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**

R9-22-731 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. § 36-2999.72

Implementing statute: A.R.S. § 36-2999.72

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. 2555, Issue Date: August 9, 2024, Issue Number: 32, File number: R24-149

Notice of Proposed Rulemaking: 30 A.A.R. 2543, Issue Date: August 9, 2024, Issue Number: 32, File number: R24-147

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

Name: Sladjana Kuzmanovic

Title: Sr. Rules Analyst

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Phoenix, AZ 85034

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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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking: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 Pursuant to A.R.S. § 36-2999.72, 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 HCIF Assessment authorized by A.R.S.

§ 36-2999.72 for the time period beginning October 1, 2024. Pursuant to A.R.S. § 36-2999.73, monies from the HCIF assessment are used to: fund directed payments by AHCCCS health plans to hospitals pursuant to 42 CFR § 438.6(c) to persons eligible for Title XIX services, increase base reimbursement for services reimbursed under the dental fee schedule and physician fee schedule, and to pay for the non-federal share of the costs for AHCCCS expenses to administer this program, not to exceed one percent of the total assessment monies collected.

Without the revisions to the current rule, HCIF may be underfunded and the State may not be able to sufficiently fund the HEALTHII directed payments and/or practitioner rate increases. In addition, new hospitals will not be assessed and will not be eligible to receive HEALTHII directed payments.

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 The Health Care Investment Fund hospital assessment established in A.R.S. § 36-2999.72 is matched by federal funds. The majority of the assessment funds and accompanying federal funds will be used to provide an increase for base reimbursement for services reimbursed under the dental fee schedule and physician fee schedule and for quarterly directed payments to Arizona hospitals. Many of the providers of that medical care are considered small businesses located in Arizona. A.R.S. §36-2999.72 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:

Name and Position of Commenter	Date of Comment	Text of Comment	AHCCCS Response
Jennifer Carusetta, Vice President, Public Affairs & Advocacy, Phoenix Children's	September 9, 2024	On behalf of Phoenix Children's, thank you for the opportunity to provide comment	Hello Ms Carusetta, Your comment has been received. AHCCCS

Hospital		in response to the Notice of Proposed Rulemaking for the FY '25 HEALTHII Program. We appreciate the engagement and consideration from both the Governor and AHCCCS throughout the development of the methodology and their collective commitment to continue in partnership going forward. As noted in previous correspondence, Phoenix Children's is transforming from a free-standing children's hospital to a comprehensive system of care for Arizona's youngest patients. This transformation will result in a shift of existing utilization from our partner hospitals to two new Phoenix Children's inpatient facilities. During our initial discussions regarding the proposed '25 methodology, we proposed a modification to the model to "reconcile" this planned shift of utilization between hospital pools. In light of the state budget shortfall, we agreed to suspend this proposal for two years in favor of contributing HEALTHII dollars to support the sustainability of behavioral health services for the AHCCCS	thanks Phoenix Children's for their support of this rulemaking. AHCCCS Team

		population. We look forward to the opportunity to engage in continued dialogue with the Agency, and with other hospital stakeholders to achieve consensus on how to achieve greater equity in the HEALTHII methodology beginning in 2027. We would also reiterate our commitment to lend our expertise to engage in a dialogue on how to best implement a model for outcome-based performance metrics in Arizona. We recognize this is an important priority for the Agency and look forward to this important discussion. Please feel free to contact me if I can answer any questions or provide additional assistance.	

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

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-731. HEALTH CARE INVESTMENT FUND - HOSPITAL ASSESSMENT

A. For purposes of this Section, terms are the same as defined in A.A.C. R9-22-730 ~~as provided below~~ unless the context specifically requires another meaning~~:~~.

B. Beginning October 1, 2024~~2023~~, 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, 2024~~2023~~, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital's 2022~~2021~~ 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. $510.25~~245.50~~ per discharge and 4.1707~~3.5063~~% 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. $510.25~~245.50~~ per discharge and 1.7378~~1.4610~~% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
3. $127.75~~61.50~~ per discharge and 1.7378~~1.4610~~% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
4. $127.75~~61.50~~ per discharge and 1.7378~~1.4610~~% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2022~~2021~~ Medicare Cost Report.
5. $408.25~~196.50~~ per discharge and 4.5182~~3.7985~~% 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~~2021~~ Uniform Accounting Report.
6. $459.25~~221.00~~ per discharge and 5.2133~~4.3829~~% 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~~2021~~ Uniform Accounting Report.
7. $102.25~~49.25~~ per discharge and 1.3902~~1.1688~~% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.
8. $510.25~~245.50~~ per discharge and 6.9511~~5.8439~~% 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 $127.75~~61.50~~ 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 20222~~2021~~ Medicare Cost Report, are assessed a rate of $0 for each discharge from the rehabilitative sub-provider as reported in the 20222~~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 22,800~~23,000~~ discharges on the hospital's 20222~~2021~~ Medicare Cost Report, discharges in excess of 22,800~~23,000~~ are assessed a rate of $51.25~~24.75~~ for each discharge in excess of 22,800~~23,000~~. The initial 22,800~~23,000~~ discharges are assessed at the rate required by subsection (B).

G. Assessment notice. On or before the 10th 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. Assessment due date. The assessment must be received by the Administration no later than the 10th day of the second month of the quarter.

I. Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's 20222~~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, 20242~~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 20222~~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 20222~~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 20222~~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 20222~~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 20222~~2021~~ Medicare Cost report, or if the 20222~~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 20222~~2021~~ Uniform Accounting Report filed by the hospital in place of the 20222~~2021~~ Medicare Cost report to calculate the assessment. If the 20222~~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 20222~~2021~~ Medicare Cost report to calculate the assessment.

N. Required information for the outpatient assessment. For any hospital that has not filed a 20222~~2021~~ Uniform Accounting Report, if the 20222~~2021~~ Uniform Accounting Report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, or if the 20222~~2021~~ Uniform Accounting Report does not reconcile to 20222~~2021~~ Audited Financial Statements, the Administration shall use the data reported on 20222~~2021~~ Audited Financial Statements to calculate the outpatient assessment. If the 20222~~2021~~ 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 20222~~2021~~ 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 20222~~2021~~ Medicare Cost report to calculate the outpatient assessment.

O. 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.