NF Assess Amend 2
Public Comments

Numb:	Date/ Commentor:	Comment:	Response:
1.	04/14/14 Kathleen Pagels AZ Health Care Association	R9-28-702 Add to C2 "as of October 1st of the assessment year".	The Administration states in rule that information can be received by November 1st under subsection D7. It is not necessary to repeat under this rule. November 1st was selected to allow time to acquire and review information and determine if more information is necessary. The later date provides greater flexibility in time to amend or clarify information submitted.
2.	04/14/14 Kathleen Pagels AZ Health Care Association	R9-28-702 Add a C6 "out of state skilled nursing providers".	R9-28-702 C provides the list of providers exempt from the assessment. The Administration does not have authority to assess out of state nursing facilities, therefore, it is not necessary to add this to rule.
3.	04/14/14 Kathleen Pagels AZ Health Care Association	R9-28-702 Comment to D5: We question whether CMS guidance indicates a new waiver is required for annual slope recalculation, but are ok with annual slope recalculation.	Whether CMS approval is required is outside the scope of this rulemaking.
4.	04/14/14 Kathleen Pagels AZ Health Care Association	R9-28-703 Add to A1: Dispute section- Suggested or Sample language "Any facility whose AHCCCS utilization percentage (Medicaid Claims Paid divided by Total Claims Paid) varies from the UAR Utilization percentage (Reported Days divided by total Reported Days) from the UAR) by more than 1 standard deviation from the Mean is considered an outlier. The calculation for percentage variance is as follows: 1. Absolute Value([AHCCCS Medicaid Utilization %] - [UAR Medicaid Utilization %]) 2. Calculate +/- 1 Standard Deviations of part #1 3. Identify each facility that falls outside of 1 standard deviation from	The payment calculation uses a consistent set of data where every provider receives a proportional payment based on that single set of consistent data. To introduce supplemental data for a select number of providers unfairly disadvantages other providers who will receive a smaller proportional payment, and may lead to ongoing submission of data from other facilities and significant delays in the calculation of the payment. In addition, the proposed process would make it difficult for the Administration to comply with the quarterly payment timeline. The State Plan approved by the federal government requires that we use adjudicated claims and encounters for the supplemental payment. A dispute resolution process is in place to address concerns.

		the mean. These would be considered an outlier. If a facility has been deemed an outlier then they should be contacted by AHCCCS and given the opportunity (30 days from the date of contact to provide paid claims data to AHCCCS, supporting their Medicaid/ALTCS days. Support would be documentation such as Remittance Advice, EFT, Check etc... that can be directly tied to a specific patient. If the facility can prove their information is accurate then AHCCCS should allow the facility to use these proven days in the supplement calculation. Any days supported over and above the claims paid number should be included in the supplementation calculation. If the facility decides not to provide the data or cannot provide the data then AHCCCS will use the paid claims percentage. When AHCCCS receives the facility information they have (30 days from the date of receipt)o analyze and then contact the facility with their discrepancies. At that time the facility has (10 days from the date of contact) to either agree with the AHCCCS determination or provide additional data. "	
5.	04/14/14 Kathleen Pagels AZ Health Care Association	R9-28-703 Revise D2: strike D2 and add… "In the event a nursing facility begins operation during the assessment year, that facility shall not receive a supplemental payment until such time as the facility has submitted to the Arizona Department of Health Services the report required by R9-11-204(A) covering a full year of operation"	A.R.S 36-2999.55 does not authorize limiting payments to nursing facilities that have filed a UAR for a full year.