

NOTICE OF FINAL 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:

June 18, 2024

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. The effective date of the rule:

This rule shall become effective on October 1, 2024. Agency has selected this date to comply with deadlines and amendments to an agency's governing statute and federal programs.

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

Notice of Rulemaking Docket Opening: 30 A.A.R. 2554, Issue Date: August 9, 2024, Issue Number: 32, File number: R24-148

Notice of Proposed Rulemaking: 30 A.A.R. 2539, Issue Date: August 9, 2024, Issue Number: 32, File number: R24-146

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

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

Pursuant to A.R.S. § 36-2901.08, AHCCCS is required to adopt rules that establish, administer and collect an assessment on hospital revenues. This rulemaking will amend rates paid by hospitals under the Hospital Assessment authorized by A.R.S. § 36-2901.08

for the fiscal year beginning October 1, 2024. 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. Several modifications to A.A.C. R9-22-730 are proposed, including but not limited to, updating the figures for the assessment to be imposed on hospitals for the period beginning October 1, 2024, incorporating hospitals that were licensed during Calendar Year 2023 into the assessment, and updating the data sources.

Without the revisions to the current rule, the State may be underfunded during Federal Fiscal Year 2025 for coverage of persons described in A.R.S. § 36-2901.01 (the Proposition 204 population) and in A.R.S. § 36-2901.07 (adults with incomes between 106% and 138% FPL). Equally important, amendments to the rule are necessary to ensure that the assessment complies with the federally required hold harmless provision. Proposed rulemaking complies with the federal regulation 42 C.F.R. 433.68, setting forth the hold harmless provision. Under its current agreement with the federal government (the State Plan), Arizona is obligated to provide this coverage unless and until the State Plan is amended. The Hospital Assessment provides a funding source for certain persons described in the voter-protected Proposition 204 who are also in federally mandated coverage categories, such as persons who are elderly, blind, or have disabilities, and certain parents. Without an approval of the assessment by Centers for Medicare & Medicaid Services, Arizona is not entitled to any federal financial participation to support health care coverage if these individuals are not covered. Ultimately, a failure to fund this coverage may result in a substantial number of Arizona citizens losing health coverage or the Administration collecting more for the assessment from the hospitals than is necessary.

8. 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:

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

9. 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

10. A 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.

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>

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

There are no changes between the proposed rulemaking and the final rulemaking.

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

There were no public or stakeholder comments made about the rulemaking.

13. 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 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:

Not applicable

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

Not applicable

15. 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:

Not applicable

16. The full text of the rules follows:

TITLE 9. HELTH SERVICES
CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINEMNT SYSTEM - ADMINISTRATION
ARTICLE 7. STANDARDS FOR PAYMENTS

Section

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

ARTICLE 7. STANDARDS FOR PAYMENTS

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. “~~20222021~~ Medicare Cost Report” means:
The Medicare Cost Report for the hospital fiscal year ending in calendar year ~~20222021~~ as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated October ~~7+8, 20232022~~.
 2. “~~20222021~~ Uniform Accounting Report” means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of ~~January 8 November 23, 20242022~~ for the hospital’s fiscal year ending in calendar year ~~20222021~~.
 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, ~~20242023~~.
 5. “Outpatient Net Patient Revenues” means an amount, calculated using data in the hospital’s ~~20222021~~ Uniform Accounting Report or other data sources specified by subsection (N), that is equal to the hospital’s ~~20222021~~ total net patient revenue multiplied by the ratio of the hospital’s ~~20222021~~ gross outpatient revenue to the hospital’s ~~20222021~~ 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 October 1, ~~20242023~~, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital’s ~~20222021~~ 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. ~~\$993.50927.75~~ per discharge and ~~1.48711.4726~~% 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. ~~\$993.50927.75~~ per discharge and ~~0.61960.6136~~% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
 3. ~~\$248.50232.00~~ per discharge and ~~0.61960.6136~~% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
 4. ~~\$248.50232.00~~ per discharge and ~~0.61960.6136~~% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the ~~20222021~~ Medicare Cost Report.
 5. ~~\$794.75742.25~~ per discharge and ~~1.61101.5953~~% 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 ~~20222021~~ Uniform Accounting Report.
 6. ~~\$894.00835.00~~ per discharge and ~~1.85881.8408~~% 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 ~~20222021~~ Uniform Accounting Report.

7. ~~\$198,75185.75~~ per discharge and ~~0.495704999%~~ of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.
 8. ~~\$993,50927.75~~ per discharge and ~~2.478524544%~~ 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~~2023.
- D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's ~~2022~~2021 Medicare Cost Report, are assessed a rate of ~~\$248,50232.00~~ for each discharge from the psychiatric sub-provider as reported in the ~~2022~~2021 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~~2021 Medicare Cost Report, are assessed a rate of \$0 for each discharge from the rehabilitative sub-provider as reported in the ~~2022~~2021 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 ~~22,80023,000~~ discharges on the hospital's ~~2022~~2021 Medicare Cost Report, discharges in excess of ~~22,80023,000~~ are assessed a rate of ~~\$99,5093.00~~ for each discharge in excess of ~~22,80023,000~~. The initial ~~22,80023,000~~ discharges are assessed at the rate required by subsection (B).
- G. 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. 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.
- I. Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's ~~2022~~2021 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~~2023:
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~~2021 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 ~~2022~~2021 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~~2021 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 ~~2022~~2021 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~~ 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.
- K.** 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.** 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.** Required information for the inpatient assessment. For any hospital that has not filed a ~~2022~~2021 Medicare Cost report, or if the ~~2022~~2021 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~~2021 Uniform Accounting Report filed by the hospital in place of the ~~2022~~2021 Medicare Cost report to calculate the assessment. If the ~~2022~~2021 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 ~~20222021~~ Medicare Cost report to calculate the assessment.

- N. Required information for the outpatient assessment. For any hospital that has not filed a ~~20222021~~ Uniform Accounting Report, if the ~~20222021~~ Uniform Accounting Report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, or if the ~~20222021~~ Uniform Accounting Report does not reconcile to ~~20222021~~ Audited Financial Statements, the Administration shall use the data reported on ~~20222021~~ Audited Financial Statements to calculate the outpatient assessment. If the ~~20222021~~ 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 ~~20222021~~ 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 ~~20222021~~ Medicare Cost report to calculate the outpatient assessment.
- O. 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.
- 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.