NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R05-70]

PREAMBLE

1. **Sections Affected** / **Rulemaking Action**

Sections Affected	Rulemaking Action
R9-22-201	Amend
R9-22-702	Amend

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

   Authorizing statute: A.R.S. § 36-2903.01(F)

   Implementing statute: A.R.S. § 36-2903.01(L)

3. **A list of all previous notices appearing in the Register addressing the proposed rule:**

   Notice of Rulemaking Docket Opening:10 A.A.C. 3978, October 1, 2004

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

   Name: Jane McVay

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

   Telephone: (602) 417-4185

   Fax: (602) 253-9115

   E-mail: AHCCCSRules@ahcccs.state.az.us

5. **An explanation of the rule, including the agency's reasons for initiating the rule:**

   The rule will clarify existing rule language regarding member billing for acute care services provided under the AHCCCS program. The existing rule needs to be modified to clarify the rule's meaning and intent. Existing rules allow a member who requests an uncovered service, or a service not authorized by a contractor, or the Administration, to receive the service and request reimbursement. The provider must give the member a list of the services that will be provided and the estimated cost. This document, which is signed by the member, states that the member is responsible for payment. The existing rule has been interpreted to mean that emergency department providers are not allowed to bill Federal Emergency Services (FES) members when services are provided for medical conditions that appear to be an emergency, which the Administration determines later are not an emergency. In these cases, AHCCCS cannot reimburse the emergency department provider because the services do not meet the criteria for emergency services. This rule will allow emergency department providers and other providers to bill members for uncovered acute care services that do not meet the definition of emergency services under the Federal Emergency Services Program (FESP). In addition, the rule will allow a registered AHCCCS provider to charge and collect payment for services from a member if the member requests an uncovered or unauthorized service. The provider must prepare a document for the member describing the services and approximate cost. When the member signs the document before a service is provided, the member accepts responsibility for the payment. The rule also clarifies that behavioral health services are not covered services if provided to a person under age 22, who is in residence at an institution for mental diseases,

unless the person is receiving inpatient psychiatric services. This change is needed to comply with federal regulations and clarifies billing issues for these services.

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

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
   The rule does not decrease the authority of political subdivisions.

8. **The preliminary economic, small business, and consumer impact**
   The rule has a positive economic impact on businesses, particularly emergency room providers by providing clarity to the issue of member billing. When emergency rooms and other medical providers deliver services to members in the Federal Emergency Services Program (FESP) in the reasonable belief that the services meet the criteria for an emergency, but the Administration determines that emergency service criteria were not met, emergency room providers will be able to bill the member. Other providers will be able to charge a member for additional services requested that are not covered or not authorized by the Administration, by following the required procedures. Although the economic impact of the rule on hospitals, emergency department providers, other medical providers, and their collections is unknown, the potential impact is expected to be favorable to them. Emergency department providers and consumers will clearly understand that a member is financially responsible for services requested that are not covered, or not authorized by a contractor or the Administration, including services to members eligible for FESP that do not meet emergency services criteria. The rule also clarifies that inpatient psychiatric services are covered services for persons under age 22, who are inmates at Institutions for Mental Diseases.

9. **The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**

   Name: Jane McVay

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

   Telephone: (602) 417-4135

   Fax: (602) 253-9115

   E-mail: AHCCCSRules@ahcccs.state.az.us

   Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of February 7, 2005. Please send written comments to the above address by 5:00 p.m., March 28, 2005. E-mail comments will be accepted.

10. **The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**

    Date: March 28, 2005

    Time: 10:00 a.m.

    Location: AHCCCS
    701 E. Jefferson
    Phoenix, AZ 85034
    Gold Room

    Nature: Public Hearing

    Date: March 28, 2005

    Time: 10:00 a.m.

    Location: ALTCS: Arizona Long-term Care System
    110 S. Church, Suite 1360
    Tucson, AZ 85701
    Training Room

    Nature: Public Hearing

Date:	March 28, 2005
Time:	10:00 a.m.
Location:	ALTCS: Arizona Long-term Care System 3480 E. Route 66 Flagstaff, AZ 86004 Conference Room
Nature:	Public Hearing

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
None

12. Incorporations by reference and their location in the rules:
None

13. 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
R9-22-201. General Requirements

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-702. ~~Prohibitions Against~~ Charges to Members

ARTICLE 2. SCOPE OF SERVICES

R9-22-201. General Requirements

A. For the purposes of this Article,
1. Authorization means written or verbal authorization by:
   a. The Administration for services rendered to a fee-for-service member, and 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 requirements and limitations specified in this Chapter, the following general requirements apply:
1. Only medically necessary, cost effective, and federally and state reimbursable services are covered services;
2. Covered services for the ~~state and federal emergency services programs~~ federal emergency services program (FESP) ~~and SESP)~~ are under R9-22-217;
3. The Administration or a contractor may waive the covered services referral requirements required by 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 shall 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 evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from and in consultation with the primary care provider, or upon authorization by the contractor or its designee;
7. A member may receive a treatment that is considered the standard of care, or that is approved by AHCCCS Chief Medical Officer after appropriate consultative input from providers who are considered experts in the field by the professional medical community;
8. A member shall receive services according to the Section 1115 Waiver as defined in A.R.S. § 36-2901;
9. An AHCCCS registered provider shall provide covered services within the provider’s scope of practice;
10. 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 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; and

11. 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 provided under Article 12 of this Chapter.
    d. A person under age 22 who is in residence at an IMD, unless the person is receiving inpatient psychiatric services.

C. The Administration or 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. Documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.

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. Diagnostic and treatment procedures for a condition that is unrelated to the emergency medical condition require prior authorization by the Administration or contractor.

F. A member shall receive covered services outside the contractor's service area only if one of the following apply:
1. A member is referred by a primary care provider for medical specialty care out of the contractor's area. If a member is referred out of the contractor's service area to receive an authorized medically necessary service, a 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 service area 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 contractor's service area; or
4. Services are provided during the prior period coverage time-frame.

