

NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

[R05-188]

Editor's Note: The Office has incorporated into this rulemaking package a replacement page filed by the agency per R1-1-109.

PREAMBLE

1. Sections Affected

R9-22-107
R9-22-701
R9-22-701
R9-22-712
R9-22-712.10
R9-22-712.15
R9-22-712.20
R9-22-712.25
R9-22-712.30
R9-22-712.35
R9-22-712.40
R9-22-712.45
R9-22-712.50

Rulemaking Action

Repeal
Repeal
New Section
Amend
New Section
New Section

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 36-2903, 36-2903.01, and 36-2904

Implementing statute: A.R.S. § 36-2903.01

3. The effective date of the rules:

July 1, 2005

4. A list of all previous notices appearing in the *Register* addressing the exempt rule:

Notice of Rulemaking Docket Opening: 10 A.A.R. 1894, May 7, 2004

Notice of Rulemaking Docket Opening: 10 A.A.R. 3761, September 10, 2004

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte

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Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

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6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from regular rulemaking procedures:

These rules have been finalized to implement provisions of Senate Bill 1410 (Arizona Laws 2004, Second Regular Session, Chapter 279, Section 3).

The rule language has been amended in R9-22-712, which pertains to general provisions for AHCCCS fee schedule for inpatient and outpatient hospital services. R9-22-712(A) and (B) contain revised language, and sections (C) through (J) have been relettered. For example, the language in R9-22-712(J) is currently found in the *Arizona Administrative Code* under R9-22-712(B). The new-language sections R9-22-712.10 through R9-22-712.50 added the changes required in SB 1410.

These rules are exempt from the Arizona Procedures Act as directed by the Legislative Second Regular Session 2004, SB 1410, Chapter 279, Section 18.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule 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:

AHCCCS Administration hired consultants EP&P to develop the methodology and calculation of the fee schedule rates. AHCCCS Administration has worked with the major stakeholders (hospitals and contractors) throughout the process and finalization of the rules and fee schedule rates.

You can contact the AHCCCS Administration to review reports related to the fee schedule rates.

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

Not applicable

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

The implementation of the outpatient fee schedule will result in AHCCCS Administration reimbursing hospitals for covered outpatient services (when AHCCCS is the primary payor) at an estimated six percent higher than the current reimbursement for those services in the aggregate.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

Not applicable

11. A summary of the comments made regarding the rule and the agency response to them:

None received

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

13. Incorporations by reference and their location in the rules:

None

14. Was this rule previously made as an emergency rule? If so, please indicate the Register citation:

No.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section

R9-22-107. ~~Standard for Payments Related Definitions~~ Repealed

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

~~R9-22-701. Scope of the Administration's Liability~~ Repealed

R9-22-701. Standard for Payments Related Definitions

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- R9-22-712. Payments by the Administration for Hospital Services Reimbursement: General
R9-22-712.10. Outpatient Hospital Reimbursement: General
R9-22-712.15. Outpatient Hospital Reimbursement: Affected Hospitals
R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule
R9-22-712.25. Outpatient Hospital Fee Schedule Calculations: Associated Service Costs for ER and Surgery Services
R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule
R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees
R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update
R9-22-712.45. Outpatient Hospital Reimbursement: Outpatient Payment Restrictions
R9-22-712.50. Outpatient Hospital Reimbursement: Billing

ARTICLE 1. DEFINITIONS

R9-22-107. ~~Standard for Payments Related Definitions Repealed~~

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Accommodation” means bed and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is semi-private except when the member must be isolated for medical reasons. Other types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which bed and board are provided.

“Aggregate” means the combined amount of hospital payments for covered services provided within and outside the service area.

“AHCCCS inpatient hospital day or days of care” means each day of an inpatient stay for a member, beginning with the day of admission, including the day of death, but excluding the day of discharge, provided that all medical necessity and medical review requirements are met.

“Ancillary department” means the department of a hospital that provides ancillary services and outpatient services, as defined in the Medicare provider Reimbursement Manual.

“Billed charges” means charges that a hospital includes on a claim for providing hospital services to a member consistent with the rates and charges filed by the hospital with the Arizona Department of Health Services.

“Capital costs” means capital-related costs, as defined in the Medicare provider Reimbursement Manual, Chapter 28, such as building and fixtures, and movable equipment.

“Copayment” means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.

“Cost to charge ratio” means a hospital’s costs for providing covered services divided by the hospital’s covered charges for the same services.

“Covered charges” means billed charges that represent medically necessary, reasonable, and customary items of expense for AHCCCS-covered services that meet medical review criteria of the Administration or contractor.

“CPT” means current procedural terminology, the manual published and updated by the American Medical Association, which is a nationally accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and provides a uniform language to accurately designate medical, surgical, and diagnostic services.

“Date of eligibility posting” means the date a member’s eligibility information is entered into the AHCCCS pre-paid medical management information system (PMMIS).

“DRI inflation factor” means the Data Resources Inc., Health Care Financing Administration hospital input price index for prospective hospital reimbursement, which is published by DRI/McGraw-Hill.

“Encounter” means a record of medical service, submitted by a contractor and processed by AHCCCS, that is rendered by an AHCCCS registered provider to a member who is enrolled with the contractor on the date of service, and for which the contractor incurs financial liability.

“ICU” means the intensive care unit of a hospital.

“Medical education costs” means direct hospital costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, which are defined in the Medicare provider Reimbursement Manual, Chapter 28.

“Medical review” means a review involving clinical judgment of a claim or a request for a service before or after it is paid or rendered to ensure that services provided to a member are medically necessary covered services and that required authorizations are obtained by the provider. The criteria for medical review are established by the Administration or contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

“Medicare claim” means a claim for Medicare covered services for a member with Medicare coverage.

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~~“New hospital” means a hospital for which Medicare Cost Report (Health Care Finance Administration form 2552) data and claim and encounter data are not available for hospital rate development from any owner or operator of the hospital, during either the initial prospective rate year or rebasing.~~

~~“NICU” means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.~~

~~“Operating costs” means an AHCCCS allowable accommodation and ancillary department hospital costs excluding capital and medical education costs.~~

~~“Outlier” means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described in R9-22-712.~~

~~“Outpatient hospital service” means a service provided in an outpatient hospital setting that does not result in an admission.~~

~~“Ownership change” means a change in a hospital’s owner, lessor, or operator under 42 CFR 489.18(A).~~

~~“Peer group” means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services.~~

~~“PPC” means prior period coverage. PPC is the period of time, prior to the member’s enrollment, during which a member is eligible for covered services. The time frame is the first day of the month of application or the first eligible month, whichever is later, to the day a member is enrolled with a contractor.~~

~~“Prospective rates” means inpatient or outpatient hospital rates defined by the Administration in advance of a payment period and representing full payment for covered services excluding any quick pay discounts, slow pay penalties, and first and third party payments regardless of billed charges or individual hospital costs.~~

~~“Prospective rate year” means the period from October 1 of each year to September 30 of the following year, except for the initial prospective rate year, which is between March 1, 1993, and September 30, 1994.~~

~~“Rebasing” means the process by which new Medicare Cost Report data (Health Care Finance Administration form 2552), and AHCCCS claim and encounter data are collected and analyzed to reset periodically the inpatient hospital tiered per diem rates or the outpatient hospital cost to charge ratios.~~

~~“Reinsurance” means a risk-sharing program provided by the Administration to contractors for the reimbursement of certain contract service costs incurred by a member beyond a certain monetary threshold.~~

~~“Remittance advice” means an electronic or paper document submitted to an AHCCCS registered provider by the Administration to explain, as applicable:~~

~~How submitted claims were paid,~~

~~Why submitted claims were denied or adjusted,~~

~~Why submitted claims were pending, and~~

~~How to grieve the Administration’s adverse action according to Article 8 of this Chapter.~~

~~“SDAD” means same day admit and discharge, which is a hospital stay with the admit and discharge occurring on the same calendar day.~~

~~“Tier” means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure or revenue codes, peer group, or NICU classification level, or any combination of these items.~~

~~“Tiered per diem” means a payment structure in which payment is made on a per-day basis depending upon the tier into which an AHCCCS inpatient hospital day of care is assigned.~~

ARTICLE 7. STANDARDS FOR PAYMENTS

~~R9-22-701. Scope of the Administration’s Liability Repealed~~

~~The Administration shall bear no liability for providing covered services to or completing a plan of treatment for any member beyond the date of eligibility termination.~~

~~R9-22-701. Standard for Payments Related Definitions~~

~~In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:~~

~~“Accommodation” means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is semi-private except when the member must be isolated for medical reasons. Other types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which room and board are provided.~~

~~“Aggregate” means the combined amount of hospital payments for covered services provided within and outside the service area.~~

~~“AHCCCS inpatient hospital day or days of care” means each day of an inpatient stay for a member, beginning with the day of admission, including the day of death, but excluding the day of discharge, provided that all eligibility, medical necessity, and medical review requirements are met.~~

~~“Ancillary department” means the department of a hospital that provides outpatient services and ancillary services, as described in the Medicare Provider Reimbursement Manual.~~

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“APC” means the Ambulatory Payment Classification system under 42 CFR Part 419 used by Medicare for grouping clinically and resource similar procedures and services.

