

# NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council or the Attorney General. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Register* after the final rules have been submitted for filing and publication.

## NOTICE OF FINAL RULEMAKING

### TITLE 2. ADMINISTRATION

#### CHAPTER 19. OFFICE OF ADMINISTRATIVE HEARINGS

*Editor's Note: The following Notice of Final Rulemaking was exempt from Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 2046.)*

[R14-104]

#### PREAMBLE

- 1. Article, Part or Section Affected (as applicable):** **Rulemaking Action:**  
R2-19-122 Amend
- 2. Citations to the agency's statutory rulemaking authority to include the authorization statute (general) and the implementing statute (specific):**  
Authorizing Statute: A.R.S. § 41-1092.01(C)(4)  
Implementing Statutes: A.R.S. §§ 41-1092, 41-1092.07(E), 41-1092.11; A.R.S. §§ 12-904, 12-909
- 3. The effective date of the rule:**  
September 8, 2014
- 4. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:**  
Notice of Rulemaking Docket Opening: 20 A.A.R. 613, March 7, 2014  
Notice of Proposed Rulemaking: 20 A.A.R. 565, March 7, 2014
- 5. The agency's contact person who can answer questions about the rulemaking:**  
Name: Cliff J. Vanell  
Address: Office of Administrative Hearings  
1400 W. Washington St., Suite 101  
Phoenix, AZ 85007  
Telephone: (602) 542-9853  
Fax: (602) 542-9859  
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- 6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**  
Prior to July 1, 2013, A.R.S. § 12-904(A) provided for judicial review of an administrative decision by the filing of a complaint with the Superior Court. A.R.S. § 12-904(B) provides that a party file a notice of the action with the Office of Administrative Hearings, and that the Office thereupon transmit the record. In furtherance of A.R.S. § 12-904(A) and (B), R2-19-122 directed parties to file a copy of the complaint filed with the Superior Court with the Office within 10 days of the filing of the complaint. Effective July 1, 2013, A.R.S. § 12-904 substituted "notice of appeal" for "complaint." The Office proposes to amend R2-19-122(A) to substitute "notice of appeal" for "complaint" to conform to the statutory change. The Office also proposes to distinguish an appeal resulting from an administrative hearing held before the Office from that of an agency, board or commission acting as an administrative law judge.  
Additionally, the Office proposes to amend R2-19-122(B) to distinguish a transcript of an appeal resulting from an administrative hearing held before the Office from that of an agency, board or commission acting as an administrative law judge.

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7. **A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**  
Not applicable
8. **A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**  
Not applicable
9. **A summary of the economic, small business, and consumer impact:**  
The economic impact of the amended rule will not differ significantly from that projected in the economic impact statement submitted in December 1998, when the rule was submitted.
10. **A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:**  
No changes
11. **An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:**  
No comments were received.
12. **All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**  
There are no matters prescribed by state applicable to the agency or to any specific rule or class or rules.
  - a. **Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**  
The rule does not require a permit.
  - b. **Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and is so, citation to the statutory authority to exceed the requirements of federal law:**  
No federal law is applicable to the rule.
  - c. **Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**  
No person has submitted an analysis to the agency that compares the rule's impact on the competitiveness of business in this state to the impact on business in other states.
13. **List of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:**  
Not applicable
14. **Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:**  
Not applicable
15. **The full text of the rule follows:**

TITLE 2. ADMINISTRATION

CHAPTER 19. OFFICE OF ADMINISTRATIVE HEARINGS

ARTICLE 1. PREHEARING AND HEARING PROCEDURES

Section

R2-19-122 Notice of Judicial Appeal; Transmitting the Transcript

ARTICLE 1. PREHEARING AND HEARING PROCEDURES

**R2-19-122 Notice of Judicial Appeal; Transmitting the Transcript**

- A. Notification to the Office. Within 10 days of filing a ~~complaint for judicial review of a final administrative decision based on or resulting from a recommended decision of an administrative law judge~~ notice of appeal of an agency action resulting from an administrative hearing before the Office, the party shall file a copy of the ~~complaint~~ notice of appeal with the Office. The Office shall then transmit the record to the Superior Court.
- B. Transcript. A party requesting a transcript of an administrative hearing before the Office shall arrange for transcription at the party's expense. The Office shall make a copy of its audio taped record available to the transcriber. The party arranging

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for transcription shall deliver the transcript, certified by the transcriber under oath to be a true and accurate transcription of the audio taped record, to the Office, together with one unbound copy.

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TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)  
ADMINISTRATION

*Editor's Note: The following Notice of Final Rulemaking was reviewed per Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 2046.) The Governor's Office authorized the notice to proceed through the rulemaking process on August 14, 2013.*

[R14-100]

**PREAMBLE**

- 1. Article, Part, or Section Affected (as applicable)**

R9-22-202	Amend
R9-22-205	Amend
R9-22-209	Amend
R9-22-210	Amend
R9-22-213	Amend
R9-22-215	Amend
- 2. Citations to the agency's statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):**

Authorizing statute: A.R.S. §§ 36-2903.01(E) and (F)  
Implementing statute: A.R.S. § 36-2907
- 3. The effective date of the rule:**

September 6, 2014
- 4. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:**

Notice of Rulemaking Docket Opening: 20 A.A.R. 729, March 21, 2014  
Notice of Proposed Rulemaking: 20 A.A.R. 709, March 21, 2014
- 5. The agency's contact person who can answer questions about the rulemaking:**

Name: Mariaelena Ugarte  
Address: AHCCCS  
701 E. Jefferson St.  
Phoenix, AZ 85034  
Telephone: (602) 417-4693  
Fax: (602) 253-9115  
E-mail: AHCCCSrules@azahcccs.gov  
Web site: www.azahcccs.gov
- 6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**

The Administration must conduct a rulemaking to implement the elements of Arizona Laws 2013, First Special Session, Chapter 10 (House Bill 2010), that relate to changes to covered services regarding well exams, and other cost-effective services. In addition to "clean up" of rules related to scope of services, such as updating cross-references and non-substantive changes to improve clarity. The provisions are necessary to comply with federal or state requirements.
- 7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

A study was not referenced or relied upon when revising the regulations.
- 8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will**

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**diminish a previous grant of authority of a political subdivision of this state:**

Not applicable

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

This rulemaking is estimated to have a minimal economic impact on the implementing agencies and taxpayer of approximately \$850,000 over a one-year timeframe, which assumes a 5% increase is experienced under the physical therapy clarification. The estimated minimal economic impact for the coverage of well visits is for Federal Fiscal Year (FFY) 2014 \$16,450,000 and for FFY 2015 \$21,357,000.

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

No changes were made between the proposed rulemaking and the final rulemaking as a result of public input, with the exception of technical changes, such as R9-22-205(A)(8) where the reference to the exception is made. These changes were made as a result of GRRC review and comments.

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

No comments were received as of the close of the comment period on April 28, 2014.

**12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**

No other matters are applicable.

**a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**

Not applicable

**b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**

These rules are consistent with federal laws under the Affordable Care Act. 42 CFR 440.330 et.seq. and 42 USC 1396u-7.

**c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**

Not applicable

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

None

**14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:**

Not applicable

**15. The full text of the rules follows:**

**TITLE 9. HEALTH SERVICES**

**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)  
ADMINISTRATION**

**ARTICLE 2. SCOPE OF SERVICES**

Section

- R9-22-202. General Requirements
- R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services
- R9-22-209. Pharmaceutical Services
- R9-22-210. Emergency Medical Services for Non-FES Members
- R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)
- R9-22-215. Other Medical Professional Services

**ARTICLE 2. SCOPE OF SERVICES**

**R9-22-202. General Requirements**

A. For the purposes of this Article, the following definitions apply:

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1. "Authorization" means written, verbal, or electronic authorization by:
  - a. The Administration for services rendered to a fee-for-service member, or
  - b. The contractor for services rendered to a prepaid capitated member.
2. Use of the phrase "attending physician" applies only to the fee-for-service population.
- B.** In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:
  1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
  2. Covered services for the federal emergency services program (FESP) are under R9-22-217.
  3. The Administration or a contractor may waive the covered services referral requirements of this Article.
  4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
  5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
  6. A member may receive behavioral health services as specified in Articles 2 and 12.
  7. AHCCCS or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
  8. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
  9. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
    - a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
    - b. Services or items furnished gratuitously, and
    - c. Personal care items except as specified under R9-22-212.
  10. Medical or behavioral health services are not covered services if provided to:
    - a. An inmate of a public institution;
    - b. A person who is in residence at an institution for the treatment of tuberculosis; or
    - c. A person age 21 through 64 who is in an IMD, unless the service is covered under Article 12 of this Chapter.
- C.** The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. The Administration or a contractor shall not provide prior authorization for services unless the provider submits documentation of the medical necessity of the treatment along with the prior authorization request.
- D.** Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.
- E.** Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.
- F.** A service is not a covered service if provided outside the GSA unless one of the following applies:
  1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;
  2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family;
  3. The contractor authorizes placement in a nursing facility located out of the GSA; or
  4. Services are provided during prior period coverage or during the prior quarter coverage.
- G.** If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.
- H.** A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.
- I.** The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care and cost effectiveness.
- J.** The restrictions, limitations, and exclusions in this Article do not apply to the following:
  - ~~1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27, and~~
  - ~~2. A contractor electing to provide noncovered services.~~
    - a. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
    - b. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

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**K.** Subject to CMS approval, the restrictions, limitations, and exclusions specified in the following subsections do not apply to American Indians receiving services through IHS or a tribal health program operating under P.L. 93-638 when those services are eligible for 100 percent federal financial participation:

1. R9-22-205(A)(8),
2. R9-22-205(B)(4)(f),
3. R9-22-206,
4. R9-22-207,
5. R9-22-212(C),
6. R9-22-212(D),
7. R9-22-212(E)(8),
8. R9-22-215(C)(2), and
9. R9-22-215(C)(5).

**R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services**

**A.** A primary care provider, attending physician, or practitioner shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:

1. Periodic health examination and assessment;
2. Evaluation and diagnostic workup;
3. Medically necessary treatment;
4. Prescriptions for medication and medically necessary supplies and equipment;
5. Referral to a specialist or other health care professional if medically necessary;
6. Patient education;
7. Home visits if medically necessary; and
8. ~~Except as provided in subsection (B),~~ preventive health services, such as, well visits, immunizations, colonoscopies, mammograms and PAP smears.

**B.** The following limitations and exclusions apply to attending physician and practitioner services and primary care provider services:

1. Specialty care and other services provided to a member upon referral from a primary care provider, or to a member upon referral from the attending physician or practitioner are limited to the service or condition for which the referral is made, or for which authorization is given by the Administration or a contractor.
2. A member's physical examination is not covered if the sole purpose is to obtain documentation for one or more of the following:
  - a. Qualification for insurance,
  - b. Pre-employment physical evaluation,
  - c. Qualification for sports or physical exercise activities,
  - d. Pilot's examination for the Federal Aviation Administration,
  - e. Disability certification to establish any kind of periodic payments,
  - f. Evaluation to establish third-party liabilities, or
  - g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
3. Orthognathic surgery is covered only for a member who is less than 21 years of age;
4. The following services are excluded from AHCCCS coverage:
  - a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgeries;
  - b. Pregnancy termination counseling services;
  - c. Pregnancy terminations, unless required by state or federal law.
  - d. Services or items furnished solely for cosmetic purposes; and
  - e. Hysterectomies unless determined medically necessary; ~~and~~
  - f. ~~Preventive services not covered are well exams, meaning physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination.~~

**R9-22-209. Pharmaceutical Services**

**A.** An inpatient or outpatient provider, including a hospital, clinic, other appropriately licensed health care facility, and pharmacy may provide covered pharmaceutical services.

**B.** The Administration or a contractor shall require a provider to make pharmaceutical services:

1. Available during customary business hours, and
2. Located within reasonable travel distance of a member's residence.

**C.** Pharmaceutical services are covered if:

1. Prescribed for a member by the member's primary care provider, attending physician, practitioner, or dentist;
2. Prescribed by a specialist upon referral from the primary care provider or attending physician; or

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3. The contractor or its designee authorizes the service.
- D. The following limitations apply to pharmaceutical services:
  1. A medication personally dispensed by a physician, dentist, or a practitioner within the individual's scope of practice is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed.
  2. A new prescription or refill in excess of ~~100-unit doses~~ a 30 day supply is not covered unless. ~~A prescription or refill in excess of a 30 day supply is not covered unless specified in subsection (D)(3).~~
  3. ~~A prescription or refill in excess of a 30 day supply is covered if:~~
    - a. ~~The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit doses, whichever is greater.~~
    - b.a. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 a 90 day supply or 100-unit doses, whichever is greater.; or
    - ~~e. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.~~
    - b. The Contractor authorizes the prescription for an extended time period not to exceed a 90-day supply.
  4. An over-the-counter medication, in place of a covered prescription medication, is covered only if the over-the-counter medication is appropriate, equally effective, safe, and less costly than the covered prescription medication.
- E. A contractor shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well being.

**R9-22-210. Emergency Medical Services for Non-FES Members**

- A. General provisions.
  1. Applicability. This Section applies to emergency medical services for non-FES members. Provisions regarding emergency behavioral health services for non-FES members are in R9-22-210.01. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
  2. Definitions.
    - a. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS or a subcontractor of ADHS/DBHS, ~~or Children's Rehabilitative Services.~~
    - b. For the purposes of this Section and R9-22-210.01, "fiscal agent" means a person who bills and accepts payment for a hospital or emergency room provider.
  3. Verification. A provider of emergency medical services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor.
  4. Prior authorization.
    - a. Emergency medical services. A provider is not required to obtain prior authorization for emergency medical services.
    - b. Non-emergency medical services. If a non-FES member's medical condition does not require emergency medical services, the provider shall obtain prior authorization as required by the terms of the provider agreement under R9-22-714(A) or the provider's subcontract with the contractor, whichever is applicable.
  5. Prohibition against denial of payment. Neither the Administration nor a contractor shall:
    - a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms,
    - b. Deny or limit payment because the provider failed to obtain prior authorization for emergency services,
    - c. Deny or limit payment because the provider does not have a subcontract.
  6. Grounds for denial. The Administration and a contractor may deny payment for emergency medical services for reasons including but not limited to:
    - a. The claim was not a clean claim;
    - b. The claim was not submitted timely; and
    - c. The provider failed to provide timely notification under subsection (B)(4) to the contractor or the Administration, as appropriate, and the contractor does not have actual notice from any other source that the member has presented for services.
- B. Additional requirements for emergency medical services for non-FES members enrolled with a contractor.
  1. Responsible entity. A contractor is responsible for the provision of all emergency medical services to non-FES members enrolled with the contractor.
  2. Prohibition against denial of payment. A contractor shall not limit or deny payment for emergency medical services when an employee of the contractor instructs the member to obtain emergency medical services.
  3. Contractor notification. A contractor shall not deny payment to a hospital, emergency room provider, or fiscal agent for an emergency medical service rendered to a non-FES member based on the failure of the hospital, emergency room provider, or fiscal agent to notify the member's contractor within 10 days from the day that the member presented for the emergency medical service.
  4. Contractor notification. A hospital, emergency room provider, or fiscal agent shall notify the contractor no later than the 11th day after presentation of the non-FES member for emergency inpatient medical services. A contractor may

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deny payment for a hospital's, emergency room provider's, or fiscal agent's failure to provide timely notice, under this subsection.