G. If a member is traveling or temporarily residing out of the member's contractor service area, 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 Article, 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.** If a member requests the provision of a service that is not covered or not authorized by a contractor or the Administration, an AHCCCS registered provider may render the service and request reimbursement from the member if:~~
~~1. The provider prepares and provides the member with a document that lists the requested services and the estimated cost of each service, and~~
~~2. The member signs the document prior to the provision of services indicating that the member understands and accepts the responsibility for payment.~~

~~**K.**~~**J.** The restrictions, limitations, and exclusions in this Article do not apply to the following groups:
1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27, and benefits not covered by AHCCCS; 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.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-702. ~~Prohibitions Against~~ Charges to Members

A. Except as provided in ~~subsection (B),~~ subsections (B), (C), and (D), an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration that the person was ineligible for AHCCCS on the date of service:
1. Charge, submit a claim to, demand, or collect payment from a person claiming to be AHCCCS eligible; or
2. Refer or report a person claiming to be AHCCCS eligible to a collection agency or credit reporting agency.

B. An AHCCCS registered provider may charge, submit a claim to, demand, or collect payment from a member as follows:
1. To collect an authorized copayment;
2. ~~To pay for non-covered services; or services not authorized by a contractor or the Administration under the provisions~~

~~of this chapter;~~

~~3.~~2. To recover from a member that portion of a payment made by a third-party to the member if the payment duplicates AHCCCS paid benefits and is not assigned to a contractor. ~~under R9-22-1002(B).~~ An AHCCCS registered provider that makes a claim shall not charge more than the actual, reasonable cost of providing the covered service; or

~~4.~~3. To ~~bill~~ obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused the payment to the provider to be reduced or denied.

C. An AHCCCS registered provider may charge, submit a claim to, demand, or collect payment for services from a member if:

1. The member requests the provision of a service that is not covered or not authorized by a contractor or the Administration; and
2. The provider prepares and provides the member with a document describing the overall services and the approximate cost of the services; and
3. The member signs the document prior to the provision of a service, indicating that the member understands and accepts the responsibility for payment.

D. Notwithstanding subsection (C), An AHCCCS registered provider may charge, submit a claim to, demand, or collect payment for services from a member eligible for the FESP, if:

1. The provider submits a claim to the Administration in the reasonable belief that the service is an emergency service; and
2. The Administration denies the claim because the service does not meet the criteria of R9-22-217.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R05-54]

PREAMBLE

1. Sections Affected | **Rulemaking Action**

Sections Affected	Rulemaking Action
R9-22-712	Amend
R9-22-712.01	New Section
R9-22-712.09	New Section

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

Authorizing statute: A.R.S. §§ 36-2904 and 36-2903.01

Implementing statute: A.R.S. §§ 36-2904, 36-2986 and 36-2903.01

3. A list of all previous notices appearing in the Register addressing the proposed rule:

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

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

Name: Mariaelena Ugarte

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

Telephone: (602) 417-4232

Fax: (602) 253-9115

E-mail: AHCCCSRules@ahcccs.state.az.us

5. An explanation of the rule, including the agency's reasons for initiating the rule:

The proposed rules were amended as result of a Five-Year Rule Review, finding that clarification was needed to address how payments are made by the Administration for hospital services. Statutory references were updated and the rule reorganized for clarity.

6. **A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on or 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:**

   No studies were reviewed.

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

   Not applicable.

8. **The preliminary summary of the economic, small business, and consumer impact:**

   AHCCCS anticipates no impact.

9. **The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**

   Name: Mariaelena Ugarte

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

   Telephone: (602) 417-4232

   Fax: (602) 256-6756

   E-mail: AHCCCSRules@ahcccs.state.az.us

   Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of February 11, 2005. Please send written comments to the above address by 5:00 p.m., April 4, 2005. E-mail will be accepted.

10. **The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**

    Date: April 4, 2005

    Time: 1:00 p.m.

    Location: AHCCCS
701 East Jefferson
Phoenix, AZ 85034
Gold Room

    Nature: Public Hearing

    Date: April 4, 2005

    Time: 1:00 p.m.

    Location: ALTCS: Arizona Long-term Care System
110 South Church, Suite 1360
Tucson, AZ 85701

    Nature: Public Hearing

    Date: April 4, 2005

    Time: 1:00 p.m.

    Location: ALTCS: Arizona Long-term Care System
3480 East Route 66
Flagstaff, AZ 86004

    Nature: Public Hearing

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

    None

12. **Incorporations by reference and their location in the rules:**

    None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-712. Payments by the Administration for Hospital Services
R9-22-712.01. Inpatient hospital reimbursement
R9-22-712.02. Reserved
R9-22-712.03. Reserved
R9-22-712.04. Reserved
R9-22-712.05. Reserved
R9-22-712.06. Reserved
R9-22-712.07. Reserved
R9-22-712.08. Reserved
R9-22-712.09. Hierarchy For Tier Assignment

ARTICLE 7. STANDARDS FOR PAYMENTS

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

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

1. ~~Tier rate data. To calculate the tiered per diem rates for the initial prospective year, the Administration shall use Medicare Cost Reports for Arizona hospitals for fiscal years ending in 1990 and a database consisting of inpatient hospital claims and encounters for each hospital with beginning dates of service for the period November 1, 1990, through October 31, 1991.~~
   a. ~~Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation for the initial prospective rate year, the Administration shall inflate all the costs to a common point in time as described in subsection (A)(2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than one hospital, the Administration shall allocate the costs to each of the respective hospitals. Hospitals shall submit information to assist the Administration in this allocation.~~
   b. ~~Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed under A.R.S. § 36-2903.01(J). The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude claims and encounters that fail these edits from the database. The Administration may make adjustments to the data as required to correct errors. The Administration shall also exclude from the database, the following claims and encounters:~~
      i. ~~Those missing information necessary for the rate calculation,~~
      ii. ~~Medicare crossovers,~~
      iii. ~~Those submitted by freestanding psychiatric hospitals, and~~
      iv. ~~Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.~~
2. ~~Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on~~

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

~~a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the rate for the operating component shall be computed as follows:~~

~~i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with federal regulation, 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.~~

~~ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports have been grouped. The ancillary department cost-to-charge ratios for a particular hospital shall be multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters shall be multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day shall exclude medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1991, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs.~~

~~iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these items. For the ICU tier, claims and encounters shall be further assigned to the urban or rural peer group. The tier rate for NICU Level II shall be calculated as 75% of the NICU Level III tier rate. For claims and encounters assigned to more than one tier, ancillary department costs shall be allocated to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component of the tiered per diem rates, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (A)(6).~~

~~iv. Operating rate calculation. The rate for the operating component for each tier shall be set by dividing total statewide or peer group hospital costs identified in subsection (A)(2)(a) within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.~~