“Billed charges” means charges for services provided to a member that a hospital includes on a claim consistent with the rates and charges filed by the hospital with Arizona Department of Health Services (ADHS).

“Capital costs” means capital-related costs such as building and fixtures, and movable equipment as described in the Medicare Provider Reimbursement Manual.

“Cost-to-charge ratio” (CCR) means a hospital’s costs for providing covered services divided by the hospital’s charges for the same services. The CCR is the percentage derived from the cost and charge data for each revenue code provided to AHCCCS by each hospital.

“Covered charges” means billed charges that represent medically necessary, reasonable, and customary items of expense for AHCCCS-covered services that meet medical review criteria of AHCCCS or a contractor.

“Critical Access Hospital” is a hospital certified by Medicare under 42 CFR 485 Subpart F and 42 CFR 440.170(g).

“CPT” means *Current Procedural Terminology*, published and updated by the American Medical Association, which is a nationally accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and provides a uniform language to accurately designate medical, surgical, and diagnostic services.

“Date of eligibility posting” means the date a member’s eligibility information is entered into the AHCCCS Pre-paid Medical Management Information System (PMMIS).

“DRI inflation factor” means Global Insights Prospective Hospital Market Basket.

“Encounter” means a record of a medically related service rendered by an AHCCCS registered provider to an AHCCCS member enrolled with a capitated contractor on the date of service.

“Existing outpatient services” means a service provided by the hospital prior to the hospital filing an increase in its charge master, regardless of whether the service was explicitly described in the hospital charge master before filing the increase, or how the service was described in the charge master before filing the increase.

“Freestanding children’s hospital” means a separately standing hospital dedicated to provide the majority of services to children with at least 120 pediatric beds.

“Global Insights Prospective Hospital Market Basket” means the Global Insights CMS Hospital price index for prospective hospital reimbursement, which is published by Global Insights.

“ICU” means the intensive care unit of a hospital.

“HCPCS” means the Health Care Procedure Coding System, published and updated by Center for Medicare and Medicaid Services (CMS), which is a listing of codes and descriptive terminology used for reporting the provision of physician services, other health care services, other substances, equipment, supplies, or other items used in health care services.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as defined under 45 CFR Part 162, which establishes standards and requirements for the electronic transmission of certain health information by defining codes sets used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

“Level I Trauma Center” means any acute care hospital that is defined under R9-22-2101(F).

“Medical education costs” means direct hospital costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, as described in the Medicare Provider Reimbursement Manual.

“Medical review” means a clinical evaluation of documentation conducted by AHCCCS or a contractor for purposes of prior authorization, concurrent review, post payment review, or medical necessity. The criteria for medical review are established by AHCCCS or a contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

“New hospital” means a hospital for which Medicare Cost Report claim and encounter data are not available for the fiscal year used for initial rate setting or rebasing.

“NICU” means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

“Non-IHS Acute Hospital” means a hospital that is not run by Indian Health Services and is not a freestanding psych hospital, such as an IMD, that is paid via ADHS rates.

“Operating costs” means an AHCCCS allowable accommodation and ancillary department hospital costs excluding capital and medical education costs.

“Outlier” means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described under Article 7 of this Chapter and A.R.S. § 36-2903.01(H)

“Outpatient hospital service” means a service provided in an outpatient hospital setting that does not result in an admission.

“Ownership change” means a change in a hospital’s owner, lessor, or operator under 42 CFR 489.18(A).

“Peer group” means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services, including specialty hospitals that limit the provision of services to specific patient populations, such as rehabilitative patients or children.

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“Procedure code” means the numeric or alphanumeric code listed in the CPT or HCPCS manual by which a procedure or service is identified.

“Prospective rates” means inpatient or outpatient hospital rates defined by AHCCCS in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-party payments regardless of billed charges or individual hospital costs.

“Public hospital” means a hospital that is owned and operated by county, state, or hospital health care district.

“Rebase” means the process by which the most currently available and complete year Medicare Cost Report data and AHCCCS claim and encounter data of the corresponding year, are collected and analyzed to reset the Inpatient Hospital Tiered Per Diem rates, or the Outpatient Hospital Capped Fee For Service Schedule.

“Reinsurance” means a risk-sharing program provided by AHCCCS to contractors for the reimbursement of certain contract service costs incurred by a member beyond a certain monetary threshold.

“Remittance advice” means an electronic or paper document submitted to an AHCCCS registered provider by AHCCCS to explain the disposition of a claim.

“Revenue code” means a numeric code, which identifies a specific accommodation, ancillary service or billing calculation, as defined by the National Uniform Billing committee for UB-92 forms.

“National Standard code sets” means codes that are accepted nationally in accordance with federal requirements under 45 CFR 160 and 45 CFR 164.

“Tier” means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure or revenue codes, peer group, or NICU classification level, or any combination of these items.

“Tiered per diem” means an AHCCCS capped fee schedule in which payment is made on a per-day basis depending upon the tier (or tiers) into which an AHCCCS inpatient hospital day of care is assigned.

R9-22-712. Payments by the Administration for Hospital Services Reimbursement: General

A. Inpatient hospital reimbursement. The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons with admissions on and after March 1, 1993, on a prospective reimbursement basis. The prospective rates shall represent payment in full, excluding quick-pay discounts, slow-pay penalties, noncategorical discounts, and third-party payments for both accommodation and ancillary department services. The rates shall include reimbursement for operating, capital, and medical education costs, as applicable. The Administration shall classify each AHCCCS inpatient hospital day of care into one of several tiers appropriate to the services rendered for payment purposes. The rate for a particular tier is referred to as the tiered per diem rate of reimbursement. Until the time of rebasing, as described in this Section, the number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier or transplant claims or payment to out-of-state hospitals, freestanding psychiatric hospitals, rehabilitation hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.

1. Tier rate data. To calculate the tiered per diem rates for the initial prospective year, the Administration shall use Medicare Cost Reports for Arizona hospitals for fiscal years ending in 1990 and a database consisting of inpatient hospital claims and encounters for each hospital with beginning dates of service for the period November 1, 1990, through October 31, 1991.

a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation for the initial prospective rate year, the Administration shall inflate all the costs to a common point in time as described in subsection (A)(2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than one hospital, the Administration shall allocate the costs to each of the respective hospitals. Hospitals shall submit information to assist the Administration in this allocation.

b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed under A.R.S. § 36-2903.01(J). The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude claims and encounters that fail these edits from the database. The Administration may make adjustments to the data as required to correct errors. The Administration shall also exclude from the database, the following claims and encounters:

- i. Those missing information necessary for the rate calculation;
- ii. Medicare crossovers;
- iii. Those submitted by freestanding psychiatric hospitals, and
- iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.

2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on the sum of the following three components: operating, capital, and medical education. The rate for the operating component shall be a statewide rate for each tier except for the ICU tier which is based on peer groups. The rate for the

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medical education component shall be hospital specific. The rate for the capital component shall be a blend of statewide and hospital-specific values based upon a sliding scale until October 1, 2002. The Administration shall not include the medical education component in the tiered per diem rates if direct medical education payments are made under subsection (A)(12). The Administration shall use the following methodologies to establish the rates for each of these components and to calculate the statewide inpatient cost-to-charge ratio used for payment of outliers and out-of-state hospitals:

- a. ~~Operating component. Using the Medicare Cost Reports and the claim and encounter database, the rate for the operating component shall be computed as follows:~~
 - i. ~~Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with federal regulation, 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.~~
 - ii. ~~Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports have been grouped. The ancillary department cost-to-charge ratios for a particular hospital shall be multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters shall be multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day shall exclude medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1991, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs.~~
 - iii. ~~Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these items. For the ICU tier, claims and encounters shall be further assigned to the urban or rural peer group. The tier rate for NICU Level II shall be calculated as 75% of the NICU Level III tier rate. For claims and encounters assigned to more than one tier, ancillary department costs shall be allocated to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component of the tiered per diem rates, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (A)(6).~~
 - iv. ~~Operating rate calculation. The rate for the operating component for each tier shall be set by dividing total statewide or peer group hospital costs identified in subsection (A)(2)(a) within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.~~
- b. ~~Medical education component:~~
 - i. ~~Calculation of medical education costs and component rate. The Administration shall calculate the rate for the medical education component of the tiered per diem rate on a hospital specific basis by identifying the total direct medical education costs listed on the hospital's Medicare Cost Report. The medical education costs identified for each hospital shall reflect the medical education costs incurred by all the payors for the hospital's services, including AHCCCS. The Administration shall reduce the medical education costs for each hospital by an audit adjustment factor based on available national data and Arizona experience in adjustments to Medicare reimbursable costs. The Administration shall divide the hospital's reduced medical education costs by the hospital's total inpatient days for all patients to yield the rate for the medical education component of the tiered per diem rate. The Administration shall inflate the medical education component to a common point in time, December 31, 1991, using the DRI inflation factor.~~
 - ii. ~~Indexing medical education component to tiers. The Administration shall index the rate for the medical education component for each tier by the relative weighting of that tier's operating component to the operating component of all tiers. The relative weighting factor for each of the hospital's tiers shall be calculated by dividing each tier's operating component rate by the weighted average operating component rate for all tiers. The weighted average operating component rate is calculated by multiplying the operating component rate for each tier by the number of AHCCCS inpatient hospital days of care for each tier. The total of these products is then divided by the total number of AHCCCS inpatient hospital days of care for all tiers. The relative weighting factor for a tier's medical education component is multiplied by the medical education component to determine the medical education component rate for the particular tier.~~
 - iii. ~~New medical education programs. The tiered per diem rates for hospitals with new medical education programs that are not reflected on the Medicare Cost Reports used to establish rates under this Section shall not include a medical education component until the Medicare Cost Reports used in rebasing reflect the costs of~~

