Fund - Hospital Assessment

R9-22-730. Hospital Assessment Fund - Hospital Assessment

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

1. "~~2022~~2023 Medicare Cost Report" means: The Medicare Cost Report for the hospital fiscal year ending in calendar year ~~2022~~2023 as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated ~~October 7, 2023~~January 5, 2025.
2. "~~2022~~2023Uniform Accounting Report" means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of ~~January 8~~December 15, 2024 for the hospital's fiscal year ending in calendar year ~~2022~~2023.
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, 2024~~1, 2025.
5. "Outpatient Net Patient Revenues" means an amount, calculated using data in the hospital's ~~2022~~2023 Uniform Accounting Report or other data sources specified by subsection (N), that is equal to the hospital's ~~2022~~2023 total net patient revenue multiplied by the ratio of the hospital's ~~2022~~2023 gross outpatient revenue to the hospital's ~~2022~~2023 total gross patient revenue.

B. Beginning January 1, 2014, for each Arizona licensed hospital not excluded under subsection (~~I~~L) 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), (G), (H) and (I). For the period beginning October 1, ~~2024~~2025, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital's ~~2022~~2023 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. ~~$993.50~~$628.25 per discharge and ~~1.4871%~~1.0634% 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. ~~$993.50~~$628.25 per discharge and ~~0.6196%~~0.4431% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
3. ~~$248.50~~$157.25 per discharge and ~~0.6196%~~0.4431% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
4. ~~$248.50~~$157.25 per discharge and ~~0.6196%~~0.4431% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the ~~2022~~2023 Medicare Cost Report.
5. ~~$794.75~~$502.75 per discharge and ~~1.6110%~~1.1520% 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 ~~2022~~2023 Uniform Accounting Report.
6. ~~$894.00~~$565.50 per discharge and ~~1.8588%~~1.3292% 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 ~~2022~~2023 Uniform Accounting Report.
7. ~~$198.75~~$125.75 per discharge and ~~0.4957%~~0.3545% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.

8. ~~$993.50~~$628.25 per discharge and ~~2.4785%~~1.7723% 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, 2024~~1, 2025.

D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's ~~2022~~2023 Medicare Cost Report, are assessed a rate of ~~$248.50~~$157.25 for each discharge from the psychiatric sub-provider as reported in the ~~2022~~2023 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 ~~2022~~2023 Medicare Cost Report, are assessed a rate of $0 for each discharge from the rehabilitative sub-provider as reported in the ~~2022~~2023 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 22,800 discharges on the hospital's ~~2022~~2023 Medicare Cost Report, discharges in excess of 22,800 are assessed a rate of ~~$99.50~~$63.00 for each discharge in excess of 22,800. The initial 22,800 discharges are assessed at the rate required by subsection (B).

G. Notwithstanding subsection (B), for any hospital that reported pediatric outpatient net patient revenues greater than $375,000,000 on the hospital's 2023 Uniform Accounting Report, pediatric outpatient net patient revenues greater than $375,000,000 are assessed a rate of .0354% for pediatric outpatient net patient revenues greater than $375,000,000 from a hospital designated as subtype children's. The initial $375,000,000 of pediatric outpatient net patient revenues are assessed at the rate required by subsection (B).

H. Notwithstanding subsection (B), for any short- term hospital 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 2023 Uniform Accounting Report that reported outpatient net patient revenues greater than $375,000,000 on the hospital's 2023 Uniform Accounting Report, outpatient net patient revenues greater than $375,000,000 are assessed a rate of .1329% for outpatient net patient revenues greater than $375,000,000 from a short- term hospital 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 2023 Uniform Accounting Report. The initial $375,000,000 of outpatient net patient revenues are assessed at the rate required by subsection (B).

I. Notwithstanding subsection (B), for any short- term hospital not included in another peer group that reported outpatient net patient revenues greater than $375,000,000 on the hospital's 2023 Uniform Accounting Report, outpatient net patient revenues greater than $375,000,000 are assessed a rate of .1772% for outpatient net patient revenues greater than $375,000,000 from a short- term hospital not included in another peer group. The initial $375,000,000 of outpatient net patient revenues are assessed at the rate required by subsection (B).

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

~~H~~K. Assessment due date. The Hospital Assessment Fund assessment must be received by the Administration no later than:

1. The 15th day of the second month of the quarter, or

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

~~H~~**L.** Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's ~~2022~~2023 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, 2024~~1, 2025:

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 ~~2022~~2023 Medicare Cost Report.
4. Hospitals designated as type: hospital, subtype; rehabilitation.
5. Hospitals designated as type: ~~med-~~hospital, subtype: special hospitals, not including subtype: children's.
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 ~~2022~~2023 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 ~~2022~~2023 Medicare Cost Report.
8. Hospitals designated as type: hospital, subtype: short-term that are an urban public acute care hospital.

~~J~~**M.** New hospitals. For hospitals that did not file a ~~2022~~2023 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 September 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 (~~H~~L)(3) apply to the assessment amount.

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

~~K~~**N.** 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 Section 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~~**O.** 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~~**P.** Required information for the inpatient assessment. For any hospital that has not filed a ~~2022~~2023 Medicare Cost report, or if the ~~2022~~2023 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 ~~2022~~2023 Uniform Accounting Report filed by the hospital in place of the ~~2022~~2023 Medicare Cost report to calculate the assessment. If the ~~2022~~2023 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 ~~2022~~2023 Medicare Cost report to calculate the assessment.

~~N~~**Q.** Required information for the outpatient assessment. For any hospital that has not filed a ~~2022~~2023 Uniform Accounting Report, if the ~~2022~~2023 Uniform Accounting Report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, or if the ~~2022~~2023 Uniform Accounting Report does not reconcile to ~~2022~~2023 Audited Financial Statements, the Administration shall use the data reported on ~~2022~~2023 Audited Financial Statements to calculate the outpatient assessment. If the ~~2022~~2023 Audited Financial Statements do not include the reliable information sufficient for the Administration to calculate the outpatient assessment, the Administration shall use data reported on the ~~2022~~2023 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 ~~2022~~2023 Medicare Cost report to calculate the outpatient assessment.

~~O~~**R.** 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 A.R.S. § 36-2901.08.

~~P~~**S.** 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.