~~b. Medical education component.~~

~~i. Calculation of medical education costs and component rate. The Administration shall calculate the rate for the medical education component of the tiered per diem rate on a hospital-specific basis by identifying the total direct medical education costs listed on the hospital's Medicare Cost Report. The medical education costs identified for each hospital shall reflect the medical education costs incurred by all the payors for the hospital's services, including AHCCCS. The Administration shall reduce the medical education costs for each hospital by an audit adjustment factor based on available national data and Arizona experience in adjustments to Medicare reimbursable costs. The Administration shall divide the hospital's reduced medical education costs by the hospital's total inpatient days for all patients to yield the rate for the medical education component of the tiered per diem rate. The Administration shall inflate the medical education component to a common point in time, December 31, 1991, using the DRI inflation factor.~~

~~ii. Indexing medical education component to tiers. The Administration shall index the rate for the medical education component for each tier by the relative weighting of that tier's operating component to the operating component of all tiers. The relative weighting factor for each of the hospital's tiers shall be calculated by dividing each tier's operating component rate by the weighted average operating component rate for all tiers. The weighted average operating component rate is calculated by multiplying the operating component rate for each tier by the number of AHCCCS inpatient hospital days of care for each tier. The total of these products is then divided by the total number of AHCCCS inpatient hospital days of care for all tiers. The relative weighting factor for a tier's medical education component is multiplied by the medical education component to determine the medical education component rate for the particular tier.~~

~~iii. New medical education programs. The tiered per diem rates for hospitals with new medical education pro-~~

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

~~c. Capital component.~~

~~i. Structure of the capital component. During the 10-year period beginning with the initial prospective rate year, the rate for the capital component of the tiered per diem rate shall represent a blend of statewide and individual hospital capital costs in accordance with A.R.S. § 36-2903.01(J)(9). After September 30, 2002, the Administration shall combine the rate for the capital component with the rate for the operating component to produce a single statewide rate for the combination of the capital and operating components.~~

~~ii. Calculation of statewide capital costs and statewide capital component rate. The capital costs associated with inpatient hospital care shall be calculated in a manner similar to that described for operating costs in subsection (A)(2)(a)(ii). Because of the way costs are reported on the Medicare Cost Report, capital costs are derived by subtracting the costs determined when the ancillary department cost-to-charge ratios and the accommodation costs per day include only operating costs and medical education costs from the costs determined when the ancillary department cost-to-charge ratios and accommodation costs per day include capital costs as well as operating costs and medical education costs. The Administration shall inflate the resulting capital costs for each hospital to December 31, 1991, using the DRI inflation factor and shall reduce the capital costs for each hospital by an audit adjustment factor based on available national data and Arizona experience in adjustments to Medicare reimbursable costs. The statewide per day rate for capital costs shall be calculated by dividing the resulting total capital costs for all hospitals by the total AHCCCS inpatient hospital days of care reflected in the claim and encounter database.~~

~~iii. Computation of hospital-specific capital costs and hospital-specific capital component rates. The Administration shall calculate the hospital-specific capital costs per day for each hospital by dividing the capital costs identified for each hospital in subsection (A)(2)(c)(ii), as adjusted by the audit factor and inflated to December 31, 1991, by the AHCCCS inpatient hospital days of care for that hospital reflected in the claim and encounter database.~~

~~iv. Blending of capital rates. The Administration shall set the rate for the capital component by blending of the statewide and hospital-specific capital rates in accordance with the following schedule:~~

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

~~v. Because the rate for the capital component is a blend of the statewide and hospital-specific costs, the capital component shall not be further inflated to the mid-point of the initial prospective rate year.~~

~~vi. Indexing capital component to tiers. The Administration shall index the rate for the capital component for each tier by the relative weighting of that tier's operating component to the operating component of all tiers. The relative weighting factor for each of the hospital's tiers shall be calculated by dividing each tier's operating component rate by the weighted average operating component rate for all tiers. The weighted average operating component rate is calculated by multiplying the operating component rate for each tier by the number of AHCCCS inpatient hospital days of care for each tier. The total of these products is then divided~~

~~by the total number of AHCCCS inpatient hospital days of care for all tiers. The relative weighting factor for a tier's capital component is multiplied by the capital component to determine the capital component rate for the particular tier.~~

~~d. Statewide inpatient hospital cost-to-charge ratio. The statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, under subsection (A)(6). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (A)(1) and used to determine the initial tiered per diem rates. For each hospital, the covered accommodation days on the claims and encounters shall be multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters shall be multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital shall be determined in the same way as described in subsection (A)(2)(a) but shall include costs for operating, capital, and medical education. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.~~

~~e. Unassigned tiered per diem rates. In the case of a hospital for which no tiered per diem rate is assigned to a tier, the Administration shall pay the statewide rate for the operating component of that tier if the hospital has qualifying claims and encounters subsequent to the base year. The rates for the capital and medical education components of a tiered per diem rate, if applicable, shall be re-weighted for a tier to which no tiered per diem rate is assigned as described in subsections (A)(2)(b) and (A)(2)(c).~~

~~3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure or revenue codes, peer group, or NICU classification level or a combination of these items.~~

~~a. Tier hierarchy. Assignment of AHCCCS inpatient hospital days of care to a tier shall follow an ordered, hierarchical processing, as defined on the Hierarchy for Tier Assignment, which is included in subsection (J). Claims for inpatient hospital services must meet medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that is submitted by the hospital. If a hospital changes its designation under Medicare from a rural to an urban hospital, or visa versa, the Administration shall continue to assign claims from that hospital to the rural ICU tiered per diem rate, or visa versa, until the tiered per diem rates are rebased.~~

~~b. Tier exclusions. The Administration shall not assign or pay AHCCCS inpatient hospital days of care that do not occur during an individual's eligibility period. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital cost-to-charge ratio multiplied by ancillary department and accommodation charges.~~

~~c. Seven tiers. The following seven tiers shall be in effect until the time of rebasing:~~

~~i. Maternity. The maternity tier shall be identified by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the AHCCCS inpatient hospital days of care on the claim shall be paid the maternity tiered per diem rate.~~

~~ii. NICU. The NICU tier shall be identified by a revenue code. For a hospital to qualify for the NICU tiered per diem rate, the hospital must be classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier, those with an NICU revenue code shall be paid at the NICU tiered per diem rate. Any remaining AHCCCS inpatient hospital day or days on the claim not meeting NICU Level II or NICU Level III medical review criteria shall be paid at the nursery tiered per diem rate.~~