- C. Post-stabilization services for non-FES members enrolled with a contractor.
1. After the emergency medical condition of a member enrolled with a contractor is stabilized, a provider shall request prior authorization from the contractor for post-stabilization services.
  2. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that have been prior authorized by the contractor.
  3. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor for prior authorization of further post-stabilization services;
  4. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain, improve, or resolve the member's stabilized condition if:
    - a. The contractor does not respond to a request for prior authorization within one hour;
    - b. The contractor authorized to give the prior authorization cannot be contacted; or
    - c. The contractor representative and the treating physician cannot reach an agreement concerning the member's care and the contractor physician is not available for consultation. In this situation, the contractor shall give the treating physician the opportunity to consult with a contractor physician. The treating physician may continue with care of the member until the contractor physician is reached or:
      - i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care,
      - ii. A contractor physician assumes responsibility for the member's care through transfer,
      - iii. The contractor's representative and the treating physician reach agreement concerning the member's care, or
      - iv. The member is discharged.
  5. Transfer or discharge. The attending physician or practitioner actually treating the member for the emergency medical condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor.
- D. Additional requirements for FFS members.
1. Responsible entity. The Administration is responsible for the provision of all emergency medical services to non-FES FFS members.
  2. Grounds for denial. The Administration may deny payment for emergency medical services if a provider fails to provide timely notice to the Administration.
  3. Notification. A provider shall notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

**R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)**

- A. The following E.P.S.D.T. services are covered for a member less than 21 years of age:
1. Screening services including:
    - a. Comprehensive health and developmental history;
    - b. Comprehensive unclothed physical examination;
    - c. Appropriate immunizations according to age and health history;
    - d. Laboratory tests; and
    - e. Health education, including anticipatory guidance;
  2. Vision services including:
    - a. Diagnosis and treatment for defects in vision;
    - b. Eye examinations for the provision of prescriptive lenses; ~~and~~
    - c. Prescriptive lenses; and
    - d. Frames.
  3. Hearing services including:
    - a. Diagnosis and treatment for defects in hearing;
    - b. Testing to determine hearing impairment; and
    - c. Hearing aids;
  4. Dental services including:
    - a. Emergency dental services as specified in R9-22-207;
    - b. Preventive services including screening, diagnosis, and treatment of dental disease; and
    - c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
  5. Orthognathic surgery;
  6. Medically necessary. Nutritional nutritional assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;

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7. Behavioral health services under 9 A.A.C. 22, Article 12;
  8. Hospice services do not include home-delivered meals or services provided and covered through Medicare. The following hospice services are covered:
    - a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
    - b. Services available to a member receiving hospice care are limited to those allowable under 42 CFR 418.202, October 1, 2006, incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments;
    - e. ~~Hospice services do not include:~~
      - i. ~~Medical services provided that are not related to the terminal illness; or~~
      - ii. ~~Home-delivered meals; and~~
    - d. ~~Hospice services that are provided and covered through Medicare are not covered by AHCCCS;~~
  9. Incontinence briefs as specified under R9-22-212; and
  10. Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5).
- B.** Providers of E.P.S.D.T. services shall meet the following standards:
1. Ensure that services are provided by or under the direction of the member's primary care provider, attending physician, practitioner, or dentist.
  2. Perform tests and examinations under 42 CFR 441 Subpart B, October 1, 2006, which is incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments.
  3. Refer a member as necessary for dental diagnosis and treatment and necessary specialty care.
  4. Refer a member as necessary for behavioral health evaluation and treatment services.
- C.** Contractors shall meet other E.P.S.D.T. requirements as specified in contract.
- D.** A primary care provider, attending physician, or practitioner shall refer a member with special health care needs under R9-7-301 to CRS.

**R9-22-215. Other Medical Professional Services**

- A.** The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office:
1. Dialysis;
  2. The following family planning services if provided to delay or prevent pregnancy:
    - a. Medications,
    - b. Supplies,
    - c. Devices, and
    - d. Surgical procedures;
  3. Family planning services are limited to:
    - a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
    - b. Sterilization; and
    - c. Natural family planning education or referral;
  4. Midwifery services provided by a certified nurse practitioner in midwifery;
  5. Midwifery services for low-risk pregnancies and home deliveries provided by a licensed midwife;
  6. Respiratory therapy;
  7. Ambulatory and outpatient surgery facilities services;
  8. Home health services under A.R.S. § 36-2907(D);
  9. Private or special duty nursing services;
  10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
  11. Total parenteral nutrition services, which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract; and
  12. ~~Inpatient chemotherapy;~~ Chemotherapy. ~~and~~
  13. ~~Outpatient chemotherapy.~~
- B.** Prior authorization from the Administration for a member is required for services listed in subsections (A)(3)(b), and (A)(4) through (11); except for:
1. Voluntary sterilization;
  2. Dialysis shunt placement;
  3. Arteriovenous graft placement for dialysis;
  4. Angioplasties or thrombectomies of dialysis shunts;
  5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis;
  6. Eye surgery for the treatment of diabetic retinopathy;

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- 7. Eye surgery for the treatment of glaucoma;
  - 8. Eye surgery for the treatment of macular degeneration;
  - 9. Home health visits following an acute hospitalization (limited up to five visits);
  - 10. Hysteroscopies (up to two, one before and one after) when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization;
  - 11. Physical therapy subject to the limitation in subsection (C);
  - 12. Facility services related to wound debridement;
  - 13. Apnea management and training for premature babies up to the age of 1; and
  - 14. Other services identified by the Administration through the Provider Participation Agreement.
- C. The following are not covered services:
- 1. Occupational and speech therapies provided on an outpatient basis for a member age 21 or older;
  - ~~2. Physical therapy provided only as a maintenance regimen;~~
  - ~~3-2.~~ Abortion counseling;
  - ~~4-3.~~ Services or items furnished solely for cosmetic purposes;
  - ~~5-4.~~ Services provided by a podiatrist; or
  - 6. ~~More than 15 outpatient physical therapy visits per benefit year with the exception of the required Medicare coinsurance and deductible payment as described in 9 A.A.C. 29, Article 3.~~
  - 5. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of restoring a skill or level of function and maintaining that skill or level of function once restored.
  - 6. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of acquiring a new skill or a new level of function and maintaining that skill or level of function once acquired.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

Editor's Note: The following Notice of Final Rulemaking was reviewed per Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 2046.) The Governor's Office authorized the notice to proceed through the rulemaking process on February 26, 2014.

[R14-101]

PREAMBLE

<u>1. Article, Part, or Section Affected (as applicable)</u>	<u>Rulemaking Action:</u>
R9-22-204	Amend
R9-22-701	Amend
R9-22-703	Amend
R9-22-705	Amend
R9-22-708	Amend
R9-22-712	Amend
R9-22-712.01	Amend
R9-22-712.09	Amend
R9-22-712.40	Amend
R9-22-712.45	Amend
R9-22-712.60	New Section
R9-22-712.61	New Section
R9-22-712.62	New Section
R9-22-712.63	New Section
R9-22-712.64	New Section
R9-22-712.65	New Section
R9-22-712.66	New Section
R9-22-712.67	New Section
R9-22-712.68	New Section
R9-22-712.69	New Section
R9-22-712.70	New Section
R9-22-712.71	New Section
R9-22-712.72	New Section
R9-22-712.73	New Section

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R9-22-712.74	New Section
R9-22-712.75	New Section
R9-22-712.76	New Section
R9-22-712.77	New Section
R9-22-712.78	New Section
R9-22-712.79	New Section
R9-22-712.80	New Section
R9-22-712.81	New Section
R9-22-715	Amend
R9-22-718	Amend

**2. Citations to the agency’s statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):**

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

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

**3. The effective date of the rule:**

September 6, 2014

**4. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:**

Notice of Rulemaking Docket Opening: 20 A.A.R. 683, March 14, 2014

Notice of Proposed Rulemaking: 20 A.A.R. 645, March 14, 2014

Notice of Supplemental Proposed Rulemaking: 20 A.A.R. 775 March 28, 2014

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

Name: Mariaelena Ugarte

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701 E. Jefferson St.  
Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

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

Arizona Laws 2013, Chapter 202, section 3, amended A.R.S. 36-2903.01(G)(12) to require the AHCCCS administration to “adopt a diagnosis-related group based hospital reimbursement methodology consistent with title XIX of the social security act for inpatient dates of service on and after October 1, 2014.” The statutory and regulatory provisions of Medicaid (Title XIX of the Social Security Act) provide states significant flexibility with respect to hospital reimbursement methodologies; however, the Medicaid Act, at 42 U.S.C. 1396a(a)(30)(A), requires that the State must adopt payment methodologies “as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”

A diagnosis-related group (DRG) based hospital reimbursement methodology pays a fixed amount on a “per discharge basis.” Under this methodology each claim is assigned to a DRG based on the patient’s diagnoses, surgical procedures performed, age, gender, birth weight, and discharge status. The goal of diagnosis related groups is to classify inpatient stays into categories based on similar clinical conditions and on similar levels of hospital resources required for treatment. These categories are identified using Diagnosis Related Group (DRG) codes each of which is assigned a relative weight appropriate for the relative amount of hospital resources expected to be used to treat the patient.

Consistent with the statutory authority in A.R.S. 36-2903.01(G)(12), the methodology provides for “additional reimbursement for extraordinarily high cost cases that exceed a threshold above the standard payment” referred to as “outlier payments.” In addition, the proposed rule includes “a separate payment methodology for specific services or hospitals serving unique populations.” In general, those exempt services will be reimbursed under a per diem methodology.

While there are several DRG classification systems in use in the national health care delivery system, the AHCCCS Administration has chosen the All Patient Refined DRG (APR-DRG) system of codes and relative weights established and maintained by 3M Health Information Systems. Transitioning to the APR-DRG classification system offers several benefits including superior recognition of the variation in inpatient hospital resources required to treat

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patients, incorporation of patient age into the classification process, facilitation of the measurement of potentially preventable readmissions and complications, enhanced recognition of the resources necessary for high severity patients and of acuity related to specialty hospitals, and reduced occurrences of outlier payments.

In adapting the APR-DRG system to the Arizona health care environment, the Administration, in collaboration with a hospital work group, established several guiding principles, including:

- Cost Effectiveness: whether the methodology aligned with incentives for hospitals to provide cost effective care.
- Access to Care: whether the methodology promotes providing patients with access to quality health care consistent with federal requirements.
- Equity of Payment: whether the methodology appropriately recognizes the varying intensity of resources and other factors for different types of admissions.
- Predictability: whether the methodology provides predictable payments for both hospitals and the state.
- Transparency: whether the methodology can be replicated by hospitals to ensure accurate payment.
- Quality: whether the methodology rewards high value, quality-driven inpatient hospital services.

In addition, the choices reflected in this proposed rule were based other design considerations such as achieving budget neutrality (recognizing that funding is not unlimited, the methodology was designed to be budget-neutral compared to past aggregate reimbursement for these services) and adaptability (whether the methodology facilitates adapting to changes in utilization and future service models).

**7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

Arizona Laws 2013, First Special Session, Chapter 10, section 35 directed the AHCCCS Administration to “establish work groups to study and provide input on the development of the hospital assessment established pursuant to this act. The work groups shall include, at a minimum, representatives from the urban, rural and critical access hospital communities.” The members of the work group and the group’s work products, including the reports of the consultants hired by the AHCCCS Administration, can be found on the agency’s website at:

<http://azahcccs.gov/commercial/ProviderBilling/DRGBasedPayments.aspx>

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

This rulemaking does not diminish a previous grant of authority to any political subdivisions of the state.

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

As part of the decision-making process that informed this rulemaking, AHCCCS engaged the services of a consultant to model the effects of a DRG payment methodology using AHCCCS claims and encounter data for inpatient services provided by in-state and selected out-of-state hospitals for the fiscal year beginning October 1, 2010. In the aggregate, the methodology is expected to have no significant economic impact to the state as the methodology as modeled is budget neutral. The estimated impact to individual hospitals was modeled and included in the report entitled Final Model Version March 2014 found at:

<http://wwwazahcccs.gov/commercial/ProviderBilling/DRGBasedPayments.aspx>

To mitigate the impact on individual hospitals as a result of the transition from a tiered per diem methodology to a DRG methodology, the proposed methodology includes hospital-specific adjustments that are designed to lessen the negative and limit the positive impacts to individual hospitals over a two year transition period. The transition adjustment factors applied to individual hospitals have been selected to limit gains or losses in aggregate payments to hospitals to 33% of modeled changes in aggregate payments to the hospital for discharges for the year beginning October 1, 2014, and 66% for discharges for the year beginning October 1, 2015.

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

After review of the proposed rulemaking, the Administration found that R9-22-712.67 erroneously specified the “DRG National Average” length of stay, rather than the length of stay, in the last portion of the formula used for calculating the transfer DRG base payment. In addition, the Administration inadvertently omitted language, similar to that in outpatient rule R9-22-712.40 that was also intended to be included in the inpatient rules. Therefore, the Administration added to the Notice of Supplemental Proposed Rulemaking the rule R9-22-712.81 which provides the Administration with authority to make adjustments to DRG state-wide standardized amounts, base payments, adjustors, and the fixed loss amounts when necessary to assure that DRG payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. The Administration also clarified R9-22-712.60 to describe that the newer version of 3M may be used.

With the implementation of the APR-DRG payment system, AHCCCS plans to implement v. 31 of the APR-DRG grouper and relative weights developed by 3M for payment of inpatient hospital services effective October 1, 2014. This system represents a nation-wide standard methodology that uses the diagnostic codes on a claim to assign the

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claim to a DRG code, sometimes referred to as a “grouper.” In addition, the system has established a relative weight for each DRG code (grouper) that reflects the level of hospital resources associated with the grouper relative to all other groupers.

Under regulations adopted as part of the Health Insurance Portability and Affordability Act of 1996, health care providers are required to use standard code sets – including a standard code set for diagnoses – when preparing claims. 45 CFR 162.923. Currently, health care providers are required to use the International Classification of Diseases, 9th Edition, Clinical Modifications (ICD-9-CM). While a newer version of that code set exists, on April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which states the federal government may not, prior to October 1, 2015, adopt ICD-10 code sets as the standard for code sets under HIPAA. When precisely ICD-10 will be adopted is unclear. However, once ICD-10-CM is adopted as the standard, hospitals will be prohibited from submitting claims using ICD-9-CM codes. Version 31 of the 3 M APR-DRG classification systems is premised on use of the ICD-9 codes.

Because the ICD-10 code set is radically different from the ICD-9 code set, it is anticipated 3M Health Information Systems will issue a new version of the APR-DRG classification system that will establish new DRG groupers and new relative weights that will be able to accept and process claims using ICD-10 codes (since that will be federally required for health care claims at that time). However, at this time, it is not clear how such a change will impact aggregate payments for inpatient hospital systems. While AHCCCS anticipates rebasing the APR-DRG reimbursement methodology for claims with dates of service on and after October 1, 2017, the agency cannot predict when ICD-10 will be adopted or how 3M Health Information Systems will address the change. For that reason, we have modified the final version of the rule to enable the agency to make adjustments necessary so that aggregate payments for inpatient hospital systems are not materially impacted by the transition to ICD-10.

This modification of the proposed rule does not constitute a substantial change from the proposed rule as contemplated by A.R.S. § 41-1025 because the proposed rule contemplated the use of an APR-DRG classification system compatible with ICD-9. It is not anticipated that this modification to the proposed rule will have any economic impact. In fact, the modification is intended to eliminate any economic impact that may result from adoption of the ICD-10 code set which change is a factor beyond the control of the agency.

In addition, changes have been made as a result of the public comments received and as a result of the Governor’s Council review. Such as cross-references and technical changes made throughout all rules, R9-22-709 was removed from the rule since no changes were required, R9-22-712.64(A) and (B) were revised and reorganized for clarity and R9-22-712.68(C) reworded to clarify when CCR ratios will be provided.

**11. An agency’s summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:**

The following comments were received as of the close of the comment period of April 29, 2014.