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the new medical education programs. New medical education programs may be recognized prior to a rebase year at the discretion of the Director. If a hospital has an existing medical education program that is reflected in its Medicare Cost Report but has added a new medical education program that is not reflected, the hospital's tiered per diem rates shall include a rate for the medical education component that reflects only those medical education costs included in the Medicare Cost Report.

e. **Capital component.**

- i. ~~Structure of the capital component. During the 10-year period beginning with the initial prospective rate year, the rate for the capital component of the tiered per diem rate shall represent a blend of statewide and individual hospital capital costs in accordance with A.R.S. § 36-2903.01(J)(9). After September 30, 2002, the Administration shall combine the rate for the capital component with the rate for the operating component to produce a single statewide rate for the combination of the capital and operating components.~~
- ii. ~~Calculation of statewide capital costs and statewide capital component rate. The capital costs associated with inpatient hospital care shall be calculated in a manner similar to that described for operating costs in subsection (A)(2)(a)(ii). Because of the way costs are reported on the Medicare Cost Report, capital costs are derived by subtracting the costs determined when the ancillary department cost to charge ratios and the accommodation costs per day include only operating costs and medical education costs from the costs determined when the ancillary department cost to charge ratios and accommodation costs per day include capital costs as well as operating costs and medical education costs. The Administration shall inflate the resulting capital costs for each hospital to December 31, 1991, using the DRI inflation factor and shall reduce the capital costs for each hospital by an audit adjustment factor based on available national data and Arizona experience in adjustments to Medicare reimbursable costs. The statewide per day rate for capital costs shall be calculated by dividing the resulting total capital costs for all hospitals by the total AHCCCS inpatient hospital days of care reflected in the claim and encounter database.~~
- iii. ~~Computation of hospital specific capital costs and hospital specific capital component rates. The Administration shall calculate the hospital specific capital costs per day for each hospital by dividing the capital costs identified for each hospital in subsection (A)(2)(e)(ii), as adjusted by the audit factor and inflated to December 31, 1991, by the AHCCCS inpatient hospital days of care for that hospital reflected in the claim and encounter database.~~
- iv. ~~Blending of capital rates. The Administration shall set the rate for the capital component by blending of the statewide and hospital specific capital rates in accordance with the following schedule:~~

PROSPECTIVE RATE YEAR	HOSPITAL SPECIFIC	STATE- WIDE
3/1/93-9/30/94	90%	10%
10/1/94-9/30/95	80%	20%
10/1/95-9/30/96	70%	30%
10/1/96-9/30/97	60%	40%
10/1/97-9/30/98	50%	50%
10/1/98-9/30/99	40%	60%
10/1/99-9/30/00	30%	70%
10/1/00-9/30/01	20%	80%
10/1/01-9/30/02	10%	90%
On and after 10/01/02	0%	100%

- v. ~~Because the rate for the capital component is a blend of the statewide and hospital specific costs, the capital component shall not be further inflated to the mid point of the initial prospective rate year.~~
- vi. ~~Indexing capital component to tiers. The Administration shall index the rate for the capital component for each tier by the relative weighting of that tier's operating component to the operating component of all tiers. The relative weighting factor for each of the hospital's tiers shall be calculated by dividing each tier's operating component rate by the weighted average operating component rate for all tiers. The weighted average operating component rate is calculated by multiplying the operating component rate for each tier by the number of AHCCCS inpatient hospital days of care for each tier. The total of these products is then divided by the total number of AHCCCS inpatient hospital days of care for all tiers. The relative weighting factor for a tier's capital component is multiplied by the capital component to determine the capital component rate for~~

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- the particular tier.
 - d. Statewide inpatient hospital cost-to-charge ratio. The statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, under subsection (A)(6). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (A)(1) and used to determine the initial tiered per diem rates. For each hospital, the covered accommodation days on the claims and encounters shall be multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters shall be multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost to charge ratios for each hospital shall be determined in the same way as described in subsection (A)(2)(a) but shall include costs for operating, capital, and medical education. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.
 - e. Unassigned tiered per diem rates. In the case of a hospital for which no tiered per diem rate is assigned to a tier, the Administration shall pay the statewide rate for the operating component of that tier if the hospital has qualifying claims and encounters subsequent to the base year. The rates for the capital and medical education components of a tiered per diem rate, if applicable, shall be re-weighted for a tier to which no tiered per diem rate is assigned as described in subsections (A)(2)(b) and (A)(2)(c).
- 3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure or revenue codes, peer group, or NICU classification level or a combination of these items:
 - a. Tier hierarchy. Assignment of AHCCCS inpatient hospital days of care to a tier shall follow an ordered, hierarchical processing, as defined on the Hierarchy for Tier Assignment, which is included in subsection (J). Claims for inpatient hospital services must meet medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that is submitted by the hospital. If a hospital changes its designation under Medicare from a rural to an urban hospital, or visa versa, the Administration shall continue to assign claims from that hospital to the rural ICU tiered per diem rate, or visa versa, until the tiered per diem rates are rebased.
 - b. Tier exclusions. The Administration shall not assign or pay AHCCCS inpatient hospital days of care that do not occur during an individual's eligibility period. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital cost-to-charge ratio multiplied by ancillary department and accommodation charges.
 - e. Seven tiers. The following seven tiers shall be in effect until the time of rebasing:
 - i. Maternity. The maternity tier shall be identified by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the AHCCCS inpatient hospital days of care on the claim shall be paid the maternity tiered per diem rate.
 - ii. NICU. The NICU tier shall be identified by a revenue code. For a hospital to qualify for the NICU tiered per diem rate, the hospital must be classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier, those with an NICU revenue code shall be paid at the NICU tiered per diem rate. Any remaining AHCCCS inpatient hospital day or days on the claim not meeting NICU Level II or NICU Level III medical review criteria shall be paid at the nursery tiered per diem rate.
 - iii. ICU. The ICU tier shall be identified by a revenue code. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the ICU tier, those with an ICU revenue code shall be paid at the ICU tiered per diem rate. If there are any AHCCCS inpatient hospital days on the claim without an ICU revenue code, they may be classified as surgery, psychiatric, or routine tiers.
 - iv. Surgery. The surgery tier shall be identified by a revenue code in combination with a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list shall identify minor procedures such as sutures that do not require the same hospital resources as other procedures. A surgery claim may also have AHCCCS inpatient hospital days of care at the ICU tier. AHCCCS shall pay the surgery tier only when the surgery occurs on a date during which the member is eligible.
 - v. Psychiatric. The psychiatric tier shall be identified by either: a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. A claim with AHCCCS inpatient hospital days of care in the psychiatric tier may split only with the ICU tier.
 - vi. Nursery. The nursery tier rate shall be identified by a revenue code. A claim with AHCCCS inpatient hospital days of care in the nursery tier may split only with the NICU tier.