~~iii. ICU. The ICU tier shall be identified by a revenue code. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the ICU tier, those with an ICU revenue code shall be paid at the ICU tiered per diem rate. If there are any AHCCCS inpatient hospital days on the claim without an ICU revenue code, they may be classified as surgery, psychiatric, or routine tiers.~~

~~iv. Surgery. The surgery tier shall be identified by a revenue code in combination with a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list shall identify minor procedures such as sutures that do not require the same hospital resources as other procedures. A surgery claim may also have AHCCCS inpatient hospital days of care at the ICU tier. AHCCCS shall pay the surgery tier only when the surgery occurs on a date during which the member is eligible.~~

~~v. Psychiatric. The psychiatric tier shall be identified by either: a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. A claim with AHCCCS inpatient hospital days of care in the psychiatric tier may split only with the ICU tier.~~

~~vi. Nursery. The nursery tier rate shall be identified by a revenue code. A claim with AHCCCS inpatient hospital days of care in the nursery tier may split only with the NICU tier.~~

~~vii. Routine. The routine tier shall be identified by particular revenue codes and shall include AHCCCS inpatient hospital days of care that are not otherwise classified into the proceeding tiers or paid in accordance with subsection (A)(11). The routine tier may split only with the ICU tier.~~

~~4. Annual update. After the initial prospective rate year and between rebasing years, the Administration shall annually update the inpatient hospital tiered per diem rates in accordance with A.R.S. § 36-2903.01(J)(2) and (J)(9) as follows:~~

~~a. Inflation factor. The rates for the operating and medical education components of the tiered per diem rate shall be inflated to the midpoint of the prospective rate year, using the DRI inflation factor.~~

~~b. Length of stay adjustment. The rate for the operating component of the tiered per diem rate shall be adjusted for any change in the statewide average length of stay for eligible persons. The change in length of stay shall be computed each year by comparing the average length of stay for each tier based on claims and encounters to the average length of stay for each tier calculated in the previous year. The operating component of the tiered per diem rates shall be adjusted by the percentage change in length of stay. If the length of stay increases for a tier, the rate for the operating component shall be adjusted downward. If the length of stay decreases for a tier, the rate for the operating component shall be adjusted upward. Except for the first annual update of the initial prospective rate year, the Administration shall use claims and encounters that are from the federal fiscal year period beginning two years before the prospective rate year that is being updated. For the annual update for the prospective rate year beginning October 1, 1996, the claims and encounters with beginning dates of service from October 1, 1994, to September 30, 1995 shall be used for making any length of stay adjustment. For the annual update of the initial prospective rate year, the Administration shall use claims and encounters with beginning dates of service from March 1, 1993, to September 30, 1993. The Administration shall subject the claim and encounter data to the same data edits described in subsection (A)(1)(b). Outliers shall be excluded as identified in subsection (A)(6)(a).~~

~~c. Capital component update. For the capital component of the tiered per diem rate, the Administration shall adjust the hospital-specific and statewide average blend described in subsection (A)(2)(c). The Administration shall adjust the hospital-specific part of the capital component by using the capital costs from the hospital's subsequent Medicare Cost Report. The Medicare Cost Report used for the first update is FY1991. The percentage change in the capital costs per day, as shown on the hospital's Medicare Cost Report from one year to the next, shall be applied to the hospital-specific part of the capital component. The Administration shall recalculate the statewide average part of the capital component based on the percentage change in hospital-specific capital costs. The percentage change shall be limited to the initial prospective rate year statewide capital costs increased by the DRI inflation factor. The Administration shall adjust the rate for the capital component of the tiered per diem downward, if after the update, the statewide average rate of the capital component as a percent of the statewide average total tiered per diem rate exceeds the percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered per diem rates for the initial prospective rate year.~~

~~5. New Hospitals. The Administration shall calculate the tiered per diem rates for new hospitals differently than the tiered per diem rates for hospitals for which Medicare Cost Reports and claims and encounters were used to establish the tiered per diem rates for the initial prospective rate year or for a rebase year. The tiered per diem rates paid to a new hospital shall be the sum of the operating and capital components. The rate for the operating component for a new hospital shall be the same as the rate for the operating component established in subsection (A)(2)(a). The rate for the capital component for a new hospital shall equal the statewide average rate for the capital component as described in subsection (A)(2)(c)(ii) and shall vary by tier based on an index that represents the statewide relative weight of each tier's operating component to the operating component of all tiers. The tiered per diem rates for new hospitals shall not include a medical education component. The annual update shall be applied to a new hospital's rates for its operating and capital components, except hospital-specific capital costs shall not be considered as described in subsection (A)(2)(c)(iii).~~

~~6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers in accordance with this Section by multiplying the cover charges on a claim by the statewide inpatient hospital cost-to-charge ratio.~~

~~a. Outlier criteria. For the initial prospective rate year, the Administration shall set the statewide outlier cost threshold for each tier at the greater of three standard deviations from the statewide mean operating cost per day within the tier, or two standard deviations from the statewide mean operating cost per day across all the tiers. Because hospitals submit charges, rather than costs, on claims and encounters, the Administration sets hospital-specific charge thresholds by dividing the statewide outlier cost threshold for each tier by the hospital's inpatient operating cost-to-charge ratio. If the covered charges per day on a claim or encounter exceed the hospital-specific charge threshold for a tier, the claim or encounter shall be considered an outlier. If there are two tiers on a claim or encounter, the Administration shall determine whether the claim or encounter is an outlier by using a weighted~~

~~threshold for the two tiers. The weighted threshold is calculated by multiplying each tier rate by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital.~~

~~b. Update. The Administration shall update the outlier cost thresholds and outlier charge thresholds for each hospital. The outlier cost thresholds are updated annually by recalculating the standard deviations based on the claims and encounters used for the length-of-stay adjustment described in subsection (A)(4)(b). The outlier charge thresholds are updated as defined in subsection (A)(6)(a). Claims and encounters exceeding the updated outlier cost thresholds will be excluded for purposes of calculating the change in length-of-stay. The Administration shall estimate the operating cost of claims and encounters based on the application of an inpatient hospital-specific operating cost-to-charge ratio.~~