<b><u>Numb:</u></b>	<b><u>Date/Com-mentor:</u></b>	<b><u>Comment:</u></b>	<b><u>Response:</u></b>
1.	04/29/14 Tina Meredith Hacienda Health Care	There is a potential negative impact the PRGs will have on Los Niños Hospital. More specifically, the transfer payments. We will always have transfer payment PRGs for every admission since our children are referred from other hospitals that will have used up most if not all the payment days associated.  Can Los Niños Hospital be made an exception?  Is it possible to be allowed to start a new APR-DRG for each admission, excluding us from the transfer PRGs? Health plans will be able to encounter their data using the new methodology but Los Niños Hospital will be compensated for care provided.	Proposed Rule R9-22-712.67(E) states: The hospital the member is transferred to will receive a full DRG payment regardless of the DRG payment made to the transferring hospital.  There is no 25 day inpatient day limit effective with dates of discharge on and after October 1, 2014. Thus there will be no situation in which payment days will be used up. See R9-22-204(B).
2.	04/25/14 Sandy Price IASIS health care	The IASIS facilities fully support the comments from AzHHA concerning the APR-DRG proposed rule A.R.S. 36-2903.01	Noted.

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3.	04/28/14 Greg Vigdor AzHHA	<p>There are some substantial policy changes contained in the proposed rule that were not discussed in DRG Workgroup or by the Legislature when the enabling legislation was vetted and enacted. These include, for example, the readmissions penalty and elimination of the annual inflation factor. We believe these issues warrant additional work and discussion with stakeholders prior to implementation.</p>	<p>The Administration did present policy decisions related to the readmissions penalty made by the Administration in December 17, 2013 at a DRG workgroup. The material can be found at: <a href="http://www.azahc-ccs.gov/commercial/Downloads/PaymentPolicyIssues121713.pdf">http://www.azahc-ccs.gov/commercial/Downloads/PaymentPolicyIssues121713.pdf</a></p> <p>The annual inflation faction is addressed under response to comment 5.</p>
4.	04/28/14 Greg Vigdor AzHHA	<p>Preamble – EIS</p> <p>We recommend that the second sentence include the words “to the state” after the phrase economic impact, to better reflect the intention and impact of the proposed rulemaking.</p> <p>The last paragraph of this section outlines a proposed two-year transition period, which we strongly support. However, the proposed rules do not appear to incorporate this transition period. As such, we request that the two-year transition period be added to the rules to prevent any confusion as to the intent of the AHCCCS Administration.</p>	<p>The Administration agrees to add words “to the state”. Updated preamble.</p> <p>Although the AHCCCS Administration contemplates a 2 year transition period, no specific time period is specified in rule to provide the Agency flexibility. The specific factor used for each hospital will be published on AHCCCS’ website.</p>
5.	04/28/14 Greg Vigdor AzHHA	<p>R9-22-712.76 Interim Claims</p> <p>In some cases, because of extraordinary lengths of stay, hospitals will ask for interim payments. The proposed rate of \$500 prescribed in R9-22-712.76, subsection B, is far below the actual average per-diem reimbursement rate, which based on the March 21, 2014 model developed by AHCCCS, is \$1,341. Based on the model, we suggest the interim claim payment rate be increased from \$500 to \$1,300 per day.</p>	<p>Hospitals submitting interim claims are required to void those claims (resulting in a recoupment of the interim payments) and resubmit a single claim that covers the entire length representing a complete and accurate description of the services rendered which will be reimbursed under the DRG methodology. Payment of interim claims at the average per diem rate will not adequate incentives hospitals to void the interim claims and submit a final claim. In consultation with consultants retained by the Administration, we conclude that a \$500 per diem payment for interim claims addresses the immediate cash flow needs of the hospital and provides the appropriate incentive for the submission of a complete and accurate final claim that will be reimbursed under the DRG methodology.</p>
6.	04/28/14 Greg Vigdor AzHHA	<p>R9-22-712.40 and R9-22-712.81</p> <p>While the Legislature has chosen to suspend inflation funding due to recent budget shortfalls, we do not believe this signals legislative intent to authorize the AHCCCS Administration to permanently eliminate inflation funding moving forward and to replace it with an “access to care standard.” The proposed regulations should include flexibility for updates that are approved through the appropriation process in the normal legislative process.</p>	<p>In Arizona Laws 2012, 2<sup>nd</sup> Regular Session, Chapter 122, Section 7, the Legislature end-dated annual adjustment of tiered per diem payments. It did not suspend inflation. In addition, the legislature did not grant AHCCCS the explicit or implicit authority to provide for an automatic adjustment for inflation of inpatient rates through rule. In the event that the Legislature appropriates additional funds in future fiscal years for this purpose and assuming that an increase is consistent with federal requirements for the establishment of rates that are consistent with efficiency and economy, the Administration will address adjustments as provided for in proposed rule R9-22-712.81 or through future amendments to this rule as necessary. AHCCCS is required to establish a program within its annual appropriation and limit capitation rate increases to no more than 3 percent in fiscal years 2015, 2016, and 2017 (see Arizona Laws 2014 Chapter 11, § 28).</p> <p>The access to care standards are required by federal law 42 USC 1396a(a)(30)(A).</p>

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7.	04/28/14 Greg Vigdor AzHHA	<p>R9-22-712.81 We urge the Administration to include an annual inflation factor in the proposed rulemaking, consistent with prior AHCCCS practices and Medicare, and we propose the following language for R9-22-712.81: <i>“In addition to the other updates provided for in sections R9-22-712.60 through R9-22-712.80 the Administration shall, beginning on October 1, 2015, and every succeeding year adjust the inpatient standard rate by the Global Insight Prospective Hospital Market Basket Inflation Index.”</i></p> <p>Similar language should be added for hospitals that will continue to be paid on a per diem basis, such as rehabilitation, psychiatric and long term acute care hospitals.</p>	See the above response.
8.	04/28/14 Greg Vigdor AzHHA	<p>R9-22-712.40 R9-22-712.40, as amended, and R9-22-712.81, as proposed, would replace a pre-existing statutory inflation factor (the DRI factor developed by Global Insights) with an “access to care” standard.</p> <p>We further urge the Administration, beginning October 1, 2015, to reinstate the annual update in R9-22-712.40 for outpatient payments, and propose the following language for Subsection C: <i>“Annual update for Outpatient Hospital Fee Schedule. Beginning on October 1, 2015 AHCCCS shall adjust outpatient fee schedule rates by the Global Insight Prospective Hospital Market Basket Inflation Index.”</i></p>	<p>The proposed rule R9-22-712.40 does not replace annual inflation for outpatient hospital services. The Administration amended the rule R9-22-712.40 effective July 18, 2012 to end-date the requirement for annual inflation as of September 30, 2011.</p> <p>In Arizona Laws 2012 Chapter 299 §19, the Arizona Legislature end-dated annual adjustments for inflation for outpatient hospital services provided as of September 30, 2011. The Administration lacks authority to do so in rule.</p> <p>See also number 5.</p>
9.	04/28/14 Greg Vigdor AzHHA	At a minimum, the AHCCCS Administration should annually evaluate the adequacy of payment rates to hospitals relative to full costs, not variable costs, and report these findings to the Legislature.	Consistent with federal requirements, 42 CFR 447.204, and as reflected in R9-22-712.40(G) and R9-22-712.81, and subject to sufficient legislative appropriations for that purpose, the Administration will evaluate its reimbursement methodologies to ensure that rates are consistent with efficiency, economy and quality of care and are sufficient to enlist enough hospital provides so that care is available to the same extent as to the general population in the same geographic area.
10.	04/28/14 Greg Vigdor AzHHA	<p>R9-22-712.62 Subsection C requires claims to be assigned a “Pre-HCAC” DRG code, which is derived from all diagnosis and surgical procedure codes, and a “post-HCAC” DRG code, which excludes codes associated with HCACs or OPPCs. The DRG code with the lower relative weight will be used to process the claim. The definition of HCACs in the proposed rule appears to align with the list of HCACs in the current AHCCCS non-payment policy. And, while we believe the intent is to limit non-payment to situations in which the HCAC is not present on admission, this is not clearly set forth in the proposed rule. We request the Administration to clarify that non-payment for HCACs is restricted to reimbursement for services in which the HCAC is not present on admission.</p>	The Administration agrees, subsection C1 has been updated to indicate the HCAC was not present on admission.

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11.	04/28/14 Greg Vigdor AzHHA	Similarly the proposed rule states that OPPCs “include a wrong surgical or other invasive procedure performed on a patient .....the use of the term “include” implies that the list is not definitive. The proposed regulations therefore allows the Administration or its contractors to expand the list to additional conditions or procedures that they deem provider-preventable, without the benefit of public input or on an ad hoc basis. We urge the Administration to replace the term “include” with “are.” Any changes to the list of OPPCs should be addressed in subsequent rulemakings with additional public input.	The Administration agrees and has made a corresponding change. The definitions of both OPPC and HCAC have been moved to R9-22-701.
12.	04/28/14 Greg Vigdor AzHHA	R9-22-712.62 (C) (2) defines an OPPC as occurring in <i>any health care setting</i> . While this aligns with the federal definition and current Administration policy generally, it is confusing in the context of this rule—the purpose of which is to establish an inpatient hospital payment methodology. We are unsure how an OPPC in an outpatient setting could be coded with a DRG. With this in mind, we recommend that the definition of OPPC in R9-22-712.62 be limited to the inpatient setting. Non-payment procedures related to OPPCs occurring in outpatient settings should be prescribed in separate outpatient rules.	The Administration agrees and has updated subsection C2 by removing “occurring in any health care setting”. The definition of OPPC has been moved to R9-22-701.
13.	04/28/14 Greg Vigdor AzHHA	As a general policy matter, we urge the Administration to appoint an advisory committee consisting of quality experts, including hospital representatives, to advise the Administration on policies relating to nonpayment for HCACs and OPPCs and other value based purchasing quality metrics. In recent years, there has been a significant increase in evidence based practices and knowledge relating to quality measurements, particular in the hospital setting. Private and public quality experts, including those at CMS have begun to reassess some of the HCAC measures included in Arizona’s state plan. An expert advisory panel could assist the Administration in developing provider- related quality metrics and other policies that are based on the best available evidence and clinical knowledge. We would welcome the opportunity to work with the Administration on this endeavor.	Thank you for your suggestion.

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14.	04/28/14 Greg Vigdor AzHHA	<p>R9-22-712.71 indicates that the final DRG payment and DRG outlier add-on payment will be "...established to limit the financial impact to individual hospitals...and to account for improvement in documentation and coding that are expected as a result of the transition." The model AHCCCS has provided does not mention, nor does the rulemaking include any other mention of accounting for improvement in documentation and coding. In order to avoid future confusion and uncertainty we recommend that the Administration clarify:</p> <p>1. How it intends to demonstrate that there has been an actual improvement in documentation and coding; and</p> <p>2. If an adjustment for the impact is built into the model, what the amount is and how it was computed.</p> <p>We recommend that this be delineated out in the rulemaking and the model.</p>	<p>The purpose of R9-22-712.71 is to provide notice to hospitals that adjustments will be made for improvements in documentation and coding and to limit the financial impact to individual hospitals due to the transition from tiered per diem payments to DRG based payments. However the values for the coding and hospital-specific adjustments are part of the capped fee schedule which is exempt from the requirements of formal rulemaking and which will provide for flexibility. ARS 41-1005(A)(9). The hospital specific values that are being used in subsections A and B are published on AHCCCS' website. Consistent with federal requirements, any changes to the values in future years during the transition will be preceded by public notice and an opportunity for comments. 42 CFR 447.205(?)</p> <p>Information on the documentation and coding improvement factor and transition factor was presented to the hospital DRG workgroup on December 17, 2013. That information is posted on the AHCCCS website at: <a href="http://www.azahcccs.gov/commercial/Downloads/AZDRGWorkgroup121713.pptx">http://www.azahcccs.gov/commercial/Downloads/AZDRGWorkgroup121713.pptx</a> and provides further detail regarding these questions.</p>
15.	04/28/14 Greg Vigdor AzHHA	<p>R9-22-712.78</p> <p>Hospitals have no idea what criteria will be used to determine whether a readmission is preventable by a hospital, nor who will make this determination. It is essential for cost effective, quality care that there be clear, transparent, standardized, evidence-based criteria for determining what readmissions are preventable, and that these decisions not be made on an ad hoc basis.</p>	<p>The determination whether a readmission is preventable is a medical determination that is made on a case by case basis. The initial determination will be made by the medical director of the healthplan or the Administration and is subject for review through the hearing process.</p>
16.	04/28/14 Greg Vigdor AzHHA	<p>We urge the Administration to delay implementation of a readmissions payment policy until it can convene a panel of quality experts, including representatives from hospitals, to advise the Administration on best practices for reducing Medicaid readmissions, including making recommendations on the appropriate criteria for determining which types of readmissions are preventable.</p>	<p>It would be inconsistent with federal law and the Administration's statutory mandate to control costs for the Administration to reimburse hospitals for inpatient services that would have been unnecessary but for some action or inaction on the part of the hospital. 42 USC 1396a(a)(30)(A) and ARS 36-2907(D).</p>
17.	04/28/14 Greg Vigdor AzHHA	<p>R9-22-712.77</p> <p>Subsection (A) should be amended as follows, to parallel AHCCCS policy and avoid confusion:</p> <p><b>A.</b> Except as provided for in subsection (b), for any claim for inpatient services with an admission date and discharge date that are the same calendar date, the claim shall be processed as an outpatient claim using the default outpatient cost-to-charge ratio and the hospital shall be reimbursed under R9-22-712.10 through R9-22-712.50. Hospitals are not being required to rebill claims as outpatient claims in order to be paid pursuant to the subsection.</p>	<p>The Administration amended the rule to improve clarity.</p>

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<p>18.</p>	<p>04/28/14 Greg Vigdor AzHHA</p>	<p>R9-22-712.74 R9-22-712.74 states that DRG payments are subject to cost avoidance, including “for claims for ancillary services covered by Part B Medicare.” We do not understand the purpose for the rule. As the rule itself states, it appears wholly duplicative of the R9-22-1003; ordinary rules of regulatory construction by courts would conclude that something different than or in addition to R9-22-1003 is intended. If that is true, we cannot tell what it is. The rule should be eliminated or AHCCCS should explain its purpose and effect and give the public opportunity to comment.</p> <p>We do not understand why AHCCCS is singling out “Part B only” claims for separate discussion of cost avoidance. Specifically we cannot tell if AHCCCS intends this “cost avoidance for claims for ancillary services” to operate any different than the current reimbursement methodology (AHCCCS inpatient allowable – Part B payment = net payment to hospital). If some new payment approach or formula is contemplated, it should be subject to public comment.</p>	<p>Because part B of Medicare reimburses certain inpatient hospital services in a manner different from DRG’s, this rule was added to clarify that consistent with R9-22-1003 payment otherwise due under the DRG reimbursement methodology will be reduced by any payments received through part B for the same inpatient services.</p>
<p>19.</p>	<p>04/28/14 Greg Vigdor AzHHA</p>	<p>R9-22-712.75 We request that the following changes be made to R9-22-712.75 Subsection A: A. . . . but is not discharged because an appropriate placement outside the hospital is not available for any reason, including the contractor’s administrative or operational delays, or the member cannot be safely discharged . . . This language parallels the language of Subsection B, and equalizes the financial risk of inaction; currently, there is no incentive for contractors to timely respond to requests for placement assistance or authorizations for post-hospital services.</p> <p>We also request that Subsection E be clarified to indicate that payment should be made for all medically necessary services provided on administrative days, and not only payment at a base, non-inclusive, rate for the “level of care.” This comes up most frequently with nursing facility days, for which the daily rate is frequently not inclusive of all services.</p>	<p>The Administration has revised the proposed rule to address your concern.</p> <p>The rule is intended to provide reimbursement at the same rate that would have been paid had the patient been discharged to an appropriate level of care.</p>