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- vii. Routine. The routine tier shall be identified by particular revenue codes and shall include AHCCCS inpatient hospital days of care that are not otherwise classified into the proceeding tiers or paid in accordance with subsection (A)(11). The routine tier may split only with the ICU tier.
4. Annual update. After the initial prospective rate year and between rebasing years, the Administration shall annually update the inpatient hospital tiered per diem rates in accordance with A.R.S. § 36-2903.01(J)(2) and (J)(9) as follows:
- a. Inflation factor. The rates for the operating and medical education components of the tiered per diem rate shall be inflated to the midpoint of the prospective rate year, using the DRI inflation factor.
 - b. Length of stay adjustment. The rate for the operating component of the tiered per diem rate shall be adjusted for any change in the statewide average length of stay for eligible persons. The change in length of stay shall be computed each year by comparing the average length of stay for each tier based on claims and encounters to the average length of stay for each tier calculated in the previous year. The operating component of the tiered per diem rates shall be adjusted by the percentage change in length of stay. If the length of stay increases for a tier, the rate for the operating component shall be adjusted downward. If the length of stay decreases for a tier, the rate for the operating component shall be adjusted upward. Except for the first annual update of the initial prospective rate year, the Administration shall use claims and encounters that are from the federal fiscal year period beginning two years before the prospective rate year that is being updated. For the annual update for the prospective rate year beginning October 1, 1996, the claims and encounters with beginning dates of service from October 1, 1994, to September 30, 1995 shall be used for making any length of stay adjustment. For the annual update of the initial prospective rate year, the Administration shall use claims and encounters with beginning dates of service from March 1, 1993, to September 30, 1993. The Administration shall subject the claim and encounter data to the same data edits described in subsection (A)(1)(b). Outliers shall be excluded as identified in subsection (A)(6)(a).
 - c. Capital component update. For the capital component of the tiered per diem rate, the Administration shall adjust the hospital specific and statewide average blend described in subsection (A)(2)(c). The Administration shall adjust the hospital specific part of the capital component by using the capital costs from the hospital's subsequent Medicare Cost Report. The Medicare Cost Report used for the first update is FY1991. The percentage change in the capital costs per day, as shown on the hospital's Medicare Cost Report from one year to the next, shall be applied to the hospital specific part of the capital component. The Administration shall recalculate the statewide average part of the capital component based on the percentage change in hospital specific capital costs. The percentage change shall be limited to the initial prospective rate year statewide capital costs increased by the DRI inflation factor. The Administration shall adjust the rate for the capital component of the tiered per diem downward, if after the update, the statewide average rate of the capital component as a percent of the statewide average total tiered per diem rate exceeds the percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered per diem rates for the initial prospective rate year.
5. New Hospitals. The Administration shall calculate the tiered per diem rates for new hospitals differently than the tiered per diem rates for hospitals for which Medicare Cost Reports and claims and encounters were used to establish the tiered per diem rates for the initial prospective rate year or for a rebase year. The tiered per diem rates paid to a new hospital shall be the sum of the operating and capital components. The rate for the operating component for a new hospital shall be the same as the rate for the operating component established in subsection (A)(2)(a). The rate for the capital component for a new hospital shall equal the statewide average rate for the capital component as described in subsection (A)(2)(c)(ii) and shall vary by tier based on an index that represents the statewide relative weight of each tier's operating component to the operating component of all tiers. The tiered per diem rates for new hospitals shall not include a medical education component. The annual update shall be applied to a new hospital's rates for its operating and capital components, except hospital specific capital costs shall not be considered as described in subsection (A)(2)(c)(iii).
6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers in accordance with this Section by multiplying the cover charges on a claim by the statewide inpatient hospital cost to charge ratio.
- a. Outlier criteria. For the initial prospective rate year, the Administration shall set the statewide outlier cost threshold for each tier at the greater of three standard deviations from the statewide mean operating cost per day within the tier, or two standard deviations from the statewide mean operating cost per day across all the tiers. Because hospitals submit charges, rather than costs, on claims and encounters, the Administration sets hospital specific charge thresholds by dividing the statewide outlier cost threshold for each tier by the hospital's inpatient operating cost to charge ratio. If the covered charges per day on a claim or encounter exceed the hospital specific charge threshold for a tier, the claim or encounter shall be considered an outlier. If there are two tiers on a claim or encounter, the Administration shall determine whether the claim or encounter is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying each tier rate by the number of

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- AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital.
- b. Update. The Administration shall update the outlier cost thresholds and outlier charge thresholds for each hospital. The outlier cost thresholds are updated annually by recalculating the standard deviations based on the claims and encounters used for the length of stay adjustment described in subsection (A)(4)(b). The outlier charge thresholds are updated as defined in subsection (A)(6)(a). Claims and encounters exceeding the updated outlier cost thresholds will be excluded for purposes of calculating the change in length of stay. The Administration shall estimate the operating cost of claims and encounters based on the application of an inpatient hospital-specific operating cost to charge ratio.
 7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered organ transplant is performed through the terms of a relevant contract agreement. Pursuant to R9-22-716, if the Administration and a hospital that performs a transplant surgery on an eligible person do not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.
 8. Rebasing. The Administration shall rebase the tiered per diem rates by the prospective rate year beginning October 1, 1998. The rebasing process shall include the following:
 - a. Rebasing data. The Administration shall use a hospital's Medicare Cost Report for a fiscal year ending at least two years before the prospective rate year in which the rebase is to begin. For example, for the rebase year of October 1, 1998, the Medicare Cost Reports would be for hospital fiscal years ending in 1996, or earlier. The Administration shall follow the procedures described in subsection (A)(1)(a) for Medicare Cost Report data, except that costs shall be inflated to December 31 of the fiscal year applicable to the Medicare Cost Report year, and a new audit factor shall be derived by the Administration based on available national and Arizona data. To calculate the rebased tiered per diem rates, the Administration may use the ancillary department or line item cost to charge ratios from the Medicare Cost Report. In addition for each hospital, the Administration shall use a database consisting of inpatient hospital claims and, if appropriate, encounters with beginning dates of service covered by the hospital's respective Medicare Cost Report reporting period. Claims and encounters included in the database will be those available at the time of rebasing that pass the Administration's data quality, reasonableness, and integrity edits described in subsection (A)(1)(b). The Administration shall exclude or adjust the claims or encounters that do not meet the medical review criteria at R9-22-717 and R9-22-209(C).
 - b. Rebasing components. The rebased tiered per diem rates shall include rates for the following two components: operating and capital. The Medical education component shall be included unless direct medical education is reimbursed under subsection (A)(12). The Administration shall follow the methodology described in subsection (A)(2) to establish the rebased rates for each of the components. However, during the rebasing process the Administration shall re-examine the current tier structure and may adopt an alternative structure, hierarchy, or number of tiers if analyses conducted by the Administration indicate that an alternative or alternatives is or are appropriate. The Administration shall add cost containment features at the time of rebasing.
 - c. Rebasing peer groups for the operating component. To rebase the rate for the operating component of the tiered per diem rate, the Administration shall re-analyze whether the operating component shall be peer-grouped according to such factors as geographical location or major teaching versus non-major teaching hospital.
 - d. Rebasing the capital component. The capital component of the tiered per diem rate shall be a blend of statewide and hospital-specific capital costs pursuant to subsection (A)(2)(c). The Administration shall adjust the rate for the capital component of the tiered per diem rate downward if after rebasing the statewide average rate for the capital component as a percent of the statewide average total tiered per diem rate exceeds:
 - i. The percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered per diem rates for the initial prospective rate year; or
 - ii. The most recently available national average percentage of capital costs to total inpatient hospital costs.
 - iii. The adjustment to the rate for the capital component shall be based on the lesser of subsection (i) or (ii).
 - e. Rebasing outliers. Depending on the payment methodology adopted at the time of rebasing, the Administration may not include provisions for payment of outliers.
 - f. Psychiatric and rehabilitation hospitals. At the time of rebasing, the Administration shall re-examine the basis of payment for freestanding rehabilitation and psychiatric hospitals. If the decision is made to continue to reimburse these hospitals according to the methodology described in subsection (A)(10), the Administration shall exclude the claims and encounters from these hospitals that are not paid by the tiered per diem reimbursement system.
 - g. Data required. Beginning with fiscal years ending in 1996, hospitals shall file with the Administration all Medicare-specific schedules of the Medicare Cost Report at the time the Medicare Cost Report is submitted to the Medicare Intermediary as required in A.R.S. § 36-125.04.
 9. Ownership change. A hospital shall not receive a change in any of the components of the hospital's tiered per diem rates upon an ownership change.
 10. Psychiatric and rehabilitation hospitals. The Administration shall pay freestanding psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Department of Health Services and shall pay freestanding

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rehabilitation hospitals the rate for the operating component of the routine tiered per diem rate plus the rates for the capital and medical education components as appropriate or an all-inclusive per diem rate that is negotiated by the Administration.

11. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section as provided by A.R.S. § 36-2903.01(J)(1).
12. Direct medical education payments. Instead of including a direct medical education component in the tiered per diem rates, the Administration may reimburse hospitals directly for the hospital's costs associated with direct medical education. In this case, the Administration shall not continue to calculate direct medical education costs using the methodology described in subsection (A)(2)(b)(i), and shall not update direct medical education payments in accordance with subsection (A)(4).

A. Inpatient and Outpatient Discounts and Penalties. If a claim is pended for additional documentation required under A.R.S. § 36-2903.01(H)(4), the additional days that the claim is pended shall not be used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § 36-2903.01(H)(5).

B. Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons on and after March 1, 1993, at the AHCCCS outpatient hospital cost to charge ratio, multiplied by the covered charges.

1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost to charge ratio on a hospital specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs shall be included in the computation but outpatient medical education costs that are included in the inpatient medical education component shall be excluded. To calculate the outpatient hospital cost to charge ratio for the initial prospective rate year for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in subsections (A)(1)(a) and (A)(1)(b). The Administration shall use the following methodology to establish the outpatient hospital cost to charge ratios:

a. Cost to charge ratios. The Administration shall calculate the costs of the claims and encounters by multiplying the ancillary line item cost to charge ratios by the covered charges for corresponding revenue codes on the claims and encounters for outpatient hospital services. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost to charge ratio for each hospital taking the average of the ancillary line items cost to charge ratios for each revenue code weighted by the covered charges.

b. Cost to charge limit. To comply with federal regulation, 42 CFR 447.325, the Administration may limit cost to charge ratios at 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost to charge ratio.

2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost to charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost to charge ratio for a new hospital until the Administration rebases the outpatient hospital cost to charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in specialty facilities.
4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than 0. The Administration shall not reimburse hospitals for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis, as described in subsection (B), if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation, or other outpatient department. The emergency room, observation, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
5. Rebasing. The Administration shall rebase the outpatient hospital cost to charge ratios at least every one to four years using updated Medicare Cost Reports and claim and encounter data.
6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which represent an aggregate increase in charges of more than 4.7 percent, the hospital specific cost to charge ratio as calculated under subsection (B)(1) through (B)(5) of this section shall be adjusted by applying the following formula:

$$CCR * [1.047 / (1 + \% \text{ increase})]$$

Where "CCR" means the hospital specific cost to charge ratio as calculated under subsections (B)(1) through (B)(5)

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and “% increase” means the aggregate percentage increase in charges for outpatient services shown on the hospital charge master.