~~7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered organ transplant is performed through the terms of a relevant contract agreement. Pursuant to R9-22-716, if the Administration and a hospital that performs a transplant surgery on an eligible person do not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.~~

~~8. Rebasing. The Administration shall rebase the tiered per diem rates by the prospective rate year beginning October 1, 1998. The rebasing process shall include the following:~~

~~a. Rebasing data. The Administration shall use a hospital's Medicare Cost Report for a fiscal year ending at least two years before the prospective rate year in which the rebase is to begin. For example, for the rebase year of October 1, 1998, the Medicare Cost Reports would be for hospital fiscal years ending in 1996, or earlier. The Administration shall follow the procedures described in subsection (A)(1)(a) for Medicare Cost Report data, except that costs shall be inflated to December 31 of the fiscal year applicable to the Medicare Cost Report year, and a new audit factor shall be derived by the Administration based on available national and Arizona data. To calculate the rebased tiered per diem rates, the Administration may use the ancillary department or line item cost-to-charge ratios from the Medicare Cost Report. In addition for each hospital, the Administration shall use a database consisting of inpatient hospital claims and, if appropriate, encounters with beginning dates of service covered by the hospital's respective Medicare Cost Report reporting period. Claims and encounters included in the database will be those available at the time of rebasing that pass the Administration's data quality, reasonableness, and integrity edits described in subsection (A)(1)(b). The Administration shall exclude or adjust the claims or encounters that do not meet the medical review criteria at R9-22-717 and R9-22-209(C).~~

~~b. Rebasing components. The rebased tiered per diem rates shall include rates for the following two components: operating and capital. The Medical education component shall be included unless direct medical education is reimbursed under subsection (A)(12). The Administration shall follow the methodology described in subsection (A)(2) to establish the rebased rates for each of the components. However, during the rebasing process the Administration shall re-examine the current tier structure and may adopt an alternative structure, hierarchy, or number of tiers if analyses conducted by the Administration indicate that an alternative or alternatives is or are appropriate. The Administration shall add cost containment features at the time of rebasing.~~

~~c. Rebasing peer groups for the operating component. To rebase the rate for the operating component of the tiered per diem rate, the Administration shall re-analyze whether the operating component shall be peer grouped according to such factors as geographical location or major teaching versus non-major teaching hospital.~~

~~d. Rebasing the capital component. The capital component of the tiered per diem rate shall be a blend of statewide and hospital-specific capital costs pursuant to subsection (A)(2)(c). The Administration shall adjust the rate for the capital component of the tiered per diem rate downward if after rebasing the statewide average rate for the capital component as a percent of the statewide average total tiered per diem rate exceeds:~~

~~i. The percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered per diem rates for the initial prospective rate year; or~~

~~ii. The most recently available national average percentage of capital costs to total inpatient hospital costs.~~

~~iii. The adjustment to the rate for the capital component shall be based on the lesser of subsection (i) or (ii).~~

~~e. Rebasing outliers. Depending on the payment methodology adopted at the time of rebasing, the Administration may not include provisions for payment of outliers.~~

~~f. Psychiatric and rehabilitation hospitals. At the time of rebasing, the Administration shall re-examine the basis of payment for freestanding rehabilitation and psychiatric hospitals. If the decision is made to continue to reimburse these hospitals according to the methodology described in subsection (A)(10), the Administration shall exclude the claims and encounters from these hospitals that are not paid by the tiered per diem reimbursement system.~~

~~g. Data required. Beginning with fiscal years ending in 1996, hospitals shall file with the Administration all Medicaid-specific schedules of the Medicare Cost Report at the time the Medicare Cost Report is submitted to the Medicare Intermediary as required in A.R.S. § 36-125.04.~~

~~9. Ownership change. A hospital shall not receive a change in any of the components of the hospital's tiered per diem rates upon an ownership change.~~

~~10. Psychiatric and rehabilitation hospitals. The Administration shall pay freestanding psychiatric hospitals an all-inclu-~~

~~sive per diem rate based on the contracted rates used by the Department of Health Services and shall pay freestanding rehabilitation hospitals the rate for the operating component of the routine tiered per diem rate plus the rates for the capital and medical education components as appropriate or an all-inclusive per diem rate that is negotiated by the Administration.~~

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

B. No change
C. No change
D. No change
E. No change
F. No change
G. No change
H. No change
I. No change
~~**J.** Hierarchy For Tier Assignment.~~

~~**TIER**~~	~~**IDENTIFICATION CRITERIA**~~	~~**ALLOWED SPLITS**~~
~~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 175 for DOS before 10/1/95 AND the provider has a Level II or Level III NICU, or Revenue Code of 174 for DOS on, or after 10/1/95 AND the provider has a Level II or Level III NICU.~~	~~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 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 175 or 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~~

R9-22-712.01. Inpatient hospital reimbursement

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, on a prospective reimbursement basis. The prospective rates shall represent payment in full, excluding quick-pay discounts, slow-pay penalties, and third-party payments for both accommodation and ancillary department services. The rates shall include reimbursement for operating and capital costs. Reimbursement for direct graduate medical education shall be made pursuant to A.R.S.§ 36-2903.01(H). The Administration shall classify each AHCCCS inpatient hospital day of care into one of several tiers appropriate to the services rendered for payment purposes. The rate for a particular tier is referred to as the tiered per diem rate of reimbursement. 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.

1. Tier rate data. The tiered per diem rates for rates effective on and after October 1, 1998 shall be based on Medicare Cost Reports for Arizona hospitals for fiscal years 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. Hospitals shall submit information to assist the Administration in this allocation.

b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed 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 claims and encounters that fail these edits from the database. The Administration may make adjustments to the data as required to correct errors. The Administration shall also exclude from the database, the following claims and encounters:
   i. Those missing information necessary for the rate calculation,
   ii. Medicare crossovers,
   iii. Those submitted by freestanding psychiatric hospitals, and
   iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.