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20.	04/28/14 Greg Vigdor AzHHA	<p>R9-22-701 Under R9-22-701, we suggest that definitions be added for APR-DRG, and the Medicare Wage Index, including which versions are being relied on. We also recommend that the Medicare Wage Index be updated annually. We recommend the Administration consider updating the definition of “Revenue Code” by replacing “UB – 92” with “UB-04”. In addition we recommend the Administration add a definition of “administrative days.” It is used as early as page 23 (R9-22-703(D) (1)), but not defined until page 59(R9-22-712.75(A));</p>	<p>The Wage Index is defined in R9-22-712.62(B). APR-DRG is described in R9-22-712.60(C).</p> <p>APR-DRG – The Administration has reviewed the proposed rule and determined that the more general term DRG and the more specific term APR-DRG are used appropriately throughout the rule.</p> <p>Revenue Code definition has been updated.</p> <p>Administrative Days – A cross-reference has been included under R9-22-703.</p> <p>APR DRG payments are made up of multiple components, none of which will be changing on an annual basis (except the outlier CCRs). All the components will be under review at rebase. One of the Administration’s goals is for the DRG payment methodology to have a budget neutral impact to the State of Arizona (subject to the State’s obligation under federal law to establish rates that are consistent with efficiency, economy, quality and access to care). An automatic adjustment to select components of the methodology conflicts with the ability of the Administration to ensure budget neutrality in future years.</p>
21.	04/28/14 Greg Vigdor AzHHA	<p>Several sections of the proposed rulemaking refer to “DRG” rather than “APR-DRG”. Unless the more general term is warranted, we recommend that the Administration consider replacing “DRG” with “APR-DRG” in these sections. (For example, see R9-22- 703, subsection K, where the proposed rule refers to DRG rate, when it should instead state APR-DRG rate, and R9-22-712.61, subsection B, where the rule refers to DRG methodology, when it should instead state APR-DRG methodology.)</p>	See above.
22.	05/14/14 Susan Watchman Gammage and Burnham	<p>In A.A.C. R9-22-712.61(B), you use the phrase “primary diagnosis upon admission.” But that confounds two codes and fields on the UB -- box 66 which is used for the “primary diagnosis code” (determined at or after discharge) and box 69, which is the “admitting diagnosis” (what they think is going on at admission).</p> <p>The current AHCCCS and ADHS policy is driven by “primary diagnosis code.” We had a matter go through hearing because a RBHA was asserting that the current policy was not clear and it believed their responsibility was driven by the admitting code, or required both to be in the range. They were incorrect, as confirmed in the decision</p> <p>The language you are using in these proposed regs now creates the very ambiguity the RBHA asserted was there before and wasn’t that is, do you mean the admitting dx code (new approach) or the primary dx code (current approach).</p>	The Administration agrees with the comment and will remove “upon admission” from the rule language.

**12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**

No other matters are applicable.

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a. **Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**

Not applicable

b. **Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**

The rules are not more stringent than federal law, The rules comply with federal law. 42 U.S.C. 1396a(a)(30)(A)

c. **Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**

Not applicable

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

R9-22-703(A) – 42 CFR 431.107(b).

14. **Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:**

Not applicable

15. **The full text of the rules follows:**

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)  
ADMINISTRATION

ARTICLE 2. SCOPE OF SERVICES

Section

R9-22-204. Inpatient General Hospital Services

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-701. Standard for Payments Related Definitions

R9-22-703. Payments by the Administration

R9-22-705. Payments by Contractors

R9-22-708. Payments for Services Provided to Eligible ~~Native Americans~~ American Indians

R9-22-712. Reimbursement: General

R9-22-712.01. Inpatient Hospital Reimbursement for claims with admission dates and discharge dates from October 1, 1998 through September 30, 2014

R9-22-712.09. Hierarchy for Tier Assignment through September 30, 2014

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

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

R9-22-712.60. Diagnosis Related Group Payments

R9-22-712.61. DRG Payments: Exceptions

R9-22-712.62. DRG Base Payment

R9-22-712.63. DRG Base Payments Not Based on the Statewide Standardized Amount

R9-22-712.64. DRG Base Payments and Outlier CCR for Out-of-State Hospitals

R9-22-712.65. DRG Provider Policy Adjustor

R9-22-712.66. DRG Service Policy Adjustor

R9-22-712.67. DRG Reimbursement: Transfers

R9-22-712.68. DRG Reimbursement: Unadjusted Outlier Add-on Payment

R9-22-712.69. DRG Reimbursement: Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment

R9-22-712.70. Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment for FES members

R9-22-712.71. Final DRG Payment

R9-22-712.72. DRG Reimbursement: Enrollment Changes During an Inpatient Stay

R9-22-712.73. DRG Reimbursement: Inpatient Stays for Members Eligible for Medicare

R9-22-712.74. DRG Reimbursement: Third Party Liability

R9-22-712.75. DRG Reimbursement: Payment for Administrative Days

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- R9-22-712.76. DRG Reimbursement: Interim Claims
- R9-22-712.77. DRG Reimbursement: Admissions and Discharges on the Same Day
- R9-22-712.78. DRG Reimbursement: Readmissions
- R9-22-712.79. DRG Reimbursement: Change of Ownership
- R9-22-712.80. DRG Reimbursement: New Hospitals
- R9-22-712.81. DRG Reimbursement: Updates
- R9-22-715. Hospital Rate Negotiations
- R9-22-718. Urban Hospital Inpatient Reimbursement Program

ARTICLE 2. SCOPE OF SERVICES

**R9-22-204. Inpatient General Hospital Services**

- ~~A.~~ A contractor, fee-for-service provider or noncontracting provider shall render inpatient general hospital services including:
- ~~1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
    - a. Maternity care, including labor, delivery, and recovery room, birthing center, and newborn nursery;
    - b. Neonatal intensive care unit (NICU);
    - c. Intensive care unit (ICU);
    - d. Surgery, including surgery room and recovery room;
    - e. Nursery and related services;
    - f. Routine care; and
    - g. Emergency behavioral health services provided under Article 12 of this Chapter for a member eligible under A.R.S. § 36-2901(6)(a).~~
  - ~~2. Ancillary services as specified by the Director and included in contract:
    - a. Laboratory services;
    - b. Radiological and medical imaging services;
    - c. Anesthesiology services;
    - d. Rehabilitation services;
    - e. Pharmaceutical services and prescription drugs;
    - f. Respiratory therapy;
    - g. Blood and blood derivatives; and
    - h. Central supply items, appliances, and equipment that are not ordinarily furnished to all patients and customarily reimbursed as ancillary services.~~
- ~~B.A.~~ The following limitations apply to inpatient general hospital services that are provided by FFS providers.
1. Providers shall obtain prior authorization from the Administration for the following inpatient hospital services:
    - a. Nonemergency and elective admission, including psychiatric hospitalization;
    - b. Elective surgery; and
    - c. Services or items provided to cosmetically reconstruct or improve personal appearance after an illness or injury.
  2. The Administration or a contractor may deny a claim if a provider fails to obtain prior authorization.
  3. Providers are not required to obtain prior authorization from the Administration for the following inpatient hospital services:
    - a. Voluntary sterilization,
    - b. Dialysis shunt placement,
    - c. Arteriovenous graft placement for dialysis,
    - d. Angioplasties or thrombectomies of dialysis shunts,
    - e. Angioplasties or thrombectomies of arteriovenous graft for dialysis,
    - f. Hospitalization for vaginal delivery that does not exceed 48 hours,
    - g. Hospitalization for cesarean section delivery that does not exceed 96 hours, and
    - h. Other services identified by the Administration through the Provider Participation Agreement.
  4. The Administration may perform concurrent review for hospitalizations of non-FES members to determine whether there is medical necessity for the hospitalization. A provider shall notify the Administration no later than 72 hours after an emergency admission.
- ~~C.B.~~ Coverage of in-state and out-of-state inpatient hospital services is limited to 25 days per benefit year for members age 21 and older for claims with discharge dates on or before September 30, 2014. The limit applies for all inpatient hospital services with dates of service during the benefit year regardless of whether the member is enrolled in Fee for Service, is enrolled with one or more contractors, or both, during the benefit year.
1. For purposes of calculating the limit:
    - a. Inpatient days are counted towards the limit if paid by the Administration or a contractor;
    - b. Inpatient days will be counted toward the limit in the order of the adjudication date of a paid claim;
    - c. Paid inpatient days are allocated to the benefit year in which the date of service occurs;

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- d. Each 24 hours of paid observation services is counted as one inpatient day if the patient is not admitted to the same hospital directly following the observation services;
  - e. Observation services, which are directly followed by an inpatient admission to the same hospital are not counted towards the inpatient limit; and
  - f. After 25 days of inpatient hospital services have been paid as provided for in this Section:
    - i. Outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered.
    - ii. Continuous periods of observation services of less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered.
    - iii. For continuous periods of observation services of 24 hours or more that are not directly followed by an inpatient admission to the same hospital, 23 hours of observations services are covered.
2. The following inpatient days are not included in the inpatient hospital limitation described in this Section:
- a. Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract;
  - b. Days related to Behavioral Health:
    - i. Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or
    - ii. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or
    - iii. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.
  - c. Days related to treatment for burns and burn late effects at an American College of Surgeons verified burn center;
  - d. Same Day Admit Discharge services are excluded from the 25 day limit; and
  - e. Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities.

ARTICLE 7. STANDARDS FOR PAYMENTS

**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. 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 GSA.

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

~~“Ancillary service” means all hospital services for patient care other than room and board and nursing services, including but not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).~~

“APC” means the Ambulatory Payment Classification system under 42 CFR 419.31 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).

“Business agent” means a company such as a billing service or accounting firm that renders billing statements and receives payment in the name of a provider.

“Capital costs” means costs as reported by the hospital to CMS as required by 42 CFR 413.20.

“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” (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

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expense for covered services that meet medical review criteria of AHCCCS or a contractor.

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

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

“Direct graduate medical education costs” or “direct program costs” means the costs that are incurred by a hospital for the education activities of an approved graduate medical education program that are the proximate result of training medical residents in the hospital, including resident salaries and fringe benefits, the portion of teaching physician salaries and fringe benefits that are related to the time spent in teaching and supervision of residents, and other related GME overhead costs.

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

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

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

“Existing outpatient service” means a service provided by a hospital before the hospital files an increase in its charge master as defined in R9-22-712(G), 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.

“Expansion funds” means funds appropriated to support GME program expansions as described under A.R.S. § ~~36-2903.01(H)(9)(b) and (e)(i)~~ 36-2903.01(G)(9)(b) and (c)(i).

“Factor” means a person or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business agent.

“Fiscal intermediary” means an organization authorized by CMS to make determinations and payments for Part A and Part B provider services for a given region.

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

“GME program approved by the Administration” or “approved GME program” means a graduate medical education program that has been approved by a national organization as described in 42 CFR 415.152.

“Graduate medical education (GME) program” means an approved residency program that prepares a physician for independent practice of medicine by providing didactic and clinical education in a medical environment to a medical student who has completed a recognized undergraduate medical education program.

“HCAC” means a condition described under 42 U.S.C. 1395ww(d)(4)(D)(iv) but does not include Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

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

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

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

“Indirect program costs” means the marginal increase in operating costs that a hospital experiences as a result of having an approved graduate medical education program and that is not accounted for by the hospital’s direct program costs.

“Intern and Resident Information System” means a software program used by teaching hospitals and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

“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 determining medical necessity. The criteria for

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medical review are established by AHCCCS or a contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

“Medicare Urban or Rural Cost-to-Charge Ratio (CCR)” means statewide average capital cost-to-charge ratio published annually by CMS added to the urban or rural statewide average operating cost-to-charge ratio published annually by CMS.

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

“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, is not a free-standing psychiatric hospital, such as an IMD, and is paid under ADHS rates.

“Observation day” means a physician-ordered evaluation period ~~of less than 24 hours~~ to determine whether a person needs treatment or needs to be admitted as an inpatient. Each observation day consists of a period of 24 hours or less.

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

“OPPC” means an Other Provider Preventable Condition that is: (1) a wrong surgical or other invasive procedure performed on a patient, (2) a surgical or other invasive procedure performed on the wrong body part, or (3) a surgical or other invasive procedure performed on the wrong patient.

“Organized health care delivery system” means a public or private organization that delivers health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

“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 this Article and A.R.S. § ~~36-2903.01(H)~~ 36-2903.01(G).

“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).

“Participating institution” means an institution at which portions of a graduate medical education program are regularly conducted and to which residents rotate for an educational experience for at least one month.

“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.

“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, until the day a member is enrolled with a contractor.

“PPS bed” means Medicare-approved Prospective Payment beds for inpatient services as reported in the Medicare cost reports for the most recent fiscal year for which the Administration has a complete set of Medicare cost reports for every rural hospital as determined as of the first of February of each year.

“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 set 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 Medicare Cost Report data for a year and AHCCCS claim and encounter data for the same 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 specified 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.

“Resident” means a physician engaged in postdoctoral training in an accredited graduate medical education program,

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including an intern and a physician who has completed the requirements for the physician's eligibility for board certification.

"Revenue code" means a numeric code, that identifies a specific accommodation, ancillary service, or billing calculation, as defined by the National Uniform Billing committee for ~~UB-92~~ UB-04 forms.

"Specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.

"Sponsoring institution" means the institution or entity that is recognized by the GME accrediting organization and designated as having ultimate responsibility for the assurance of academic quality and compliance with the terms of accreditation.

"Tier" means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure, or revenue codes, peer group, 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.

**R9-22-703. Payments by the Administration**

- A.** General requirements. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of ~~March 6, 1992~~ October 1, 2012, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
- B.** Timely submission of claims.
1. Under A.R.S. § 36-2904, the Administration shall deem a paper or electronic claim to be submitted on the date that it is received by the Administration. The Administration shall do one or more of the following for each claim it receives:
    - a. Place a date stamp on the face of the claim,
    - b. Assign a system-generated claim reference number, or
    - c. Assign a system-generated date-specific number.
  2. Unless a shorter time period is specified in contract, the Administration shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
    - a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
    - b. Six months from the date of eligibility posting.
  3. Unless a shorter time period is specified in contract, the Administration shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
    - a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
    - b. Twelve months from the date of eligibility posting.
  4. Unless a shorter time period is specified in contract, the Administration shall not pay a claim submitted by an IHS or tribal facility for a covered service unless the claim is initially submitted within 12 months from the date of service, date of discharge, or eligibility posting, whichever is later.
- C.** Claims processing.
1. The Administration shall notify the AHCCCS-registered provider with a remittance advice when a claim is processed for payment.
  2. The Administration shall reimburse a hospital for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and in the manner and at the rate described in A.R.S. § 36-2903.01:
    - a. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
    - b. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
    - c. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a fee of one percent per month for each month or portion of a month following the 60th day of receipt of the bill until date of payment.
  3. A claim is paid on the date indicated on the disbursement check.
  4. A claim is denied as of the date of the remittance advice.
  5. The Administration shall process a hospital claim under this Article.
- D.** Prior authorization.
1. An AHCCCS-registered provider shall:
    - a. Obtain prior authorization from the Administration for non-emergency hospital admissions, ~~and~~ covered services as specified in Articles 2 and 12 of this Chapter, and for administrative days as described in R9-22-712.75.
    - b. Notify the Administration of hospital admissions under Article 2 of this Chapter, and

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- c. Make records available for review by the Administration upon request.
  2. The Administration may deny a claim if the provider fails to comply with subsection (D)(1).
  3. If the Administration issues prior authorization for an inpatient hospital admission, a specific service, or level of care but subsequent medical review indicates that the admission, a different the service, or level of care was not medically appropriate, the Administration shall adjust the claim payment. ~~to pay for the cost of the appropriate level of care.~~
- E. Review of claims and coverage for hospital supplies.
  1. The Administration may conduct prepayment and postpayment review of any claims, including but not limited to hospital claims.
  2. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
    - a. Patient care kit,
    - b. Toothbrush,
    - c. Toothpaste,
    - d. Petroleum jelly,
    - e. Deodorant,
    - f. Septi soap,
    - g. Razor or disposable razor,
    - h. Shaving cream,
    - i. Slippers,
    - j. Mouthwash,
    - k. Shampoo,
    - l. Powder,
    - m. Lotion,
    - n. Comb, and
    - o. Patient gown.
  3. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
    - a. Arm board,
    - b. Diaper,
    - c. Underpad,
    - d. Special mattress and special bed,
    - e. Gloves,
    - f. Wrist restraint,
    - g. Limb holder,
    - h. Disposable item used instead of a durable item,
    - i. Universal precaution,
    - j. Stat charge, and
    - k. Portable charge.
  4. The Administration shall determine in a hospital claims review whether services rendered were:
    - a. Covered services as defined in ~~R9-22-102~~ Article 2;
    - b. Medically necessary;
    - c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
    - d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2903.01.
  5. If the Administration adjudicates a claim, a person may file a claim dispute challenging the adjudication under 9 A.A.C. 34.
- F. Overpayment for AHCCCS services.
  1. An AHCCCS-registered provider shall notify the Administration when the provider discovers the Administration made an overpayment.
  2. The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS-registered provider fails to return the overpaid amount to the Administration.
  3. The Administration shall document any recoupment of an overpayment on a remittance advice.
  4. An AHCCCS-registered provider may file a claim dispute under 9 A.A.C. 34 if the AHCCCS-registered provider disagrees with a recoupment action.
- G. For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.
- H. Prior quarter reimbursement. A provider shall:
  1. Bill the Administration for services provided during a prior quarter eligibility period upon verification of eligibility or upon notification from a member of AHCCCS eligibility.
  2. Reimburse a member when payment has been received from the Administration for covered services during a prior quarter eligibility period. All funds paid by the member shall be reimbursed.