“Charge master” means the schedule of rates and charges and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services pursuant to A.R.S. § 36-436.

“Existing outpatient services” means a service provided by the hospital prior to the hospital filing an increase in its charge master, regardless of whether the service was explicitly described in the hospital charge master before filing the increase, or how the service was described in the charge master before filing the increase.

- B.** Inpatient and Outpatient Out-of-State Hospital Payments. AHCCCS shall reimburse out-of-state hospitals for covered inpatient and outpatient services provided to AHCCCS members at the lesser of the negotiated rate or the AHCCCS FFS rate as described under A.R.S. § 36-2903.01 and 9 A.A.C., Chapter 22, Article 7.
- C.** Discounts and penalties. The Administration shall subject all inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, to quick pay discounts and slow pay penalties in accordance with Laws 1992, Ch. 302, § 14, as amended by Laws 1993, 2nd S.S., Ch. 6, § 27; Laws 1995, 1st Special Session, Ch. 5, § 6 and A.R.S. § 36-2903.01(J)(6).
- C.** Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall not withhold access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or its designated representative in performance of the Administration’s utilization control activities. Failure to cooperate may result in denial or non-payment of claims.
- D.** Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall not withhold access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or its designated representative in performance of the Administration’s utilization control activities. Failure to cooperate may result in denial or non-payment of claims.
- D.** Prior authorization. Failure to obtain prior authorization required by R9-22-210 shall be cause for denial or nonpayment of claims.
- E.** Prior authorization. Failure to obtain prior authorization required by R9-22-210 shall be cause for denial or nonpayment of claims.
- E.** Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers to prepayment medical review, or post-payment review or both by the Administration. Post-payment reviews shall be consistent with A.R.S. § 36-2903.01(M) and erroneously paid claims are subject to recoupment. If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more appropriate level of care, which shall be effective on the date when the different level of care was medically appropriate.
- F.** Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers to prepayment medical review, or post-payment review or both by the Administration. Post-payment reviews shall be consistent with A.R.S. § 36-2903.01(O) and erroneously paid claims are subject to recoupment. If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more appropriate level of care, which shall be effective on the date when the different level of care was medically appropriate.
- F.** Claim receipt. The Administration’s date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the claim reference number. Hospital claims will be considered paid on the date indicated on disbursement checks. Denied claims will be considered adjudicated on the date of their denial. Claims that are denied and are resubmitted will receive new date stamps. Claims that are pending for additional supporting documentation from hospitals will receive new date stamps upon receipt of the additional documentation, except as provided under R9-22-717. Claims that pend for additional supporting documentation shall not be counted in the calculation of the quick-pay discounts and slow-pay penalties as described under R9-22-712 (A). For purposes of this subsection, the time-frames for submitting claims and the definition of a clean claim are consistent with A.R.S. § 36-2904.
- G.** Claim receipt. The Administration’s date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the claim reference number. Hospital claims will be considered paid on the date indicated on disbursement checks. Denied claims will be considered adjudicated on the date of their denial. Claims that are denied and are resubmitted will receive new date stamps. Claims that are pending for additional supporting documentation from hospitals will receive new date stamps upon receipt of the additional documentation, except as provided under R9-22-717. Claims that pend for additional supporting documentation shall not be counted in the calculation of the quick pay discounts and slow pay penalties pursuant to R9-22-712 (C). For purposes of this subsection, the time-frames for submitting claims and the definition of a clean claim are consistent with A.R.S. § 36-2904.
- G.** Prior period payments. The Administration shall pay for covered hospital services provided to eligible persons with inpatient hospital admissions and outpatient hospital services before March 1, 1993.
- H.** Out-of-state hospital payments. The Administration shall pay for covered hospital services provided to eligible persons by

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~~out-of-state hospitals at negotiated discounted rates, the statewide average inpatient or outpatient cost-to-charge ratio multiplied by covered charges or, if reasonably and promptly available, the Medicaid rate that is in effect at the time services are provided in the state in which the hospital is located, whichever is lowest.~~

- H.** Inpatient hospital reimbursement. The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons with admissions on and after March 1, 1993, on a prospective reimbursement basis. The prospective rates shall represent payment in full, excluding quick-pay discounts, slow-pay penalties, noncategorical discounts, and third-party payments for both accommodation and ancillary department services. The rates shall include reimbursement for operating, capital, and medical education costs, as applicable. The Administration shall classify each AHCCCS inpatient hospital day of care into one of several tiers appropriate to the services rendered for payment purposes. The rate for a particular tier is referred to as the tiered per diem rate of reimbursement. Until the time of rebasing, as described in this Section, the number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier or transplant claims or payment to out-of-state hospitals, freestanding psychiatric hospitals, rehabilitation hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.
1. Tier rate data. To calculate the tiered per diem rates for the initial prospective year, the Administration shall use Medicare Cost Reports for Arizona hospitals for fiscal years ending in 1990 and a database consisting of inpatient hospital claims and encounters for each hospital with beginning dates of service for the period November 1, 1990, through October 31, 1991.
 - a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation for the initial prospective rate year, the Administration shall inflate all the costs to a common point in time as described in subsection (H)(2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than one hospital, the Administration shall allocate the costs to each of the respective hospitals. Hospitals shall submit information to assist the Administration in this allocation.
 - b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed under A.R.S. § 36-2903.01. The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude claims and encounters that fail these edits from the database. The Administration may make adjustments to the data as required to correct errors. The Administration shall also exclude from the database the following claims and encounters:
 - i. Those missing information necessary for the rate calculation.
 - ii. Medicare crossovers.
 - iii. Those submitted by freestanding psychiatric hospitals, and
 - iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.
 2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on the sum of the following three components: operating, capital, and medical education. The rate for the operating component shall be a statewide rate for each tier except for the ICU tier, which is based on peer groups. The rate for the medical education component shall be hospital-specific. The rate for the capital component shall be a blend of statewide and hospital-specific values based upon a sliding scale until October 1, 2002. The Administration shall not include the medical education component in the tiered per diem rates if direct medical education payments are made under subsection (H)(12). The Administration shall use the following methodologies to establish the rates for each of these components and to calculate the statewide inpatient cost-to-charge ratio used for payment of outliers and out-of-state hospitals.
 - a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the rate for the operating component shall be computed as follows:
 - i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with federal regulation, 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.
 - ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports have been grouped. The ancillary department cost-to-charge ratios for a particular hospital shall be multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters shall be multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The

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- ancillary cost-to-charge ratios and accommodation costs per day shall exclude medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1991, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs.
- iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these items. For the ICU tier, claims and encounters shall be further assigned to the urban or rural peer group. The tier rate for NICU Level II shall be calculated as 75 percent of the NICU Level III tier rate. For claims and encounters assigned to more than one tier, ancillary department costs shall be allocated to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component of the tiered per diem rates, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (H)(6).
 - iv. Operating rate calculation. The rate for the operating component for each tier shall be set by dividing total statewide or peer group hospital costs identified in subsection (H)(2)(a) within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.
- b. Medical education component.
- i. Calculation of medical education costs and component rate. The Administration shall calculate the rate for the medical education component of the tiered per diem rate on a hospital-specific basis by identifying the total direct medical education costs listed on the hospital's Medicare Cost Report. The medical education costs identified for each hospital shall reflect the medical education costs incurred by all the payors for the hospital's services, including AHCCCS. The Administration shall reduce the medical education costs for each hospital by an audit adjustment factor based on available national data and Arizona experience in adjustments to Medicare reimbursable costs. The Administration shall divide the hospital's reduced medical education costs by the hospital's total inpatient days for all patients to yield the rate for the medical education component of the tiered per diem rate. The Administration shall inflate the medical education component to a common point in time, December 31, 1991, using the DRI inflation factor.
 - ii. Indexing medical education component to tiers. The Administration shall index the rate for the medical education component for each tier by the relative weighting of that tier's operating component to the operating component of all tiers. The relative weighting factor for each of the hospital's tiers shall be calculated by dividing each tier's operating component rate by the weighted average operating component rate for all tiers. The weighted average operating component rate is calculated by multiplying the operating component rate for each tier by the number of AHCCCS inpatient hospital days of care for each tier. The total of these products is then divided by the total number of AHCCCS inpatient hospital days of care for all tiers. The relative weighting factor for a tier's medical education component is multiplied by the medical education component to determine the medical education component rate for the particular tier.
 - iii. New medical education programs. The tiered per diem rates for hospitals with new medical education programs that are not reflected on the Medicare Cost Reports used to establish rates under this Section shall not include a medical education component until the Medicare Cost Reports used in rebasing reflect the costs of the new medical education programs. New medical education programs may be recognized prior to a rebase year at the discretion of the Director. If a hospital has an existing medical education program that is reflected in its Medicare Cost Report but has added a new medical education program that is not reflected, the hospital's tiered per diem rates shall include a rate for the medical education component that reflects only those medical education costs included in the Medicare Cost Report.
- c. Capital component.
- i. Structure of the capital component. During the 10-year period beginning with the initial prospective rate year, the rate for the capital component of the tiered per diem rate shall represent a blend of statewide and individual hospital capital costs in accordance with A.R.S. § 36-2903.01. After September 30, 2002, the Administration shall combine the rate for the capital component with the rate for the operating component to produce a single statewide rate for the combination of the capital and operating components.
 - ii. Calculation of statewide capital costs and statewide capital component rate. The capital costs associated with inpatient hospital care shall be calculated in a manner similar to that described for operating costs in subsection (H)(2)(a)(ii). Because of the way costs are reported on the Medicare Cost Report, capital costs are derived by subtracting the costs determined when the ancillary department cost-to-charge ratios and the accommodation costs per day include only operating costs and medical education costs from the costs determined when the ancillary department cost-to-charge ratios and accommodation costs per day include capital costs as well as operating costs and medical education costs. The Administration shall inflate the resulting capital costs for each hospital to December 31, 1991, using the DRI inflation factor and shall reduce the capital costs for each hospital by an audit adjustment factor based on available national data and Arizona experience