2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on the sum of the following two components: operating and capital. The rate for the operating component shall be a statewide rate for each tier except for the NICU and Routine tier, which shall be based on peer groups. The rate for the capital component shall be a blend of statewide and hospital-specific values, as described under A.R.S.§ 36-2903.01(H). The Administration shall use the following methodologies to establish the rates for each of these components and to calculate the statewide inpatient cost-to-charge ratio used for payment of outliers and out-of-state hospitals.
   a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the rate for the operating component shall be computed as follows:
      i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with federal regulation, 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.
      ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports have been grouped. The ancillary department cost-to-charge ratios for a particular hospital shall be multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters shall be multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day shall exclude medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 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 operating costs shall be further inflated 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 items. For the NICU tier, claims and encounters shall be further assigned to NICU Level II and NICU Level III peer groups, based on the hospitals certification by the Arizona Perinatal Trust. For the Routine tier, claims and encounters shall be further assigned to the general acute care hospital or rehabilitation hospital peer groups, based on state licensure. For claims and encounters assigned to more than one tier, ancillary department costs shall be allocated to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component of the tiered per diem rates, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (6).
      iv. Operating rate calculation. The rate for the operating component for each tier shall be set by dividing total statewide or peer group hospital costs identified in 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 shall be frozen at the blended rate in effect on January 1, 1999, hospital specific 40 percent and statewide 60 percent and as adjusted annually by Global Insights Prospective Hospital Market Basket, described under A.R.S.§ 36-2903.01(H).

c. Statewide inpatient hospital cost-to-charge ratio. The statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, as described in subsection (4), and out-of-state hospitals, as described in subsection (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 shall be multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters shall be multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital shall be determined in the same way as described in subsection (2)(a) but shall 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. In the case of a hospital which 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, or NICU classification level or a combination of these items.

a. Tier hierarchy. Assignment of AHCCCS inpatient hospital days of care to a tier shall follow an ordered, hierarchical processing, as defined on the Hierarchy for Tier Assignment, which is included in subsection R9-22-712.09. Claims for inpatient hospital services must meet medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that are submitted by the hospital.

b. Tier exclusions. The Administration shall not assign or pay AHCCCS inpatient hospital days of care that do not occur during an individual's eligibility period. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.

c. Seven tiers. The following seven tiers are in effect:

i. Maternity. The maternity tier shall be identified by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the AHCCCS inpatient hospital days of care on the claim shall be paid the maternity tiered per diem rate.

ii. NICU. The NICU tier shall be identified by a revenue code. For a hospital to qualify for the NICU tiered per diem rate, the hospital must be classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier, those with an NICU revenue code shall be paid at the NICU tiered per diem rate. Any remaining AHCCCS inpatient hospital day or days on the claim not meeting NICU Level II or NICU Level III medical review criteria shall be paid at the nursery tiered per diem rate.

iii. ICU. The ICU tier shall be identified by a revenue code. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the ICU tier, those with an ICU revenue code shall be paid at the ICU tiered per diem rate. If there are any AHCCCS inpatient hospital days on the claim without an ICU revenue code, they may be classified as surgery, psychiatric, or routine tiers.

iv. Surgery. The surgery tier shall be identified by a revenue code in combination with a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list shall identify minor procedures such as sutures that do not require the same hospital resources as other procedures. A surgery claim may also have AHCCCS inpatient hospital days of care at the ICU tier. AHCCCS shall pay the surgery tier only when the surgery occurs on a date during which the member is eligible.

v. Psychiatric. The psychiatric tier shall be identified by either: a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. A claim with AHCCCS inpatient hospital days of care in the psychiatric tier may split only with the ICU tier.

vi. Nursery. The nursery tier rate shall be identified by a revenue code. A claim with AHCCCS inpatient hospital days of care in the nursery tier may split only with the NICU tier.

vii. Routine. The routine tier shall be identified by particular revenue codes and shall include AHCCCS inpatient hospital days of care that are not otherwise classified into the proceeding tiers or paid in accordance with subsection (11). The routine tier may split only with the ICU tier.

4. Annual update. The Administration shall annually update the inpatient hospital tiered per diem rates in accordance with A.R.S. § 36-2903.01(H).

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. New hospital tiered per diem rates will be updated annually pursuant

to A.R.S. § 36-2903.01(H).

6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers in accordance with this Section by multiplying the covered charges on a claim by the statewide inpatient hospital cost-to-charge ratio.
   a. Outlier criteria. For rates effective on and after October 1, 1998, the Administration shall set the statewide outlier cost threshold for each tier at the greater of three standard deviations from the statewide mean operating cost per day within the tier, or two standard deviations from the statewide mean operating cost per day across all the tiers. Because hospitals submit charges, rather than costs, on claims and encounters, the Administration sets hospital-specific charge thresholds by dividing the statewide outlier cost threshold for each tier by the hospital's inpatient operating cost-to-charge ratio. If the covered charges per day on a claim or encounter exceed the hospital-specific charge threshold for a tier, the claim or encounter shall be considered an outlier. If there are two tiers on a claim or encounter, the Administration shall determine whether the claim or encounter is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying each tier rate by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital.
   b. Update. The Administration shall update the outlier cost thresholds for each hospital as described under A.R.S. 36-2903.01(H).
7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered organ transplant as described under R9-22-206 is performed through the terms of a relevant contract agreement. As described under R9-22-716, if the Administration and a hospital that performs a transplant surgery on an eligible person do not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.
8. Ownership change. A hospital shall not receive a change in any of the components of the hospital's tiered per diem rates upon an ownership change.
9. Psychiatric hospitals. The Administration shall pay freestanding psychiatric hospitals an all-inclusive per diem rate based on the 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(H).

R9-22-712.02. Reserved

R9-22-712.03. Reserved

R9-22-712.04. Reserved

R9-22-712.05. Reserved

R9-22-712.06. Reserved

R9-22-712.07. Reserved

R9-22-712.08. Reserved

R9-22-712.09. Hierarchy For Tier Assignment

TIER	IDENTIFICATION CRITERIA	ALLOWED SPLITS
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 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

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R05-71]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-28-702 — Amend

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

Authorizing statute: A.R.S. § 36-2903.01(F)

Implementing statute: A.R.S. § 36-2903.01(L)

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 10A.A.C. 3978, October 1, 2004

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

Name: Jane McVay

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

Telephone: (602) 417-4135

Fax: (602) 253-9115

E-mail: AHCCCSRules@ahcccs.state.az.us

5. An explanation of the rule, including the agency's reasons for initiating the rule:

The Administration plans to amend the existing member billing rules for the Arizona Long-term Care System to make them more clear, concise, and understandable. The objectives of the Administration are to make the member billing rules for services consistent in the Arizona Long-term Care System, as well as for acute care and Kids Care services, and to clarify that a member, who requests services which are not authorized or not covered, is financially responsible for the services. When a member requests uncovered or unauthorized services, and signs a document showing the overall services and the approximate cost, the member will be held financially responsible for those charges. An AHCCCS registered provider has clear authority under the rule to submit a claim to a member for payment of services.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on or 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:

No studies were reviewed relating to this rule.