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3. Accept payment received by the Administration as payment in full.
- I.** Payment for in-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. The Administration shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article.
- J.** Payment for out-of-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. The Administration shall reimburse an out-of-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b).
- K.** Payment for inpatient hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. The Administration shall reimburse an in-state or out-of-state provider of inpatient hospital services rendered with a discharge date on or after October 1, 2014, the DRG rate established by the Administration.
- L.** The Administration may enter into contracts for the provisions of transplant services.

**R9-22-705. Payments by Contractors**

- A.** General requirements. A contractor shall contract with providers to provide covered services to members enrolled with the contractor. The contractor is responsible for reimbursing providers and coordinating care for services provided to a member. Except as provided in subsection (A)(2), a contractor is not required to reimburse a noncontracting provider for services rendered to a member enrolled with the contractor.
  1. Providers. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
  2. A contractor shall reimburse a noncontracting provider for services rendered to a member enrolled with the contractor as specified in this Article if:
    - a. The contractor referred the member to the provider or authorized the provider to render the services and the claim is otherwise payable under this Chapter, or
    - b. The service is emergent under Article 2 of this Chapter.
- B.** Timely submission of claims.
  1. Under A.R.S. § 36-2904, a contractor shall deem a paper or electronic claim as submitted on the date that the claim is received by the contractor. The contractor shall do one or more of the following for each claim the contractor receives:
    - a. Place a date stamp on the face of the claim,
    - b. Assign a system-generated claim reference number, or
    - c. Assign a system-generated date-specific number.
  2. Unless a shorter time period is specified in subcontract, a contractor shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
    - a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
    - b. Six months from the date of eligibility posting.
  3. Unless a shorter time period is specified in subcontract, a contractor shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
    - a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
    - b. Twelve months from the date of eligibility posting.
- C.** Date of claim.
  1. A contractor's date of receipt of an inpatient or an outpatient hospital claim is the date the claim is received by the contractor as indicated by the date stamp on the claim, the system-generated claim reference number, or the system-generated date-specific number assigned by the contractor.
  2. A hospital claim is considered paid on the date indicated on the disbursement check.
  3. A denied hospital claim is considered adjudicated on the date of the claim's denial.
  4. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the contractor shall assign a new date of receipt upon receipt of the additional documentation.
  5. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the contractor shall not assign a new date of receipt.
  6. A contractor and a hospital may, through a contract approved as specified in R9-22-715, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.
- D.** Payment for in-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. A contractor shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014 ~~an admission date on or after March 1, 1993,~~ at either a rate specified by subcontract or, in absence of the subcontract, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715. This subsection

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does not apply to an urban contractor as specified in R9-22-718 and A.R.S. § 36-2905.01.

- E.** Payment for Inpatient out-of-state hospital payments for claims with discharge dates on or before September 30, 2014. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b).
- F.** Payment for inpatient hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. Subject to R9-22-718 and A.R.S. § 36-2905.01 regarding urban hospitals, a contractor shall reimburse an in-state or out-of-state provider of inpatient hospital services, at either a rate specified by subcontract or, in absence of a subcontract, the DRG rate established by the Administration and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
- ~~E.G.~~** Payment for in-state outpatient hospital services.
- ~~1. A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after March 1, 1993 through June 30, 2005, at either a rate specified by a subcontract that complies with R9-22-715(A) or, in absence of a subcontract, as described in R9-22-712 or under A.R.S. § 36-2903.01. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.~~
  2. A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other sections of this Article. The terms of the subcontract are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
- F.** Inpatient and outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost to charge ratio as determined in R9-22-712.01(6)(b). In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the contractor shall pay the claim by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio.
- H.** Outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the contractor shall pay the claim by multiplying the covered charges for the outpatient services by the statewide outpatient cost-to-charge ratio.
- ~~G.I.~~** Payment for observation days. A contractor shall reimburse a provider and a noncontracting provider for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, as prescribed under R9-22-712, R9-22-712.10, and R9-22-712.45. An “observation day” means a physician-ordered evaluation period of less than 24 hours to determine the need of treatment or the need for admission as an inpatient.
- ~~H.J.~~** Review of claims and coverage for hospital supplies.
1. A contractor may conduct a review of any claims submitted and recoup any payments made in error.
  2. A hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. When issuing prior authorization, a contractor shall consider the medical necessity of the service, and the availability and cost effectiveness of an alternative treatment. Failure to obtain prior authorization when required is cause for nonpayment or denial of a claim. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the subcontract regarding utilization control activities. A hospital shall cooperate with a contractor’s reasonable activities necessary to perform concurrent review and shall make the hospital’s medical records pertaining to a member enrolled with a contractor available for review.
  3. Regardless of prior authorization or concurrent review activities, a contractor may make prepayment or post-payment review of all claims, including but not limited to a hospital claim. A contractor may recoup an erroneously paid claim. ~~If prior authorization was given for a specific level of care, but medical review of a claim indicates that a different level of care was medically appropriate, a contractor shall adjust the claim to pay for the cost for the appropriate level of care. An adjustment in payment for a different level of care is effective on the date when the different level of care is medically appropriate.~~  
If prior authorization was given for an inpatient hospital admission, a specific service, or level of care but subsequent medical review indicates that the admission, the service, or level of care was not medically appropriate, the contractor shall adjust the claim payment.
  4. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures if the subcontract meets the requirements of R9-22-715.
  5. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
    - a. Patient care kit,
    - b. Toothbrush,

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- c. Toothpaste,
- d. Petroleum jelly,
- e. Deodorant,
- f. Septi soap,
- g. Razor,
- h. Shaving cream,
- i. Slippers,
- j. Mouthwash,
- k. Disposable razor,
- l. Shampoo,
- m. Powder,
- n. Lotion,
- o. Comb, and
- p. Patient gown.

- 6. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
  - a. Arm board,
  - b. Diaper,
  - c. Underpad,
  - d. Special mattress and special bed,
  - e. Gloves,
  - f. Wrist restraint,
  - g. Limb holder,
  - h. Disposable item used instead of a durable item,
  - i. Universal precaution,
  - j. Stat charge, and
  - k. Portable charge.
- 7. The contractor shall determine in a hospital claims review whether services rendered were:
  - a. Covered services as defined in ~~R9-22-102~~ R9-22-201;
  - b. Medically necessary;
  - c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
  - d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2904.
- 8. If a contractor adjudicates a claim or recoups payment for a claim, a person may file a claim dispute challenging the adjudication or recoupment as described under 9 A.A.C. 34.

~~K.~~ K. Non-hospital claims. A contractor shall pay claims for non-hospital services in accordance with contract, or in the absence of a contract, at a rate not less than the Administration's capped fee-for-service schedule or at a lower rate if negotiated between the two parties.

~~J.~~ J. Payments to hospitals. A contractor shall pay for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and as described in A.R.S. § 36-2904:

- 1. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
- 2. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
- 3. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a 1 percent penalty of the rate for each month or portion of the month following the 60th day of receipt of the bill until date of payment.

~~K.~~ M. Interest payment. In addition to the requirements in subsection ~~(J)~~ (L), a contractor shall pay interest for late claims as defined by contract.

~~L.~~ N. For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

**R9-22-708. Payments for Services Provided to Eligible ~~Native Americans~~ American Indians**

- A. For purposes of this Article "IHS enrolled" or "enrolled with IHS" means ~~a Native American~~ an American Indian who has elected to receive covered services through IHS instead of a contractor.
- B. For ~~a Native American~~ an American Indian who is enrolled with IHS, AHCCCS shall pay IHS the most recent all-inclusive inpatient, outpatient or ambulatory surgery rates published by Health and Human Services (HHS) in the Federal Register, or a separately contracted rate with IHS, for AHCCCS-covered services provided in an IHS facility. AHCCCS shall reimburse providers for the Medicare coinsurance and deductible amounts required to be paid by the Administration or contractor in Chapter 29, Article 3 of this Title.
- C. When IHS refers ~~a Native American~~ an American Indian enrolled with IHS to a provider other than an IHS or tribal facility, the provider to whom the referral is made shall obtain prior authorization from AHCCCS for services as required under Articles 2, 7 or 12 of this Chapter.

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- D. For a ~~Native American~~ an American Indian enrolled with a contractor, AHCCCS shall pay the contractor a monthly capitation payment.
- E. Once a ~~Native American~~ an American Indian enrolls with a contractor, AHCCCS shall not reimburse any provider other than IHS or a Tribal facility.

**R9-22-712. Reimbursement: General**

- 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)~~ 36-2903.01(G)(4), the period during which the claim is pended is not used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § ~~36-2903.01(H)(5)~~ 36-2903.01(G)(5).
- B. Inpatient and outpatient in-state or out-of-state hospital payments.
  - 1. Payment for inpatient out-of-state hospital services for claims with discharge dates on or before September 30, 2014. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent ~~state-wide~~ state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(d). ~~In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse an out-of-state hospital for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the Administration shall pay the claim by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio.~~
  - 2. Payment for inpatient in-state hospital services for claims with discharge dates on or before September 30, 2014. AHCCCS shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, at the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article.
  - 3. Payment for inpatient in-state or out-of-state hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. Subject to R9-22-718 and A.R.S. § 36-2905.01 regarding urban hospitals, a contractor shall reimburse an in-state or out-of-state provider of inpatient hospital services, at either a rate specified by subcontract or, in the absence of a subcontract, the DRG rate established by the Administration and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
  - 4. Outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse an out-of-state hospital for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the Administration shall pay the claim by multiplying the covered charges for the outpatient services by the statewide outpatient cost-to-charge ratio.
  - 5. Outpatient in-state hospital payments. A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other sections of this Article. The terms of the subcontract are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
- C. Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or the Administration's designated representative in performance of the Administration's utilization control activities. The Administration shall deny a claim for failure to cooperate.
- D. Prior authorization. The Administration or contractor may deny a claim if a provider fails to obtain prior authorization as required under R9-22-210.
- 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. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims. ~~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, effective on the date when the different level of care was medically appropriate.~~
- F. Claim receipt.
  - 1. 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 system-generated claim reference number or system-generated date-specific number.
  - 2. Hospital claims are considered paid on the date indicated on disbursement checks.
  - 3. A denied claim is considered adjudicated on the date the claim is denied.
  - 4. Claims that are denied and are resubmitted are assigned new receipt dates.
  - 5. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation.
  - 6. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.
- G. Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eli-

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gible persons with dates of service from March 1, 1993 through June 30, 2005, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the amount of 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 are included in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calculate the outpatient hospital cost-to-charge ratio annually 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 R9-22-712.01. 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 for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. 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 by 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 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 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 a specialty facility.
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 zero. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. Services provided in the emergency room, observation area, 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 four years but no more than once a year 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 represents an aggregate increase in charges of more than 4.7%, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (5) by applying the following formula:  

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

Where "CCR" means the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (5) 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 as described under A.R.S. § 36-436 and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services.

**R9-22-712.01. Inpatient Hospital Reimbursement for claims with admission dates and discharge dates from October 1, 1998 through September 30, 2014**

Inpatient hospital reimbursement. The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons ~~with admissions on and after October 1, 1998~~ for claims with admission dates and discharge dates from October 1, 1998 through September 30, 2014, on a prospective reimbursement basis. The prospective rates represent payment in full, excluding quick-pay discounts, slow-pay penalties, and third-party payments for both accommodation and ancillary department services. The rates include reimbursement for operating and capital costs. The Administration shall make reimbursement for direct graduate medical education as described in A.R.S. § 36-2903.01. For payment purposes, the Administration shall classify each AHCCCS inpatient hospital day of care into one of several tiers appropriate to the services rendered. The rate for a tier is referred to as the tiered per diem rate of reimbursement. The number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier claims, transplant claims, or payment to out-of-state hospitals, freestanding psychiatric hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.