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- rience in adjustments to Medicare reimbursable costs. The statewide per day rate for capital costs shall be calculated by dividing the resulting total capital costs for all hospitals by the total AHCCCS inpatient hospital days of care reflected in the claim and encounter database.
- iii. Computation of hospital-specific capital costs and hospital-specific capital component rates. The Administration shall calculate the hospital-specific capital costs per day for each hospital by dividing the capital costs identified for each hospital in subsection (H)(2)(c)(ii), as adjusted by the audit factor and inflated to December 31, 1991, by the AHCCCS inpatient hospital days of care for that hospital reflected in the claim and encounter database.
 - iv. Blending of capital rates. The Administration shall set the rate for the capital component by blending of the statewide and hospital-specific capital rates in accordance with the following schedule:

<u>PROSPECTIVE RATE YEAR</u>	<u>HOSPITAL SPECIFIC</u>	<u>STATEWIDE</u>
<u>3/1/93-9/30/94</u>	<u>90%</u>	<u>10%</u>
<u>10/1/94-9/30/95</u>	<u>80%</u>	<u>20%</u>
<u>10/1/95-9/30/96</u>	<u>70%</u>	<u>30%</u>
<u>10/1/96-9/30/97</u>	<u>60%</u>	<u>40%</u>
<u>10/1/97-9/30/98</u>	<u>50%</u>	<u>50%</u>
<u>10/1/98-9/30/99</u>	<u>40%</u>	<u>60%</u>
<u>10/1/99-9/30/00</u>	<u>30%</u>	<u>70%</u>
<u>10/1/00-9/30/01</u>	<u>20%</u>	<u>80%</u>
<u>10/1/01-9/30/02</u>	<u>10%</u>	<u>90%</u>
<u>On and after</u>	<u>0%</u>	<u>100%</u>
<u>10/01/02</u>		

- v. Because the rate for the capital component is a blend of the statewide and hospital-specific costs, the capital component shall not be further inflated to the mid-point of the initial prospective rate year.
- vi. Indexing capital component to tiers. The Administration shall index the rate for the capital component for each tier by the relative weighting of that tier's operating component to the operating component of all tiers. The relative weighting factor for each of the hospital's tiers shall be calculated by dividing each tier's operating component rate by the weighted average operating component rate for all tiers. The weighted average operating component rate is calculated by multiplying the operating component rate for each tier by the number of AHCCCS inpatient hospital days of care for each tier. The total of these products is then divided by the total number of AHCCCS inpatient hospital days of care for all tiers. The relative weighting factor for a tier's capital component is multiplied by the capital component to determine the capital component rate for the particular tier.
- d. Statewide inpatient hospital cost-to-charge ratio. The statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, under subsection (H)(6). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (H)(1) and used to determine the initial tiered per diem rates. For each hospital, the covered accommodation days on the claims and encounters shall be multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters shall be multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital shall be determined in the same way as described in subsection (H)(2)(a) but shall include costs for operating, capital, and medical education. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.
- e. Unassigned tiered per diem rates. In the case of a hospital for which no tiered per diem rate is assigned to a tier, the Administration shall pay the statewide rate for the operating component of that tier if the hospital has qualifying claims and encounters subsequent to the base year. The rates for the capital and medical education components of a tiered per diem rate, if applicable, shall be re-weighted for a tier to which no tiered per diem rate is assigned as described in subsections (H)(2)(b) and (H)(2)(c).

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3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure or revenue codes, peer group, or NICU classification level or a combination of these items.
 - a. Tier hierarchy. Assignment of AHCCCS inpatient hospital days of care to a tier shall follow an ordered, hierarchical processing, as defined on the Hierarchy for Tier Assignment, which is included in subsection (I). Claims for inpatient hospital services shall meet medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that is submitted by the hospital. If a hospital changes its designation under Medicare from a rural to an urban hospital, or visa versa, the Administration shall continue to assign claims from that hospital to the rural ICU tiered per diem rate, or visa versa, until the tiered per diem rates are rebased.
 - b. Tier exclusions. The Administration shall not assign or pay AHCCCS inpatient hospital days of care that do not occur during an individual's eligibility period. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.
 - c. Seven tiers. The following seven tiers shall be in effect until the time of rebasing:
 - i. Maternity. The maternity tier shall be identified by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the AHCCCS inpatient hospital days of care on the claim shall be paid the maternity tiered per diem rate.
 - ii. NICU. The NICU tier shall be identified by a revenue code. For a hospital to qualify for the NICU tiered per diem rate, the hospital must be classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier, those with an NICU revenue code shall be paid at the NICU tiered per diem rate. Any remaining AHCCCS inpatient hospital day or days on the claim not meeting NICU Level II or NICU Level III medical review criteria shall be paid at the nursery tiered per diem rate.
 - iii. ICU. The ICU tier shall be identified by a revenue code. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the ICU tier, those with an ICU revenue code shall be paid at the ICU tiered per diem rate. If there are any AHCCCS inpatient hospital days on the claim without an ICU revenue code, they may be classified as surgery, psychiatric, or routine tiers.
 - iv. Surgery. The surgery tier shall be identified by a revenue code in combination with a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list shall identify minor procedures such as sutures that do not require the same hospital resources as other procedures. A surgery claim may also have AHCCCS inpatient hospital days of care at the ICU tier. AHCCCS shall pay the surgery tier only when the surgery occurs on a date during which the member is eligible.
 - v. Psychiatric. The psychiatric tier shall be identified by either: a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. A claim with AHCCCS inpatient hospital days of care in the psychiatric tier may split only with the ICU tier.
 - vi. Nursery. The nursery tier rate shall be identified by a revenue code. A claim with AHCCCS inpatient hospital days of care in the nursery tier may split only with the NICU tier.
 - vii. Routine. The routine tier shall be identified by particular revenue codes and shall include AHCCCS inpatient hospital days of care that are not otherwise classified into the proceeding tiers or paid in accordance with subsection (H)(11). The routine tier may split only with the ICU tier.
4. Annual update. After the initial prospective rate year and between rebasing years, the Administration shall annually update the inpatient hospital tiered per diem rates in accordance with A.R.S. § 36-2903.01 as follows:
 - a. Inflation factor. The rates for the operating and medical education components of the tiered per diem rate shall be inflated to the midpoint of the prospective rate year, using the DRI inflation factor.
 - b. Length of stay adjustment. The rate for the operating component of the tiered per diem rate shall be adjusted for any change in the statewide average length of stay for eligible persons. The change in length of stay shall be computed each year by comparing the average length of stay for each tier based on claims and encounters to the average length of stay for each tier calculated in the previous year. The operating component of the tiered per diem rates shall be adjusted by the percentage change in length of stay. If the length of stay increases for a tier, the rate for the operating component shall be adjusted downward. If the length of stay decreases for a tier, the rate for the operating component shall be adjusted upward. Except for the first annual update of the initial prospective rate year, the Administration shall use claims and encounters that are from the federal fiscal year period beginning two years before the prospective rate year that is being updated. For the annual update for the prospective rate year beginning October 1, 1996, the claims and encounters with beginning dates of service from October 1, 1994, to September 30, 1995 shall be used for making any length of stay adjustment. For the annual update of the initial prospective rate year, the Administration shall use claims and encounters with beginning dates of service