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

The rule has no impact on the authority of political subdivisions.

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

The rule will allow providers to hold members, who receive uncovered or unauthorized services and sign a document showing the cost, financially responsible for the service. The rule clarifies the member's financial responsibility to pay for services that are not covered or are not authorized by the Administration.

The rule is expected to have a positive economic impact on medical providers because they will be able to bill for services provided that are not covered or not authorized by the Administration. Although the existence of the rule cannot

ensure providers that members will pay for services, consumers will clearly understand their financial responsibility. The rule sets forth a clear billing procedure for members who request an uncovered or unauthorized service. Consumers will also benefit by receiving information about the cost of uncovered or unauthorized services, and by requiring them to sign a document stating that they are financially responsible for uncovered or unauthorized services.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Jane McVay

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

Telephone: (602) 417-4135

Fax: (602) 253-9115

E-mail: AHCCCSRules@ahcccs.state.az.us

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of February 7, 2005. Please send written comments to the above address by 5:00 p.m., March 28, 2005. E-mail comments will be accepted.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: March 28, 2005

Time: 10:00 a.m.

Location: AHCCCS
701 East Jefferson
Phoenix, AZ 85034
Gold Room

Nature: Public Hearing

Date: March 28, 2005

Time: 10:00 a.m.

Location: ALTCS: Arizona Long-term Care System
110 South Church, Suite 1360
Tucson, AZ 85701

Nature: Public Hearing

Date: March 28, 2005

Time: 10:00 a.m.

Location: ALTCS: Arizona Long-term Care System
3480 East Route 66
Flagstaff, AZ 86004

Nature: Public Hearing

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

None

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

None

13. 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

Section
R9-28-702. ~~Prohibition Against~~ Charges to Members

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-28-702. ~~Prohibition Against~~ Charges to Members

A. Except as provided in ~~subsection (B),~~ subsections (B), (C), and (D), an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration that the person was ineligible for AHCCCS on the date of service:
1. Charge, submit a claim to, demand, or collect payment from a person claiming to be AHCCCS eligible; or
2. Refer or report a person claiming to be AHCCCS eligible to a collection agency or credit reporting service.

B. An AHCCCS registered provider may charge, submit a claim to, demand, or collect payment from a member as follows:
1. To collect an authorized copayment;
~~2. To pay for non-covered services;~~
~~3.~~2. To recover from a member that portion of a payment made by a third-party to the member if the payment duplicates AHCCCS paid benefits and is not assigned to a contractor. ~~under A.A.C. R9-22-1002(B).~~ An AHCCCS registered provider that makes a claim under this Article shall not charge more than the actual, reasonable cost of providing the covered service; or
~~4.~~3. To ~~bill~~ obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally withheld information pertaining to the member's AHCCCS eligibility or enrollment that caused the payment to the provider to be reduced or denied.

C. An AHCCCS registered provider may charge, submit a claim to, demand, or collect payment for services from a member if:
1. The member requests the provision of a service that is not covered or not authorized by a contractor or the Administration; and
2. The provider prepares and provides the member with a document describing the overall services and the approximate cost of the services; and
3. The member signs the document prior to the provision of a service indicating that the member understands and accepts the responsibility for payment.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) CHILDREN'S HEALTH INSURANCE PROGRAM

[R05-72]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

Sections Affected	Rulemaking Action
R9-31-201	Amend
R9-31-702	Amend
R9-31-1620	Amend

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

Authorizing statute: A.R.S. § 36-2903.01(F)

Implementing statute: A.R.S. § 36-2903.01(L)

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 10 A.A.C. 3979, October 1, 2004

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

Name: Jane McVay

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

Telephone: (602) 417-4135

Fax: (602) 253-9115

E-mail: AHCCCSRules@ahcccs.state.az.us

5. An explanation of the rule, including the agency's reasons for initiating the rule:

The rulemaking is needed to allow AHCCCS registered providers to bill members when they request services that are not covered or not authorized by the Administration. The provider prepares a document for the member, describing the services and the approximate cost. When the member signs the document, the member accepts financial responsibility to pay for those services. The rule will clarify the procedures under which an AHCCCS registered provider may bill a member for uncovered or unauthorized services. The rule also clarifies that behavioral health services are not covered services if provided to a person under age 22, who is in residence at an institution for mental diseases, unless the person is receiving inpatient psychiatric services. This change is needed to comply with federal regulations and clarifies billing issues for these services.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on or 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:

No studies were reviewed.

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

The rule has no impact on the authority of political subdivisions.

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

The rule is expected to have a positive economic impact on medical providers by allowing them to bill a member who requests an uncovered service or a service not authorized by the Administration. The rule provides clear authority for providers to bill a member for these services. By signing a document describing services requested by the member that are not authorized or covered by the Administration, a member accepts financial responsibility for the cost of services. Although the ability of providers to collect payment for these services is unknown, collections will provide a positive economic impact to these businesses. Consumers will also understand that they are financially responsible for uncovered or unauthorized services, and will know the approximate cost of the services. The rule clarifies billing issues for inpatient psychiatric services, which are covered services only for persons under age 22, who are inmates at institutions for mental diseases.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Jane McVay

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

Telephone: (602) 417-4135

Fax: (602) 253-9115

E-mail: AHCCCSRules@ahcccs.state.az.us

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of February 7, 2005. Please send written comments to the above address by 5:00 p.m., March 28, 2005. E-mail comments will be accepted.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: March 28, 2005

Time: 10:00 a.m.

Location: AHCCCS

	701 East Jefferson Phoenix, AZ 85034 Gold Room
Nature:	Public Hearing

Date:	March 28, 2005
Time:	10:00 a.m.
Location:	ALTCS: Arizona Long-term Care System 110 South Church, Suite 1360 Tucson, AZ 85701 Training Room
Nature:	Public Hearing

Date:	March 28, 2005
Time:	10:00 a.m.
Location:	ALTCS: Arizona Long-term Care System 3480 East Route 66 Flagstaff, AZ 86004 Conference Room
Nature:	Public Hearing

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

None

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

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) CHILDREN'S HEALTH INSURANCE PROGRAM

ARTICLE 2. SCOPE OF SERVICES

Section
R9-31-201. General Requirements

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-31-702. ~~Prohibitions Against~~ Charges to Members

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

Section
R9-31-1620. ~~Prohibitions Against~~ Charges to Members

ARTICLE 2. SCOPE OF SERVICES

R9-31-201. General Requirements

A. The Administration shall administer the Children's Health Insurance Program under A.R.S. § 36-2982.
B. Scope of Services for fee for service members is under Article 16 of this Chapter.
C. A contractor or RBHA shall provide behavioral health services under 9 A.A.C. 31, Article 12 and Article 16.