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1. Tier rate data. The Administration shall base tiered per diem rates effective on and after October 1, 1998 on Medicare Cost Reports for Arizona hospitals for the fiscal year ending in 1996 and a database consisting of inpatient hospital claims and encounters for dates of service matching each hospital's 1996 fiscal year end.
  - 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, the Administration shall inflate all the costs to a common point in time as described in subsection (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. A hospital 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 for rates effective on and after October 1, 1998. The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude from the database or adjust claims and encounters that fail these edits. 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 operating and capital components. The rate for the operating component is a statewide rate for each tier except for the NICU and Routine tiers, which are based on peer groups. The rate for the capital component is a blend of statewide and hospital-specific values, as described in A.R.S. § 36-2903.01. The Administration shall use the following methodologies to establish the rates for each of these components.
  - a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the Administration shall compute the rate for the operating component 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 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 are grouped. The ancillary department cost-to-charge ratios for a particular hospital are 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 are 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 do not include 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, 1996, 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. The Administration shall further inflate operating costs to the midpoint of the rate year (March 31, 1999).
    - 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. For the NICU tier, the Administration shall further assign claims and encounters to NICU Level II or NICU Level III peer groups, based on the hospital's certification by the Arizona Perinatal Trust. For the Routine tier, the Administration shall further assign claims and encounters to the general acute care hospital or rehabilitation hospital peer groups, based on state licensure by the Department of Health Services. For claims and encounters assigned to more than one tier, the Administration shall allocate ancillary department costs to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (6).
    - iv. Operating rate calculation. The Administration shall set the rate for the operating component for each tier by dividing total statewide or peer group hospital costs identified in this subsection 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. Capital component. For rates effective October 1, 1999 the capital component is calculated as described in A.R.S. § 36-2903.01.
  - c. Statewide inpatient hospital cost-to-charge ratio. For dates of service prior to October 1, 2007, the statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, as described in subsections (4), (5), and (6), and out-of-state hospitals, as described in R9-22-712(B). 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 (1) and used to determine the tiered per diem rates. For each hospital, the covered inpatient days of care on the claims and encounters are multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters are 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 are determined in the same way described in subsection (2)(a) but include costs for operating and capital. 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.
  - d. Unassigned tiered per diem rates. If a hospital has an insufficient number of claims to set a tiered per diem rate, the Administration shall pay that hospital the statewide average rate for that tier.
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, NICU classification level, or a combination of these.
- a. Tier hierarchy. In assigning claims for AHCCCS inpatient hospital days of care to a tier, the Administration shall follow the Hierarchy for Tier Assignment through September 30, 2014 in R9-22-712.09. The Administration shall not pay a claim for inpatient hospital services unless the claim meets 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 are submitted by the hospital.
  - b. Tier exclusions. The Administration shall not assign to a tier or pay AHCCCS inpatient hospital days of care that do not occur during a period when the person is eligible. 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. The Administration shall pay same day admit and discharge claims that qualify for either the maternity or nursery tiers based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.
  - c. Seven tiers. The seven tiers are:
    - i. Maternity. The Administration shall identify the Maternity Tier by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the Administration shall pay the AHCCCS inpatient hospital days of care on the claim at the maternity tiered per diem rate.
    - ii. NICU. The Administration shall identify the NICU Tier by a revenue code. A hospital does not qualify for the NICU tiered per diem rate unless the hospital is classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier and have a NICU revenue code at the NICU tiered per diem rate. The Administration shall pay any remaining AHCCCS inpatient hospital day on the claim that does not meet NICU Level II or NICU Level III medical review criteria at the nursery tiered per diem rate.
    - iii. ICU. The Administration shall identify the ICU Tier by a revenue code. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meets the medical review criteria for the ICU tier and has an ICU revenue code at the ICU tiered per diem rate. The Administration may classify any AHCCCS inpatient hospital days on the claim without an ICU revenue code, as surgery, psychiatric, or routine tiers.
    - iv. Surgery. The Administration shall identify the Surgery Tier by a revenue code and a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list identifies minor procedures such as sutures that do not require the same hospital resources as other procedures. The Administration shall only split a surgery tier with an ICU tier. AHCCCS shall pay at the surgery tier rate only when the surgery occurs on a date during which the member is eligible.
    - v. Psychiatric. The Administration shall identify the Psychiatric Tier by either a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the psychiatric tier with any tier other than the ICU tier.
    - vi. Nursery. The Administration shall identify the Nursery Tier by a revenue code. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the nursery tier with any tier other than the NICU tier.

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- vii. Routine. The Administration shall identify the Routine Tier by revenue codes. The routine tier includes AHCCCS inpatient hospital days of care that are not classified in another tier or paid under any other provision of this Section. The Administration shall not split the routine tier with any tier other than the ICU tier.
4. Annual update. The Administration shall annually update the inpatient hospital tiered per diem rates through September 30, 2011.
5. New hospitals. For rates effective on and after October 1, 1998, the Administration shall pay new hospitals the statewide average rate for each tier, as appropriate. The Administration shall update new hospital tiered per diem rates through September 30, 2011.
6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers under this Section by multiplying the covered charges on a claim by the Medicare Urban or Rural Cost-to-Charge Ratio. The Urban cost-to-charge ratio will be used for hospitals located in a county of 500,000 residents or more. The Rural cost-to-charge ratio will be used for hospitals located in a county of fewer than 500,000 residents.
  - a. Outlier criteria. For rates effective on and after October 1, 1998, the Administration 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. If the covered costs per day on a claim exceed the urban or rural cost threshold for a tier, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the applicable Medicare Urban or Rural CCR. The resulting amount will be the outlier payment. If there are two tiers on a claim, the Administration shall determine whether the claim 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. Routine maternity stays shall be excluded from outlier reimbursement. A routine maternity is any one-day stay with a delivery of one or two babies. A routine maternity stay will be paid at tier.
  - b. Update. The CCR is updated annually by the Administration for dates of service beginning October 1, using the most current Medicare cost-to-charge ratios published or placed on display by CMS by August 31 of that year. The Administration shall update the outlier cost thresholds for each hospital through September 30, 2011 as described under A.R.S. § 36-2903.01. For inpatient hospital admissions with begin dates of service on and after October 1, 2011, AHCCCS will increase the outlier cost thresholds by 5% of the thresholds that were effective on September 30, 2011.
  - c. Medicare Cost-to-Charge Ratio Phase-In. AHCCCS shall phase in the use of the Medicare Urban or Rural Cost-to-Charge Ratios for outlier determination, calculation and payment. The three-year phase-in does not apply to out-of-state or new hospitals.
    - i. Medicare Cost-to-Charge Ratio Phase-In outlier determination and threshold calculation. For outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. For outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. The adjusted hospital specific inpatient cost-to-charge ratios shall be used for all calculations using the Medicare Urban or Rural Cost-to-Charge Ratios, including outlier determination, and threshold calculation.
    - ii. Medicare Cost-to-Charge Ratio Phase-In calculation for payment. For payment of outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio. For payment of outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio.
    - iii. Medicare Cost-to-Charge Ratio for outlier determination, threshold calculation, and payment. For outlier claims with dates of service on or after October 1, 2009, the full Medicare Urban or Rural Cost-to-Charge Ratios shall be utilized for all outlier calculations.
  - d. Cost-to-Charge Ratio used for qualification and payment of outlier claims.
    - i. For qualification and payment of outlier claims with begin dates of service on or after April 1, 2011 through September 30, 2011, the CCR will be equal to 95% of the ratios in effect on October 1, 2010.
    - ii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011, the CCR will be equal to 90.25% of the most recent published Urban or Rural Medicare CCR as described in subsection (6)(b).

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- iii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011 through September 30, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after April 1, 2011 by an additional percentage equal to the total percent increase reported on the charge master.
- iv. Subject to approval by CMS, for qualification and payment of outlier claims with begin dates of service on or after October 1, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after June 1, 2012 by an additional percentage equal to the total percent increase reported on the charge master.
- 7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered transplant as described in R9-22-206 is performed through the terms of the relevant contract. ~~As described in R9-22-716,~~ ~~¶~~ If the Administration and a hospital that performs transplant surgery on an eligible person do not have a contract for the transplant surgery, the Administration shall not reimburse the hospital more than what would have been paid to the contracted hospital for that same surgery.
- 8. Ownership change. The Administration shall not change any of the components of a hospital's tiered per diem rates upon an ownership change.
- 9. Psychiatric 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.
- 10. 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. For purposes of this subsection, "specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.
- 11. Outliers for new hospitals. Outliers for new hospitals will be calculated using the Medicare Urban or Rural Cost-to-Charge Ratio times covered charges. If the resulting cost is equal to or above the cost threshold, the claim will be paid at the Medicare Urban or Rural Cost-to-Charge ratio.
- 12. Reductions to tiered per diem payment for inpatient hospital services. Inpatient hospital admissions with begin dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the tiered per diem rates in effect on September 30, 2011.

**R9-22-712.09. Hierarchy for Tier Assignment through September 30, 2014**

<b>TIER</b>	<b>IDENTIFICATION CRITERIA</b>	<b>ALLOWED SPLITS</b>
MATERNITY	A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx.	None
NICU	Revenue Code of 174 and the provider has a Level II or Level III NICU.	Nursery
ICU	Revenue Codes of 200-204, 207-212, or 219.	Surgery Psychiatric Routine
SURGERY	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.	ICU
PSYCHIATRIC	Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND primary 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.	ICU
NURSERY	Revenue Code of 17x, not equal to 174.	NICU
ROUTINE	Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.	ICU

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

- A. Procedure codes. When procedure codes are issued by CMS and added to the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add to the Outpatient Capped Fee-for-Service Schedule the new procedure codes for covered outpatient services and shall either assign the default CCR under R9-22-712.40(F)(2), the Medicare rate, or calculate an appropriate fee.
- B. APC changes. AHCCCS may reassign procedure codes to new or different APC groups when APC groups are revised by CMS. AHCCCS may reassign procedure codes to a different APC group than Medicare. If AHCCCS determines that utilization of a procedure code within the Medicare program is substantially different from utilization of the procedure code in the AHCCCS program, AHCCCS may choose not to assign the procedure code to any APC group. For procedure codes not grouped into an APC by Medicare, AHCCCS may assign the code to an APC group when AHCCCS determines that the cost and resources associated with the non-assigned code are substantially similar to those in the APC group.

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- C. Annual update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, through September 30, 2011, AHCCCS shall adjust outpatient fee schedule rates:
  - 1. Annually by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or
  - 2. In a particular year the director may substitute the increases in subsection (C)(1) by calculating the dollar value associated with the inflation index in subsection (C)(1), and applying the dollar value to adjust rates at varying levels.
- D. Reductions to the Outpatient Capped Fee-For-Service Schedule. Claims paid using the Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rates in effect on September 30, 2011, subject to the annual adjustments to procedure codes and APCs under this section.
- E. Rebase. AHCCCS shall rebase the outpatient fees every five years.
- F. Statewide CCR:
  - 1. For begin dates of service on or before September 30, 2011, the statewide CCR calculated in R9-22-712.30 shall be recalculated at the time of rebasing. When rebasing, AHCCCS may recalculate the statewide CCR based on the costs and charges for services excluded from the outpatient hospital fee schedule.
  - 2. For begin dates of service on or after October 1, 2011, the statewide CCR shall be set under R9-22-712.30 (C).
- G. Other Updates. In addition to the other updates provided for in this section, the Administration may adjust the Outpatient Capped Fee-For-Service Fee Schedule and the Statewide CCR to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

**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.
  - 1. For discharges before September 30, 2014. 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.
  - 2. For discharge dates on and after October 1, 2014. Same day admit and discharge claims are paid for through the outpatient fee schedule.

**R9-22-712.60 Diagnosis Related Group Payments**

- A. Inpatient hospital services with discharge dates on or after October 1, 2014, shall be reimbursed using the diagnosis related group (DRG) payment methodology described in this section and sections R9-22-712.61 through R9-22-712.81.
- B. Payments made using the DRG methodology shall be the sole reimbursement to the hospital for all inpatient hospital services and related supplies provided by the hospital. Services provided in the emergency room, observation area, or other outpatient departments that are directly followed by an inpatient admission to the same hospital are not reimbursed separately. Are reimbursed through the DRG methodology and not reimbursed separately.
- C. Each claim for an inpatient hospital stay shall be assigned a DRG code and a DRG relative weight based on version 31 of the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. If version 31 of the APR-DRG classification system will no longer support assigning DRG codes and relative weights to claims, and 3M Health Information Systems issues a newer version of the APR-DRG classification system using updated DRG codes and/or updated relative weights, then the more current version established by 3M Health Information Systems will be used; however, if the newer version employs updated relative weights, those weights will be adjusted using a single adjustment factor applied to all relative weights to ensure that the statewide weighted average of the updated relative weights does not increase or decrease from the statewide weighted average of the relative weights used under version 31.
- D. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to quick pay discounts and slow pay penalties under A.R.S. 36-2904.
- E. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to the Urban Hospital Reimbursement Program under R9-22-718.
- F. For purposes of this section and sections R9-22-712.61 through R9-22-712.81:
  - 1. “DRG National Average length of stay” means the national arithmetic mean length of stay published in version 31 of the All Patient Refined Diagnosis Related Group (APR-DRG) classification established by 3M Health Information Systems.
  - 2. “Length of stay” means the total number of calendar days of an inpatient stay beginning with the date of admission through discharge, but not including the date of discharge (including the date of a discharge to another hospital, i.e., a

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transfer) unless the member expires.

3. "Medicare" means Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.
4. "Medicare labor share" means a hospital's labor costs as a percentage of its total costs as determined by CMS for purposes of the Medicare Inpatient Prospective Payment System.

**R9-22-712.61. DRG Payments: Exceptions**

- A.** Notwithstanding section R9-22-712.60, claims for inpatient services from the following hospitals shall be paid on a per diem basis, including provisions for outlier payments, where rates and outlier thresholds are included in the capped fee schedule published by the Administration on its website and available for inspection during normal business hours at 701 E. Jefferson St., Phoenix, AZ. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The outlier CCR will be the sum of the urban or rural default operating CCR appropriate to the location of the hospital and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. The resulting amount will be the total reimbursement for the claim. There is no provision for outlier payments for hospitals described under subsection (A)(3).
1. Hospitals designated as type: hospital, subtype: rehabilitation in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website in March of each year;
  2. Hospitals designated as type: hospital, subtype: long term in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
  3. Hospitals designated as type: hospital, subtype: psychiatric in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
  4. Transplant facilities to the extent the inpatient days associated with the transplant exceed the terms of the contract.
- B.** Notwithstanding section R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the primary diagnosis is a behavioral health diagnosis, shall be reimbursed as prescribed by ADHS; however, if the primary diagnosis is a medical diagnosis, the claim shall be processed under the DRG methodology described in this section, even if behavioral health services are provided during the inpatient stay.
- C.** Notwithstanding section R9-22-712.60, claims for services associated with transplant services shall be paid in accordance with the contract between the AHCCCS administration and the transplant facility.
- D.** Notwithstanding section R9-22-712.60, claims from an IHS facility or from a hospital operated as a 638 facility shall be paid the all-inclusive rate on a per visit basis in accordance with the rates published annually by IHS in the federal register. A 638 facility is a hospital operated by an Indian tribe or tribal organization, as defined in 25 USC 1603, funded, in whole or part, by the IHS as provided for in a contract or compact with IHS under 25 U.S.C. §§ 450 through 458aaa-18.

**R9-22-712.62. DRG Base Payment**

- A.** The initial DRG base payment is the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code assigned to the claim, and any applicable provider and service policy adjusters.
- B.** The DRG base rate for each hospital is the statewide standardized amount of which the hospital's labor-related share of that amount is adjusted by the hospital's wage index, where the standardized amount is \$5,295.40, and the hospital's labor share and the hospital's wage index are those used in the Medicare inpatient prospective payment system for the fiscal year beginning October 1, 2013.
- C.** Claims shall be assigned both a DRG code derived from all diagnosis and surgical procedure codes included on the claim (the "pre-HCAC" DRG code) and a DRG code derived excluding diagnosis and surgical procedure codes associated with the health care acquired conditions that were not present on admission or any other provider-preventable conditions (the "post-HCAC" DRG code). The DRG code with the lower relative weight shall be used to process claims using the DRG methodology.

**R9-22-712.63. DRG Base Payments Not Based on the Statewide Standardized Amount**

Notwithstanding section R9-22-712.62, the amount of \$3,436.08 shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) to calculate the DRG base rate for the following hospitals:

1. Hospitals located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2011 Medicare Cost Report are reimbursed by Medicare.
2. Hospitals designated as type: hospital, subtype: short-term that has a license number beginning "SH" in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year.

**R9-22-712.64. DRG Base Payments and Outlier CCR for Out-of-State Hospitals**

- A.** DRG Base payment:

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1. For high volume out-of-state hospitals defined in subsection (C), the wage adjusted DRG base payment is determined as described in R9-22-712.62.
2. Notwithstanding subsection R9-22-712.62 the wage adjusted DRG base rate for out-of-state hospitals that are not high volume hospitals shall be \$5,184.75.

**B. Outlier CCR:**

1. Notwithstanding subsection R9-22-712.68, the CCR used for the outlier calculation for out-of-state hospitals that are not high volume hospitals shall be the sum of the statewide urban default operating cost-to-charge ratio and the statewide capital CCR in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
2. The CCR used for the outlier calculation for high volume out-of-state hospitals is the same as in-state hospitals as described in R9-22-712.68.