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- from March 1, 1993, to September 30, 1993. The Administration shall subject the claim and encounter data to the same data edits described in subsection (H)(1)(b). Outliers shall be excluded as identified in subsection (H)(6)(a).
- c. Capital component update. For the capital component of the tiered per diem rate, the Administration shall adjust the hospital-specific and statewide average blend described in subsection (H)(2)(c). The Administration shall adjust the hospital-specific part of the capital component by using the capital costs from the hospital's subsequent Medicare Cost Report. The Medicare Cost Report used for the first update is FY1991. The percentage change in the capital costs per day, as shown on the hospital's Medicare Cost Report from one year to the next, shall be applied to the hospital-specific part of the capital component. The Administration shall recalculate the statewide average part of the capital component based on the percentage change in hospital-specific capital costs. The percentage change shall be limited to the initial prospective rate year statewide capital costs increased by the DRI inflation factor. The Administration shall adjust the rate for the capital component of the tiered per diem downward, if after the update, the statewide average rate of the capital component as a percent of the statewide average total tiered per diem rate exceeds the percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered per diem rates for the initial prospective rate year.
 5. New Hospitals. The Administration shall calculate the tiered per diem rates for new hospitals differently than the tiered per diem rates for hospitals for which Medicare Cost Reports and claims and encounters were used to establish the tiered per diem rates for the initial prospective rate year or for a rebase year. The tiered per diem rates paid to a new hospital shall be the sum of the operating and capital components. The rate for the operating component for a new hospital shall be the same as the rate for the operating component established in subsection (H)(2)(a). The rate for the capital component for a new hospital shall equal the statewide average rate for the capital component as described in subsection (H)(2)(c)(ii) and shall vary by tier based on an index that represents the statewide relative weight of each tier's operating component to the operating component of all tiers. The tiered per diem rates for new hospitals shall not include a medical education component. The annual update shall be applied to a new hospital's rates for its operating and capital components, except hospital-specific capital costs shall not be considered as described in subsection (H)(2)(c)(iii).
 6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers in accordance with this Section by multiplying the cover charges on a claim by the statewide inpatient hospital cost-to-charge ratio.
 - a. Outlier criteria. For the initial prospective rate year, the Administration shall set the statewide outlier cost threshold for each tier at the greater of three standard deviations from the statewide mean operating cost per day within the tier, or two standard deviations from the statewide mean operating cost per day across all the tiers. Because hospitals submit charges, rather than costs, on claims and encounters, the Administration sets hospital-specific charge thresholds by dividing the statewide outlier cost threshold for each tier by the hospital's inpatient operating cost-to-charge ratio. If the covered charges per day on a claim or encounter exceed the hospital-specific charge threshold for a tier, the claim or encounter shall be considered an outlier. If there are two tiers on a claim or encounter, the Administration shall determine whether the claim or encounter is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying each tier rate by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital.
 - b. Update. The Administration shall update the outlier cost thresholds and outlier charge thresholds for each hospital. The outlier cost thresholds are updated annually by recalculating the standard deviations based on the claims and encounters used for the length-of-stay adjustment described in subsection (H)(4)(b). The outlier charge thresholds are updated as defined in subsection (H)(6)(a). Claims and encounters exceeding the updated outlier cost thresholds will be excluded for purposes of calculating the change in length-of-stay. The Administration shall estimate the operating cost of claims and encounters based on the application of an inpatient hospital-specific operating cost-to-charge ratio.
 7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered organ transplant is performed through the terms of a relevant contract agreement. As described under R9-22-716, if the Administration and a hospital that performs a transplant surgery on an eligible person do not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.
 8. Rebasing. The Administration shall rebase the tiered per diem rates by the prospective rate year beginning October 1, 1998. The rebasing process shall include the following:
 - a. Rebasing data. The Administration shall use a hospital's Medicare Cost Report for a fiscal year ending at least two years before the prospective rate year in which the rebase is to begin. For example, for the rebase year of October 1, 1998, the Medicare Cost Reports would be for hospital fiscal years ending in 1996, or earlier. The Administration shall follow the procedures described in subsection (H)(1)(a) for Medicare Cost Report data, except that costs shall be inflated to December 31 of the fiscal year applicable to the Medicare Cost Report year.

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and a new audit factor shall be derived by the Administration based on available national and Arizona data. To calculate the rebased tiered per diem rates, the Administration may use the ancillary department or line item cost-to-charge ratios from the Medicare Cost Report. In addition for each hospital, the Administration shall use a database consisting of inpatient hospital claims and, if appropriate, encounters with beginning dates of service covered by the hospital's respective Medicare Cost Report reporting period. Claims and encounters included in the database will be those available at the time of rebasing that pass the Administration's data quality, reasonableness, and integrity edits described in subsection (H)(1)(b). The Administration shall exclude or adjust the claims or encounters that do not meet the medical review criteria at R9-22-717 and R9-22-209(C).

- b. Rebasing components. The rebased tiered per diem rates shall include rates for the following two components: operating and capital. The Medical education component shall be included unless direct medical education is reimbursed under subsection (H)(12). The Administration shall follow the methodology described in subsection (H)(2) to establish the rebased rates for each of the components. However, during the rebasing process the Administration shall re-examine the current tier structure and may adopt an alternative structure, hierarchy, or number of tiers if analyses conducted by the Administration indicate that an alternative or alternatives is or are appropriate. The Administration shall add cost containment features at the time of rebasing.
 - c. Rebasing peer groups for the operating component. To rebase the rate for the operating component of the tiered per diem rate, the Administration shall re-analyze whether the operating component shall be peer grouped according to such factors as geographical location or major teaching versus non-major teaching hospital.
 - d. Rebasing the capital component. The capital component of the tiered per diem rate shall be a blend of statewide and hospital-specific capital costs as described under subsection (H)(2)(c). The Administration shall adjust the rate for the capital component of the tiered per diem rate downward if after rebasing the statewide average rate for the capital component as a percent of the statewide average total tiered per diem rate exceeds:
 - i. The percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered per diem rates for the initial prospective rate year; or
 - ii. The most recently available national average percentage of capital costs to total inpatient hospital costs.
 - iii. The adjustment to the rate for the capital component shall be based on the lesser of subsection (i) or (ii).
 - e. Rebasing outliers. Depending on the payment methodology adopted at the time of rebasing, the Administration may not include provisions for payment of outliers.
 - f. Psychiatric and rehabilitation hospitals. At the time of rebasing, the Administration shall re-examine the basis of payment for freestanding rehabilitation and psychiatric hospitals. If the decision is made to continue to reimburse these hospitals according to the methodology described in subsection (H)(10), the Administration shall exclude the claims and encounters from these hospitals that are not paid by the tiered per diem reimbursement system.
 - g. Data required. Beginning with fiscal years ending in 1996, hospitals shall file with the Administration all Medicare-specific schedules of the Medicare Cost Report at the time the Medicare Cost Report is submitted to the Medicare Intermediary as required in A.R.S. § 36-125.04.
9. Ownership change. A hospital shall not receive a change in any of the components of the hospital's tiered per diem rates upon an ownership change.
10. Psychiatric and rehabilitation hospitals. The Administration shall pay freestanding psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Department of Health Services and shall pay freestanding rehabilitation hospitals the rate for the operating component of the routine tiered per diem rate plus the rates for the capital and medical education components as appropriate or an all-inclusive per diem rate that is negotiated by the Administration.
11. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section as provided by A.R.S. § 36-2903.01.
12. Direct medical education payments. Instead of including a direct medical education component in the tiered per diem rates, the Administration may reimburse hospitals directly for the hospital's costs associated with direct medical education. In this case, the Administration shall not continue to calculate direct medical education costs using the methodology described in subsection (H)(2)(b)(i), and shall not update direct medical education payments in accordance with subsection (H)(4).
- I. Prior period payments. The Administration shall pay for covered hospital services, provided to eligible persons with inpatient hospital admissions and outpatient hospital services before March 1, 1993, pursuant to R9-22-706.
- I. Hierarchy For Tier Assignment.

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<u>TIER</u>	<u>IDENTIFICATION CRITERIA</u>	<u>ALLOWED SPLITS</u>
<u>MATERNITY</u>	<u>A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx.</u>	<u>None</u>
<u>NICU</u>	<u>Revenue Code of 175 for DOS before 10/1/95 AND the provider has a Level II or Level III NICU, or Revenue Code of 174 for DOS on, or after 10/1/95 AND the provider has a Level II or Level III NICU.</u>	<u>Nursery</u>
<u>ICU</u>	<u>Revenue Codes of 200-204, 207-212, or 219.</u>	<u>Surgery Psychiatric Routine</u>
<u>SURGERY</u>	<u>Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list.</u>	<u>ICU</u>
<u>PSYCHIATRIC</u>	<u>Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx - 316.xx, classify as a psychiatric claim.</u>	<u>ICU</u>
<u>NURSERY</u>	<u>Revenue Code of 17x, not equal to 175 or 174.</u>	<u>NICU</u>
<u>ROUTINE</u>	<u>Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.</u>	<u>ICU</u>

J. Hierarchy For Tier Assignment:

<u>TIER</u>	<u>IDENTIFICATION CRITERIA</u>	<u>ALLOWED SPLITS</u>
<u>MATERNITY</u>	<u>A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx.</u>	<u>None</u>
<u>NICU</u>	<u>Revenue Code of 175 for DOS before 10/1/95 AND the provider has a Level II or Level III NICU, or Revenue Code of 174 for DOS on, or after 10/1/95 AND the provider has a Level II or Level III NICU.</u>	<u>Nursery</u>
<u>ICU</u>	<u>Revenue Codes of 200-204, 207-212, or 219.</u>	<u>Surgery Psychiatric Routine</u>
<u>SURGERY</u>	<u>Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list.</u>	<u>ICU</u>
<u>PSYCHIATRIC</u>	<u>Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx - 316.xx, classify as a psychiatric claim.</u>	<u>ICU</u>
<u>NURSERY</u>	<u>Revenue Code of 17x, not equal to 175 or 174.</u>	<u>NICU</u>
<u>ROUTINE</u>	<u>Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.</u>	<u>ICU</u>

J. Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons with dates of service on and after March 1, 1993 through June 30, 2005, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the covered charges.