D. In addition to requirements and limitations specified in this Chapter, the following general requirements apply:
1. Only medically necessary, cost effective, and federally and state reimbursable services are covered services;
2. The Administration or a contractor may waive the covered services referral requirements required by this Article;
3. Except as authorized by a contractor, a primary care provider, practitioner, or dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner shall not diminish the role or responsibility of the primary care provider;
4. 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;
5. A member may receive behavioral health evaluation services without a referral from a primary care provider. Behavioral health treatment services are provided only under referral from and in consultation with the primary care provider, or upon authorization by the contractor or its designee;
6. A member may receive a treatment that is considered the standard of care, or that is approved by AHCCCS Chief Medical Officer after appropriate consultative input from providers who are considered experts in the field by the professional medical community;
7. An AHCCCS registered provider shall provide covered services within the provider's scope of practice;
8. In addition to the specific exclusions and limitations otherwise specified under this Article the following are not covered:
   a. A service that the Chief Medical Officer determines to be experimental or provided primarily for the purpose of research;
   b. Services or items furnished gratuitously;
   c. Personal care items; and
9. Medical or behavioral health services are not covered if provided to:
   a. An inmate of a public institution,
   b. A person who is a resident of an institution for the treatment of tuberculosis, or
   c. A person who is in an IMD at the time of application, unless provided under Article 12 of this Chapter.
   d. A person under age 22 who is in residence at an IMD, unless the person is receiving inpatient psychiatric services.

E. The contractor may deny payment of non-emergency services if prior authorization is not obtained under this Article and Article 7 of this Chapter. The provider shall submit documentation of diagnosis and treatment for reimbursement of services that require prior authorization.

F. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. Diagnostic and treatment procedures for a condition that is unrelated to the emergency medical condition require prior authorization by the contractor.

G. Under A.R.S. § 36-2989, a member shall receive covered services outside the contractor service area only if one of the following ~~apply~~ applies:
1. A member is referred by a primary care provider for medical specialty care out of the contractor's area. If a member is referred out of a contractor's service area to receive an authorized medically necessary service, a contractor shall also provide all other medically necessary covered services for a member;
2. There is a net savings in service delivery costs as a result of going outside the service area 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 contractor's service area; or

H. If a member is traveling or temporarily residing out of the member's contractor service area, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

I. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.

~~**J.** If a member requests the provision of a service that is not covered or not authorized by a contractor, an AHCCCS-registered service provider may render the service and request reimbursement from the member if:~~
~~1. The provider prepares, and provides the member with, a document that lists the requested services and the estimated cost of each service; and~~
~~2. The member signs a document before the provision of services indicating that the member understands the services and accepts the responsibility for payment.~~

~~**K.**~~**J.** The restrictions, limitations, and exclusions in this Article do not apply to a contractor if the contractor elects to provide noncovered services:
1. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate;
2. A contractor shall pay noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-31-702. ~~Prohibitions Against~~ Charges to Members

A. Except as provided in ~~subsection (B),~~ subsections (B), (C), and (D), an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration that the person was ineligible for AHCCCS on the date of service:
   1. Charge, submit a claim to, demand or collect payment from a person claiming to be AHCCCS eligible; or
   2. Refer or report a person claiming to be AHCCCS eligible to a collection agency or credit reporting agency.

B. An AHCCCS registered provider may charge, submit a claim to, demand or collect payment from a member as follows:
   1. To collect an authorized copayment;
   ~~2. To pay for non-covered services;~~
   ~~3.~~2. To recover from a member that portion of a payment made by a third-party to the member if the payment duplicates AHCCCS paid benefits and is not assigned to a contractor. ~~under R9-31-1002(B).~~ An AHCCCS registered provider that makes a claim under this Article shall not charge more than the actual, reasonable cost of providing the covered service; or
   ~~4.~~3. To ~~bill~~ obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused the payment to the provider to be reduced or denied.

C. An AHCCCS registered provider may charge, submit a claim to, demand or collect payment for services from a member, if:
   1. The member requests the provision of a service that is not covered or not authorized by a contractor or the Administration; and
   2. The provider prepares and provides the member with a document describing the overall services and the approximate cost of the services; and
   3. The member signs the document prior to the provision of a service indicating that the member understands and accepts the responsibility for payment.

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1620. ~~Prohibitions Against~~ Charges to Members

A. Except as provided in ~~subsection (B),~~ subsections (B), (C), and (D), the IHS, a Tribal Facility, or a provider under referral, shall not do either of the following, unless services are not covered or without first receiving verification from the Administration that the person was ineligible for AHCCCS on the date of service.
   1. Charge, submit a claim to, demand or collect payment from a person claiming to be AHCCCS eligible; or
   2. Refer or report a person claiming to be AHCCCS eligible to a collection agency or credit reporting agency.

B. The IHS, a Tribal Facility, or a provider under referral may charge, submit a claim to, demand or collect payment from a member as follows:
   1. To collect an authorized copayment;
   ~~2. To pay for non-covered services;~~
   ~~3.~~2. To recover from a member that portion of a payment made by a third-party to the member if the payment duplicates AHCCCS paid benefits and is not assigned to a contractor. An AHCCCS registered provider that makes a claim under this Article shall not charge more than the actual, reasonable cost of providing the covered service; or
   ~~4.~~3. To ~~bill~~ obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided accurate information pertaining to the member's AHCCCS eligibility or enrollment that caused the payment to the provider to be reduced or denied.

C. An AHCCCS registered provider may charge, submit a claim to, demand, or collect payment for services from a member, if:
   1. The member requests the provision of a service that is not covered or not authorized by a contractor or the Administration; and
   2. The provider prepares and provides the member with a document describing the overall services and the approximate cost of the services; and
   3. The member signs the document prior to the provision of a service indicating that the member understands and accepts the responsibility for payment.