**C. A high volume out-of-state hospital is a hospital not otherwise excluded under R9-22-712.61, that is located in a county that borders the State of Arizona and had 500 or more AHCCCS covered inpatient days for the fiscal year beginning October 1, 2010.**

**D. Other than as required by this section, DRG reimbursement for out-of-state hospitals is determined under R9-22-712.60 through R9-22-712.81.**

**R9-22-712.65. DRG Provider Policy Adjustor**

**A. After calculating the DRG base payment as required in sections R9-22-712.62, R9-22-712.63, or R9-22-712.64, for claims from a high-utilization hospital, the product of the DRG base rate and the DRG relative weight for the post-HCAC DRG code shall be multiplied by a provider policy adjustor of 1.055.**

**B. A hospital is a high-utilization hospital if the hospital had:**

1. At least 46,112 AHCCCS-covered inpatient days using adjudicated claim and encounter data during the fiscal year beginning October 1, 2010, which is equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals of 11,528 days; and,
2. A Medicaid inpatient utilization rate greater than 30% calculated as the ratio of AHCCCS-covered inpatient days to total inpatient days as reported in the hospital's Medicare Cost Report for the fiscal year ending 2011.

**R9-22-712.66. DRG Service Policy Adjustor**

In addition to subsection R9-22-712.65, for claims with DRG codes in the following categories, the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code, and the DRG provider policy adjustor shall be multiplied by the following service policy adjustors:

1. Normal newborn DRG codes: 1.55
2. Neonates DRG codes: 1.10
3. Obstetrics DRG codes: 1.55
4. Psychiatric DRG codes: 1.65
5. Rehabilitation DRG codes: 1.65
6. Claims for members under age 19 assigned DRG codes other than listed above: 1.25

**R9-22-712.67. DRG Reimbursement: Transfers**

**A. For purposes of this subsection a "transfer" means the transfer of a member from a hospital to a short-term general hospital for inpatient care, to a designated cancer center or children's hospital, or a critical access hospital.**

**B. Designated cancer center or children's hospitals are those hospitals identified as such in the UB-04 billing manual published by the National Uniform Billing Committee.**

**C. The hospital the member is transferred from shall be reimbursed either the initial DRG base payment or the transfer DRG base payment, whichever is less.**

**D. The transfer DRG base payment is an amount equal to the initial DRG base payment, as determined after making any provider or service policy adjustors, divided by the DRG National Average length of stay for the DRG code multiplied by the sum of one plus the length of stay.**

**E. The hospital the member is transferred to shall be reimbursed under the DRG payment methodology without a reduction due to the transfer.**

**F. Unadjusted DRG base payment. The unadjusted DRG base payment is either the initial DRG base payment, as determined after making any provider or service policy adjustors, or the transfer DRG base payment, whichever is less.**

**R9-22-712.68. DRG Reimbursement: Unadjusted Outlier Add-on Payment**

**A. Claims for inpatient hospital services qualify for an outlier add-on payment if the claim cost exceeds the outlier cost threshold.**

**B. The claim cost is determined by multiplying covered charges by an outlier CCR as described by the following subsections:**

1. For hospitals designated as type: hospital, subtype: children's in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year. The outlier CCR will be calculated by dividing the hospital total costs by the total charges using the most recent Medicare Cost

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Report available as of September 1st of that year.

2. For Critical Access Hospitals the outlier CCR will be the sum of the statewide rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
3. For all other hospitals the outlier CCR will be the sum of the operating cost-to-charge ratio and the capital cost-to-charge ratio established for each hospital in the impact file established as part of the Medicare Inpatient Prospective Payment System by CMS.

**C.** AHCCCS shall update the CCRs described in subsection (B) to conform to the most recent CCRs established by CMS as of September 1 of each year, and the CCRs so updated shall be used For claims with dates of discharge on or after October 1 of that year.

**D.** The outlier threshold is equal to the sum of the unadjusted DRG base payment plus the fixed loss amount. The fixed loss amount is \$5,000 for critical access hospitals and \$65,000 for all other hospitals.

**E.** For those inpatient hospital claims that qualify for an outlier add-on payment, the payment is calculated by subtracting the outlier threshold from the claim cost and multiplying the result by the DRG marginal cost percentage. The DRG marginal cost percentage is 90% for claims assigned DRG codes associated with the treatment of burns and 80% for all other claims.

**R9-22-712.69. DRG Reimbursement: Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment**

Adjustments to the payments are made to account for days not covered by AHCCCS as follows:

1. A covered day reduction factor unadjusted is determined if the member is not eligible on the first day of the inpatient stay but is eligible for subsequent days during the inpatient stay. In this case, a covered day reduction factor unadjusted is calculated by dividing the number of AHCCCS covered days by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of days the member is eligible during inpatient stay.
2. A covered day reduction factor unadjusted is also determined if the member is eligible on the first day of the inpatient stay but is determined ineligible for one or more days prior to the date of discharge. In this case, a covered day reduction factor unadjusted is calculated by adding one to the number of AHCCCS covered days and dividing the result by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of days the member is eligible during the inpatient stay.
3. If the covered day reduction factor unadjusted is greater than one, then the covered day reduction factor final is one; otherwise, the covered day reduction factor final is equal to the covered day reduction factor unadjusted.
4. The covered day adjusted DRG base payment is an amount equal to the product of the unadjusted DRG base payment and the covered day reduction factor final.
5. The covered day adjusted DRG outlier add-on payment is an amount equal to the product of the unadjusted DRG outlier add-on payment and the covered day reduction factor final.

**R9-22-712.70. Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment for FES members**

In addition to the covered day reduction factor in R9-22-712.69, a covered day reduction factor unadjusted is determined for an inpatient stay during which an FES member receives services for the treatment of an emergency medical condition and also receives services once the condition no longer meets the criteria as an emergency medical condition described in R9-22-217.

1. A covered day reduction factor unadjusted is calculated by adding one to the AHCCCS covered days and dividing the result by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of inpatient days during which an FES member receives services for an emergency medical condition as described in R9-22-217. For purposes of this adjustment, any portion of a day during which the FES member receives treatment for an emergency medical condition is counted as an AHCCCS covered day.
2. If the covered day reduction factor unadjusted is greater than one, then the covered day reduction factor final is one; otherwise, the covered day reduction factor final is equal to the covered day reduction factor unadjusted.
3. The covered day adjusted DRG base payment is an amount equal to the product of the unadjusted DRG base payment and the covered day reduction factor final.
4. The covered day adjusted DRG outlier add-on payment is an amount equal to the product of the unadjusted DRG outlier add-on payment and the covered day reduction factor final.

**R9-22-712.71. Final DRG Payment**

**A.** The final DRG payment is the sum of the final DRG base payment and the final DRG outlier add-on payment. The final DRG base payment is an amount equal to the product of the covered day adjusted DRG base payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

**B.** The final DRG outlier add-on payment is an amount equal to the product of the covered day adjusted DRG outlier add-on payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition

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from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

- C. The factor for each hospital and for each federal fiscal year is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS administration's website and is on file for public inspection at the AHCCCS administration located at 701 E. Jefferson St., Phoenix, AZ.

**R9-22-712.72. DRG Reimbursement: Enrollment Changes During an Inpatient Stay**

- A. If a member's enrollment changes during an inpatient stay, including changing enrollment from fee-for-service to a contractor, or vice versa, or changing from one contractor to another contractor, the contractor with whom the member is enrolled on the date of discharge shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in sections R9-22-712.60 through R9-22-712.81. If the member is eligible but not enrolled with a contractor on the date of discharge, then the AHCCCS administration shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in sections R9-22-712.60 through R9-22-712.81.
- B. When a member's enrollment changes during an inpatient stay, the hospital shall use the date of enrollment with the payer responsible on the date of discharge as the "from" date of service on the claim regardless of the date of admission. The claim may include all surgical procedures performed during the entire inpatient stay, but the hospital shall only include revenue codes, service units, and charges for services performed on or after the date of enrollment.
- C. Interim claims submitted to a payer other than the payer responsible on the day of discharge shall be processed in the same manner as other interim claims as described in R9-22-712.76.

**R9-22-712.73. DRG Reimbursement: Inpatient Stays for Members Eligible for Medicare**

If the hospital receives less than the full Medicare payment for a member eligible for benefits under Part A of Medicare because the member has exceeded the maximum benefit permitted under Part A of Medicare, the hospital shall submit a separate claim for services performed after the date the maximum Medicare Part A benefit is exceeded. The claim may include all diagnosis codes for the entire inpatient stay, but the hospital is only required to include revenue codes, surgical procedure codes, service units, and charges for services performed after the date the Medicare Part A benefit is exceeded. A claim so submitted shall be reimbursed using the DRG payment methodology.

**R9-22-712.74. DRG Reimbursement: Third Party Liability**

DRG payments are subject to reduction based on cost avoidance under section R9-22-1003 and other rules regarding first-and third-party liability under Article 10 of this Chapter including cost avoidance for claims for ancillary services covered under Part B of Medicare.

**R9-22-712.75. DRG Reimbursement: Payment for Administrative Days**

- A. Administrative days are days of a hospital stay in which a member does not meet criteria for an acute inpatient stay, but is not discharged because an appropriate placement outside the hospital is not available, the Administration or the contractor fail to provide for the appropriate placement outside the hospital in a timely manner, or the member cannot be safely discharged or transferred.
- B. Administrative days do not include days when the member is awaiting appropriate placement or services that are currently available but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays.
- C. Prior authorization is required for administrative days.
- D. A hospital shall submit a claim for administrative days separate from any claim for reimbursement for the inpatient stay otherwise reimbursable under the DRG payment methodology.
- E. Administrative days are reimbursed at the rate the claim would have paid had the services not been provided in an inpatient hospital setting but had been provided at the appropriate level of care (e.g., as nursing facility days).

**R9-22-712.76. DRG Reimbursement: Interim Claims**

- A. For inpatient stays with a length of stay greater than 29 days, a hospital may submit interim claims for each 30 day period during the inpatient stay.
- B. Hospitals shall be reimbursed for interim claims at a per diem rate of \$500 per day.
- C. Following discharge, the hospital shall void all interim claims. In such circumstances, the hospital shall submit a claim to the payer with whom the member is enrolled on the date of discharge, whether the Administration or a contractor, for the entire inpatient stay for which the final claim shall be reimbursed under the DRG payment methodology. Interim claims will be recouped.

**R9-22-712.77. DRG Reimbursement: Admissions and Discharges on the Same Day**

- A. Except as provided for in subsection (B), for any claim for inpatient services with an admission date and discharge date that are the same calendar date, the contractor or the Administration shall process the claim as an outpatient claim and the hospital shall be reimbursed under R9-22-712.10 through R9-22-712.50.
- B. Claims with an admission date and discharge date that are the same calendar date that also indicate that the member expired on the date of discharge shall be reimbursed under the DRG methodology.

**R9-22-712.78. DRG Reimbursement: Readmissions**

If a member is readmitted without prior authorization to the same hospital that the member was discharged from within 72 hours and the DRG code assigned to the claim for the prior admission has the same first three digits as the DRG code assigned to the claim for the readmission, then payment for the claim for the readmission will be disallowed only if the readmission could have been prevented by the hospital.

**R9-22-712.79. DRG Reimbursement: Change of Ownership**

The administration shall not change any of the components of the calculation of reimbursement for inpatient services using the DRG methodology based upon a change in the hospital's ownership except to the extent those components would change under the methodology had the hospital not changed ownership (e.g., updating the hospital's cost-to-charge ratio as of September 1 of each year under R9-22-712.68).

**R9-22-712.80. DRG Reimbursement: New Hospitals**

- A.** DRG base payment for new hospitals. For any hospital that does not have a labor share or wage index published by CMS as described in section R9-22-712.62(B) because the hospital was not in operation, the DRG base rate described in section R9-22-712.62(B) shall be calculated as the statewide standardized amount of \$5,295.40 after adjusting that amount for the labor-related share and the wage index published by CMS as described in section R9-22-712.62(B) that is appropriate to the location of the hospital published by CMS as described in section R9-22-712.62(B).
- B.** Outlier calculations for new hospitals. For any hospital that does not have an operating cost-to-charge ratio listed in the impact file described in section R9-22-712.68(B) because the hospital was not in operation prior to the publication of the impact file, the statewide urban or rural default operating cost-to-charge ratio appropriate to the location of the hospital and the statewide capital cost-to-charge ratio shall be used to determine the unadjusted outlier add-on payment. The statewide urban or rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio shall be based on the ratios published by CMS and updated by the Administration as described in section R9-22-712.68(C).
- C.** In addition to the requirement of this section, DRG reimbursement for new hospitals is determined under R9-22-712.60 through R9-22-712.79.

**R9-22-712.81. DRG Reimbursement: Updates**

In addition to the other updates provided for in sections R9-22-712.60 through R9-22-712.80, the Administration may adjust the state-wide standardized amount in section R9-22-712.62, the base payments in sections R9-22-712.63 and R9-22-712.64, the provider policy adjustor in section R9-22-712.65, service policy adjustors section R9-22-712.66, and the fixed loss amounts and marginal cost percentages used to calculate the outlier threshold in section R9-22-712.68 to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

**R9-22-715. Hospital Rate Negotiations**

- A.** A contractor that negotiates with hospitals for inpatient or outpatient services shall reimburse hospitals for services rendered on or after March 1, 1993, as described in A.R.S. § 36-2903.01 and this Article, or at the negotiated rate that, in the aggregate, does not exceed reimbursement levels that would have been paid under A.R.S. § 36-2903.01, and this Article. This subsection does not apply to urban hospitals described under R9-22-718.
  - 1. Contractors may engage in rate negotiations with a hospital at any time during the contract period.
  - 2. Within seven days before the effective date of a contract, a contractor shall submit copies of the contractor's negotiated rate agreements with hospitals, including all rates, terms, and conditions, to the Administration for approval.
- B.** The Administration may negotiate or contract with a hospital on behalf of a contractor for discounted hospital rates and may require that the negotiated discounted rates be included in a subcontract between the contractor and hospital.