1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs shall be included in the computation but outpatient medical education costs that are included in the inpatient medical education component shall be excluded. To calculate the outpatient hospital cost-to-charge ratio for the initial prospective rate year for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified

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in subsections (H)(1)(a) and (H)(1)(b). The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:

- a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters for outpatient hospital services. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
- b. Cost-to-charge limit. To comply with federal regulation, 42 CFR 447.325, the Administration may limit cost-to-charge ratios at 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in specialty facilities.
4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than 0. The Administration shall not reimburse hospitals for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis, as described in subsection (J), if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation, or other outpatient department. The emergency room, observation, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every one to four years using updated Medicare Cost Reports and claim and encounter data.
6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which represent an aggregate increase in charges of more than 4.7 percent, the hospital-specific cost-to-charge ratio as calculated under subsection (J)(1) through (J)(5) of this Section shall be adjusted by applying the following formula:

$$\text{CCR} * [1.047 / (1 + \% \text{ increase})]$$

Where "CCR" means the hospital-specific cost-to-charge ratio as calculated under subsection (J)(1) through (J)(5) of this Section and "% increase" means the aggregate percentage increase in charges for outpatient services shown on the hospital charge master.

"Charge master" means the schedule of rates and charges and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services as described under A.R.S. § 36-436.

"Existing outpatient services" means a service provided by the hospital prior to the hospital filing an increase in its charge master, regardless of whether the service was explicitly described in the hospital charge master before filing the increase, or how the service was described in the charge master before filing the increase.

R9-22-712.10. Outpatient Hospital Reimbursement: General

- A.** Effective rule. The outpatient hospital reimbursement rules apply to dates of service beginning July 1, 2005, subject to Laws 2004, Ch. 279, § 19.
- B.** Basis For Payment. Except as provided under R9-22-712.30, AHCCCS shall pay for designated outpatient procedures provided to AHCCCS members according to the AHCCCS Outpatient Capped Fee-For-Service Schedule as defined in R9-22-712.20.
- C.** Data. AHCCCS shall use Medicare Cost Report and adjudicated claim and encounter data from non-IHS acute care hospitals located in the state of Arizona to develop fees for the AHCCCS Outpatient Capped Fee-For-Service Schedule.
- D.** Hospital Services Subject To Fees. AHCCCS shall reimburse services, in the following outpatient hospital categories under the AHCCCS Outpatient Capped Fee-For-Service Schedule:
 1. Surgery.
 2. Emergency Department.
 3. Laboratory.
 4. Radiology.

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5. Clinic, and
6. Other services.
- E. Reimbursement. AHCCCS shall reimburse outpatient hospital services by procedure codes, in proper combination with revenue codes, as prescribed by AHCCCS.

R9-22-712.15. Outpatient Hospital Reimbursement: Affected Hospitals

Except as provided in R9-22-712(G), the AHCCCS Outpatient Capped Fee-For-Service Schedule shall apply to AHCCCS payments for outpatient services in all non-IHS acute hospitals.

R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule

To establish the AHCCCS Outpatient Capped Fee-For-Service Schedule, AHCCCS shall:

1. Define the dataset of claims and encounters that shall be used to establish the AHCCCS Outpatient Capped Fee-For-Service Schedule.
2. Identify all the claims and encounters from non-IHS acute hospitals located in Arizona for services that shall be paid under the AHCCCS Outpatient Capped Fee-For-Service Schedule.
3. Match the revenue code on each detail of each claim and encounter to the ancillary line item CCR as reported on hospital-specific mapping documents and hospital-specific Medicare Cost Report for those hospitals that have submitted Medicare Cost Reports FYE 2002.
4. Multiply the line item CCR from subsection (3) by the covered billed charge for that revenue code to establish the cost for the service.
5. Inflate the cost for the service from subsection (4) using Global Insight Health-Care Cost Review inflation factors from date of service month to the midpoint of the rate year in which the fees are initially effective.
6. Include associated costs under R9-22-712.25 to calculate the rates for emergency room and surgery services.
7. Combine data from all Arizona hospitals identified in subsection (3) for each procedure code to establish the statewide median cost for each procedure.
8. Group procedure codes according to the Ambulatory Payment Classification (APC) System groups as listed in 69 FR 65682, November 15, 2004, and establish a statewide median cost for each APC. Multiply each statewide median APC cost by 116 percent to establish the AHCCCS-based fee for each procedure in that specific APC group. AHCCCS shall assign each procedure in the group the same fee.
9. For those procedure codes that are not grouped into any APC, establish a procedure-specific fee using either:
 - a. The AHCCCS Non-hospital Capped Fee-for-Service Fee Schedule;
 - b. 116% of procedure-specific median cost AHCCCS-based fee; or
 - c. The Medicare Clinical Laboratory Fee Schedule for laboratory services.
10. Compare the AHCCCS-based fee established in subsections (8) and (9) against the comparable Medicare fee established for the Medicare APC group as listed in the 69 FR 65682, November 15, 2004. The fee for each procedure shall be the greater of the AHCCCS-based fee or the Medicare fee but no more than 150 percent of the AHCCCS-based fee; however, for those laboratory services for which a limit is established in the Medicare Clinical Laboratory Fee Schedule, the fee shall not exceed that limit.
11. Assign the 2005 Medicare fee in the AHCCCS Outpatient Capped Fee-For-Service Schedule for those procedures for which there are fewer than 20 occurrences of the procedure code in the dataset, either independently, or, if applicable, for all procedure codes within an APC Group.

R9-22-712.25. Outpatient Hospital Fee Schedule Calculations: Associated Service Costs for ER and Surgery Services

- A. AHCCCS shall include the costs of associated services, as defined by revenue codes and procedure codes, when determining the specific fees for the outpatient hospital procedures for emergency department and surgery services.
- B. A complete listing of the revenue codes and procedure codes for associated costs included in the payment for emergency and surgery services is available with the AHCCCS Outpatient Capped Fee-For-Service Schedule on file and online with AHCCCS.

R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule

- A. AHCCCS shall calculate a statewide CCR for a service where a specific fee cannot be determined under R9-22-712.20.
- B. The statewide CCR shall be calculated based on the costs and covered charges associated with a service under subsection (A) for all Arizona hospitals, using the costing method defined in R9-22-712.20 (3).
- C. To determine the payment amount for procedures where a specific fee is not determined under R9-22-712.20, the statewide CCR is multiplied times the covered charges.

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

- A. AHCCCS shall increase the fees established under R9-22-712.20 (except for laboratory services) for the following hospitals submitting any claims:
 1. By 48 percent for public hospitals on July 1, 2005, as well as hospitals that were public in calendar year 2004,

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2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the year in which the rates are effective.
 3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the year in which the rates are effective.
 4. By 92 percent for hospitals designated as Critical Access Hospitals, or for hospitals that have not been designated as Critical Access Hospitals, but meet the criteria.
 5. By 113 percent for a freestanding children's hospital with at least 110 pediatric beds.
 6. By 14 percent for a University Affiliated Hospital defined as those hospitals that have a majority of the member of its board of directors appointed by the Board of Regents.
- B.** In addition to (A) the following increase may be established:
A 50 percent adjustment for a Level 2 and 3 emergency department procedures billed by a level 1 Trauma center as defined by R9-22-2101.
- C.** Fee adjustments in subsection (A) are available with the AHCCCS Outpatient Capped Fee-For Service Schedule on file and online with AHCCCS.

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

- A.** Procedure Codes. AHCCCS shall add new procedure codes for covered outpatient services and shall either assign the default CCR or calculate an appropriate fee when procedure codes are issued by CMS or the Current Procedural Terminology published by the American Medical Association.
- B.** Annual Update For Outpatient Hospital Fee Schedule. Beginning October 1, 2006, AHCCCS shall adjust outpatient fee schedule rates:
1. On an annual basis by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or
 2. In any given year the director may substitute the increases in (B)(1) by calculating the dollar value associated with the inflationary increase in (B)(1), and applying that dollar value to adjust rates at varying levels.
- C.** Rebase. AHCCCS shall rebase the outpatient fees every five years.
- D.** Statewide CCR. The statewide CCR shall be recalculated at the time of rebasing, at which time AHCCCS may consider recalculating the statewide CCR based on the costs and charges for those services excluded from the outpatient hospital fee schedule.

R9-22-712.45. Outpatient Hospital Reimbursement: Outpatient Payment Restrictions

- A.** AHCCCS shall not reimburse hospitals for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis if the member is admitted as an inpatient to the same hospital directly from the emergency room, observation, or other outpatient department.
- B.** AHCCCS shall include payment for the emergency room, observation, and other outpatient hospital services provided to the member before the hospital admission in the AHCCCS Inpatient Tiered Per Diem Capped Fee-For-Service Schedule under Article 7 of this Chapter.
- C.** Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.

R9-22-712.50. Outpatient Hospital Reimbursement: Billing

To receive appropriate reimbursement, hospitals shall:

1. Bill outpatient hospital services on the CMS approved Uniform Billing Form or in electronic format using the appropriate HIPAA transaction.
2. Follow the UB Manual Guidelines, as published by the National Uniform Billing Committee, and use the appropriate revenue code and procedure code combination as prescribed by AHCCCS and on file and online with AHCCCS.