**R9-22-718. Urban Hospital Inpatient Reimbursement Program**

- A.** Definitions. The following definitions apply to this Section:
  - 1. "Noncontracted Hospital" means an urban hospital which does not have a contract under this Section with an urban contractor in the same county.
  - 2. "Rural Contractor" means a contractor or program contractor as defined in A.R.S. Title 36, Chapter 29 that does not provide services to members residing in either Maricopa or Pima County.
  - 3. "Urban Contractor" means a contractor or program contractor as defined in A.R.S. Title 36, Chapter 29, that provides services to members residing in Maricopa or Pima County and may also provide services to members who reside in other counties. An urban contractor does not include ~~ADHS/BHS, CRS, CMDP, HCG or a Tribal government TRBHA.~~
  - 4. "Rural Hospital" means a hospital, as defined in R9-22-712.07, that is physically located in Arizona but in a county other than Maricopa and Pima County.
  - 5. "Urban Hospital" means a hospital that is not a rural hospital and is physically located in Maricopa or Pima County.
- B.** General Provisions.
  - 1. This Section applies to an urban hospital who receives payment for inpatient hospital services under A.R.S. §§ 36-

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- 2903.01 and 36-2904.
2. AHCCCS shall operate an inpatient hospital reimbursement program under A.R.S. § 36-2905.01 and this Section.
  3. Residency of the member receiving inpatient AHCCCS covered services is not a factor in determining which hospitals are required to contract with which contractors.
  4. An urban contractor shall enter into a contract for reimbursement for inpatient AHCCCS covered services with one or more urban hospitals located in the same county as the urban contractor.
  5. A noncontracted urban hospital shall be reimbursed for inpatient services by an urban contractor at 95% of the amount calculated as defined in A.R.S. § 36-2903.01 and this Article, unless otherwise negotiated by both parties.
- C.** Contract Begin Date. A contract under this Article shall cover inpatient acute care hospital services for members with hospital admissions on and after October 1, 2003.
- D.** Outpatient urban hospital services. Outpatient urban hospital services, including observation days and emergency room treatments that do not result in an admission, shall be reimbursed either through an urban hospital contract negotiated between a contractor and an urban hospital, or the reimbursement rates set forth in A.R.S. § 36-2903.01. Outpatient services in an urban hospital that result in an admission shall be paid as inpatient services in accordance with this Section.
- E.** Urban Hospital Contract.
1. Provisions of an urban hospital contracts. The urban hospital contract shall contain but is not limited to the following provisions:
    - a. Required provisions as described in the Request for Proposals (RFP);
    - b. Dispute settlement procedures. If the AHCCCS Grievance System prescribed in A.R.S. § 36-2903.01(B) and rule is not used, then arbitration shall be used;
    - c. Arbitration procedure. If arbitration is used, the urban hospital contract shall identify:
      - i. The parties' agreement on arbitrating claims arising from the contract,
      - ii. Whether arbitration is nonbinding or binding,
      - iii. Timeliness of arbitration,
      - iv. What contract provisions may be appealed,
      - v. What rules will govern arbitrations,
      - vi. The number of arbitrators that shall be used,
      - vii. How arbitrators shall be selected, and
      - viii. How arbitrators shall be compensated.
    - d. Timeliness of claims submission and payment;
    - e. Prior authorization;
    - f. Concurrent review;
    - g. Electronic submission of claims;
    - h. Claims review criteria;
    - i. Payment of discounts or penalties such as quick-pay and slow-pay provisions;
    - j. Payment of outliers;
    - k. Claim documentation specifications under A.R.S. § 36-2904.
    - l. Treatment and payment of emergency room services; and
    - m. Provisions for rate changes and adjustments.
  2. AHCCCS review and approval of urban hospital contracts:
    - a. AHCCCS may review, approve, or disapprove the hospital contract rates, terms, conditions, and amendments to the contract;
    - b. ~~An urban contractor shall submit urban hospital contracts and amendments as specified in the RFPs for the contract year beginning October 1, 2003, or as specified in the RFP for a new urban hospital contract negotiated after October 1, 2003;~~
    - e.b. The AHCCCS evaluation of each urban hospital contract shall include but not be limited to the following areas:
      - i. Availability and accessibility of services to members,
      - ii. Related party interests,
      - iii. Inclusion of required terms pursuant to this Section, and
      - iv. Reasonableness of the rates.
  3. ~~Evaluation of urban contractor's use of a noncontracted hospital. AHCCCS shall evaluate the contractor's use of a contracted versus noncontracted hospital.~~
- F.** Quick-Pay/Slow-Pay. A payment made by urban contractor to a noncontracted hospital shall be subject to quick-pay discounts and slow-pay penalties under A.R.S. § 36-2904.



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

No changes were made between the proposed rulemaking and the final rulemaking, In addition, technical and grammatical changes were made as a result of the Governors Regulatory Review Council’s review.

**11. An agency’s summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:**

Comment received from Kathleen Pagels, April 14, 2014. No other comments were received as of the close of the comment period of April 21, 2014.

<b><u>Numb:</u></b>	<b><u>Date/Commen- tor:</u></b>	<b><u>Comment:</u></b>	<b><u>Response:</u></b>
1.	04/14/14 Kathleen Pagels AZ Health Care Association	R9-28-702 Add to C2 “as of October 1 <sup>st</sup> of the assess- ment year”.	The Administration states in rule that information can be received by November 1 <sup>st</sup> under subsection D7. It is not necessary to repeat under this rule. November 1 <sup>st</sup> was selected to allow time to acquire and review information and determine if more information is necessary. The later date provides greater flexibility in time to amend or clarify information submitted.
2.	04/14/14 Kathleen Pagels AZ Health Care Association	R9-28-702 Add a C6 “out of state skilled nursing provid- ers”.	R9-28-702 C provides the list of providers exempt from the assessment. The Administration does not have authority to assess out of state nursing facilities, therefore, it is not necessary to add this to rule.
3.	04/14/14 Kathleen Pagels AZ Health Care Association	R9-28-702 Comment to D5: We question whether CMS guidance indicates a new waiver is required for annual slope recalculation, but are ok with annual slope recalculation.	Whether CMS approval is required is outside the scope of this rulemaking.
4.	04/14/14 Kathleen Pagels AZ Health Care Association	R9-28-703 Add to A1: Dispute section - Suggested or Sample language  “Any facility whose AHCCCS utilization per- centage (Medicaid Claims Paid divided by Total Claims Paid) varies from the UAR Util- ization percentage (Reported Days divided by total Reported Days) from the UAR) by more than 1 standard deviation from the Mean is considered an outlier. The calculation for percentage variance is as follows:  1. Absolute Value([AHCCCS Medicaid Utili- zation %] - [UAR Medicaid Utilization %])  2. Calculate +/- 1 Standard Deviations of part #1  3. Identify each facility that falls outside of 1 standard deviation from the mean. These would be considered an outlier. If a facility has been deemed an outlier then they should be contacted by AHCCCS and given the opportunity (30 days from the date of contact to provide paid claims data to AHCCCS, supporting their Medicaid/ALTCS days. Support would be documentation such as Remittance Advice, EFT, Check etc... that can be directly tied to a specific patient.	The payment calculation uses a consistent set of data where every provider receives a proportional payment based on that single set of consistent data. To introduce supplemental data for a select number of providers unfairly disadvantages other providers who will receive a smaller proportional payment, and may lead to ongoing submission of data from other facilities and significant delays in the calculation of the payment.  In addition, the proposed process would make it difficult for the Administration to comply with the quarterly payment timeline.  The State Plan approved by the federal government requires that we use adjudicated claims and encounters for the supplemental payment.  A dispute resolution process is in place to address concerns.

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

**12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**

No other matters are applicable.

**a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**

Not applicable

**b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**

The rule must conform to the requirements of 42 U.S.C. § 1396b(w) and the implementing federal regulations found at 42 C.F.R. Part 433, Subpart B. An assessment or supplemental payments that do not meet federal requirements would result in a reduction in federal financial participation in the Medicaid program administered in Arizona. As indicated in the statute, federal approval for the assessment and the supplemental payments is required. As such, the rule will not exceed the parameters of federal law.

**c. Whether a person submitted an analysis to the agency that compares the rule’s impact of the competitiveness of business in this state to the impact on business in other states:**

Not applicable

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

None

**14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:**

Not applicable

**15. The full text of the rules follows:**

**TITLE 9. HEALTH SERVICES**

**CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)  
ARIZONA LONG-TERM CARE SYSTEM**

**ARTICLE 7. STANDARDS FOR PAYMENTS**

*Arizona Administrative Register / Secretary of State*  
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Section

- R9-28-702. Nursing Facility Assessment  
R9-28-703. Nursing Facility Supplemental Payments

**ARTICLE 7. STANDARDS FOR PAYMENTS**

**R9-28-702. Nursing Facility Assessment**

- A. For purposes of ~~this Section~~ R9-28-702 and R9-28-703, in addition to the definitions under A.R.S. 3 6-2999.51, the following terms have the following meaning unless the context specifically requires another meaning:
- “820 transaction” means the standard health care premium payments transaction required by 45 CFR 162.1702.
  - “Assessment year” means the 12 month period beginning October 1<sup>st</sup> each year
  - “Nursing Facility Assessment” means ~~a tax paid by a qualifying nursing facility to the Department of Revenue on a quarterly basis established under A.R.S. § 36-2999.52.~~
  - “Medicaid days” means ~~days of nursing facility services paid for by the Administration or its contractors as the primary payor and as reported in AHCCCS’ claim and encounter data.~~
  - “Medicaid patient days” means patient days reported on the Nursing Care Institution Uniform Accounting Report (UAR) as attributable to AHCCCS and its contractors as the primary payor.
  - “Medicare days” means ~~resident days where the Medicare program, a Medicare advantage or special needs plan, or the Medicare hospice program is the primary payor.~~
  - “Medicare patient days” means patient days reported on the Nursing Care Institution UAR as Skilled Medicare Patient Days or Part C/Advantage/Medicare Replacement Days.
  - “Nursing Care Institution UAR” means the Nursing Care Institution Uniform Accounting Report described by R9-11-204.
  - “Payment year” means ~~the 12 month period beginning October 1<sup>st</sup> each year.~~
- B. Subject to Centers for Medicare and Medicaid Services (CMS) approval, effective October 1, 2012, nursing facilities shall be subject to a provider assessment payable on a quarterly basis.
- C. All nursing facilities licensed in the state of Arizona shall be subject to the provider assessment except for:
1. A continuing care retirement community,
  2. A facility with 58 or fewer beds, according to the Arizona Department of Health Services, Division of Licensing Services, Provider & Facility Database.
  3. A facility designated by the Arizona Department of Health Services as an Intermediate Care Facility for the ~~Mentally Retarded~~ Intellectually Disabled,
  4. A tribally owned or operated facility located on a reservation, or
  5. Arizona Veteran’s Homes
- D. The Administration shall calculate the prospective nursing facility provider assessment for qualifying nursing facilities as follows:
- ~~1. The Administration shall utilize each nursing facility’s Uniform Accounting Report (UAR) submitted to the Arizona Department of Health Services as of August 1<sup>st</sup> immediately preceding the assessment year. In addition, by August 1<sup>st</sup> each year, each nursing facility shall provide the Administration with any additional information necessary to determine the assessment. For any nursing facility that does not provide by August 1<sup>st</sup> the additional information requested by the Administration, the Administration shall determine the assessment based on the information available.~~
  1. In September of each year, the Administration shall obtain from the Arizona Department of Health Services the most recently published Nursing Care Institution UAR and the information required in subsection (C)(2). At the request of the Administration, a nursing facility shall provide the Administration with any additional information necessary to determine the assessment.
  2. The Administration shall use the information obtained under subsection (D)(1) to determine:
    - a. Each nursing facility’s total annual Medicaid patient days.
    - b. Each nursing facility’s total annual Medicare patient days.
    - c. Each nursing facility’s total annual patient days.
    - d. The aggregate net patient service revenue of all assessed providers, and
    - e. The slope described under 42 CFR 433.68(e)(2).
  - ~~2-3. For each nursing facility, other than a nursing facility ~~noted~~ exempted in subsection ~~(D)(3)~~ (C) or described in subsection (D)(4), the provider assessment is calculated by multiplying the nursing facility’s ~~non-Medicare resident day data for each assessment year by \$7.50~~ total annual patient days other than Medicare patient days by \$10.50.~~
  - ~~3-4. For a nursing facility, other than a nursing facility exempted in subsection (C), with ~~the~~ a number of total annual Medicaid patient days greater than or equal to the number required to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2), the provider assessment is calculated by multiplying the nursing facility’s ~~non-Medicare resident day data for each assessment year by \$1.00~~ total annual patient days, other than Medicare patient days, by \$1.40.~~

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- 4.5. ~~The number of annual Medicaid days used in subsection (D)(3) shall be recalculated each August 1, to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2). For each assessment year the slope described under 42 CFR 433.68(e)(2) shall be recalculated.~~
- 5.6. The total annual assessment calculated under subsections ~~(D)(2), (D)(3) and (D)(4)~~ (D)(3), (D)(4) and (D)(5), shall not exceed 3.5 percent of the aggregate net patient service revenue of all assessed providers as reported on the Nursing Care Institution UAR obtained under subsection (D)(1).
- 7. All calculations and determinations necessary for the provider assessment shall be based on information possessed by the Administration on or before November 1 of the assessment year.
- 6.8. The Administration ~~will~~ shall forward the provider assessments ~~by facility~~ for all assessed facilities to the Arizona Department of Revenue by no later than December 1 ~~of preceding~~ of the assessment year.
- 7.9. In the event a nursing facility closes during the assessment year, the nursing facility shall cease to be responsible for the portion of the assessment applied to the dates the nursing facility is not operating.
- 8.10. In the event a nursing facility begins operation during the assessment year, that facility ~~would~~ will have no responsibility for the assessment until such time as the facility has UAR data that falls within the collection period for the assessment calculation submitted to the Arizona Department of Health Services the report required by R9-11-204(A) covering a full year of operation.
- 9.11. In the event a nursing facility has a change of ownership such that the facility remains open and the ownership of the facility changes, the assessment liability transfers with the change in ownership.

**R9-28-703. Nursing Facility Supplemental Payments**

**A. Nursing Facility Supplemental Payments**

- 1. Using Medicaid resident bed day information from the most recent and complete twelve months of adjudicated claims and encounter data, for every combination of contractor and every facility eligible for a supplemental payment, the Administration shall determine annually a ratio equal to the number of bed days for the facility paid by each contractor divided by the total number of bed days paid to all facilities by all contractors and the Administration.
- 2. Using the same information as used in (A)(1), for every facility eligible for a supplemental payment, the Administration shall determine annually a ratio equal to the number of bed days for the facility paid by the Administration divided by the total number of bed days paid to all facilities by all contractors and the Administration.
- 3. Quarterly, each contractor shall make payments to each facility in an amount equal to 98% of the amounts identified as Nursing Facility Enhanced Payments in the 820 transaction sent from AHCCCS to the contractor for the quarter multiplied by the percentage determined in subsection ~~(A)(2)~~ (A)(1) applicable to the contractor and to each facility.
- 4. Quarterly, the Administration shall make payments to each facility in an amount equal to 99% of the amounts collected during the preceding quarter under R9-28-702, less amounts collected and used to fund the Nursing Facility Enhanced Payments included in the capitation paid to contractors and the corresponding federal financial participation, multiplied by the percentage determined in subsection (A)(2) applicable to the Administration and to each facility. The Administration shall make the supplemental payments to the nursing facilities within 20 calendar days of the determination of the quarterly supplemental payment.
- 5. Neither the Administration nor ~~the Contractors~~ its contractors shall be required to make quarterly payments to facilities otherwise required by subsections (A)(3) or (A)(4) until the assessment collected and actually amount available in the nursing facility assessment fund established by A.R.S. § 36-2999.53, plus the corresponding federal financial participation, are is equal to or greater than 101% of the amount necessary for contractors to make the payments to facilities described in subsections (A)(4) and (A)(5) to make such payments in full.
- 6. Contractors shall not be required to make quarterly payments to a facility otherwise required by subsection ~~(A)(4)~~ (A)(3) until the Administration has made a retroactive adjustment to the capitation rates paid to contractors to correct the Nursing Facility Enhanced ~~payments~~ Payments based on actual member months for the specified quarter.

**B.** Each contractor must pay each facility the amount computed within 20 calendar days of receiving the ~~nursing facility enhanced payment~~ Nursing Facility Enhanced Payment from the Administration. The contractors must confirm each payment and payment date to the Administration within 20 calendar days from receipt of the funds.

**C.** After each assessment year, the Administration shall reconcile the payments made by contractors under ~~subsection (A)~~ subsections (A)(3) and (B) to the portion of the annual collections under R9-28-702 attributable to Medicaid resident bed days paid for by contractors for the same year, less one percent, plus available federal financial participation. The proportion of each nursing facility's Medicaid resident bed days as described in subsection ~~(A)(2)(ii)~~ (A)(1) shall be used to calculate the reconciliation amounts. Contractors shall make additional payments to or recoup payments from nursing facilities based on the reconciliation in compliance with the requirements of subsection (B).

**D. General requirements for all payments.**

- 1. A facility must be open on the date the supplemental payment is made in order to receive a payment. In the event a nursing facility closes during the assessment year, the nursing facility shall cease to be eligible for supplemental payments.
- 2. In the event a nursing facility begins operation during the assessment year, that facility shall not receive a supplemental payment until such time as the facility has claims and encounter data that falls within the collection period for the

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- payment calculation.
3. In the event a nursing facility has a change of ownership, payments shall be made to the owner of the facility as of the date of the supplemental payment.
  4. Subsection (E)(3) shall not be interpreted to prohibit the current and prior owner from agreeing to a transfer of the payment from the current owner to the prior owner.
- E.** The Arizona Veterans' Homes are not eligible for supplemental payments.