NOTICES OF EXEMPT RULEMAKING

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

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

[R07-312]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-701	Amend
R9-22-712.01	Amend
R9-22-718	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, as amended by Laws 2007, Ch 263, § 9

Implementing statute: A.R.S. § 36-2903.01, as amended by Laws 2007, Ch 263, § 9

3. The effective date of the rules:

October 1, 2007

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

None

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

Name: Mariaelena Ugarte

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

Telephone: (602) 417-4693

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

Laws 2007, Ch 263, § 9 A.R.S. § 36-2903.01 requires the Administration to implement and describe in rule by October 1, 2007 an outlier payment methodology where the Medicare Urban and Rural Cost to Charge ratio will be used in lieu of the Hospital specific Cost-to-Charge ratio for the calculation of outlier claims. In addition, a routine maternity stay will be excluded as a qualifying claim for outlier payment. The new Cost to Charge ratio will be phased in by 2009.

Laws 2007, Ch 263, § 29 exempts the Administration from rulemaking requirements of Title 41, Chapter 6, Arizona Revised Statutes, until December 31, 2008.

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

No studies were or will be reviewed in relation to this rulemaking.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previ-

ous grant of authority of a political subdivision of this state:
Not applicable

9. The summary of the economic, small business, and consumer impact:
Not applicable

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):
Not applicable

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

	Date:	Commenter:	Comment/Questions:	AHCCCS Response:	Response Date:
1	08/15/07	Ethel Hoffman PCH	1. Page 14, #6 Medicare rural or urban cost to charge ratio to be used as counties defined for the 500,000. How does that differ or mimic the federal regulations definition. When the analysis was done relative to the cost savings, was the 500,000 a discriminator that you used?	The Urban/Rural population definition was used in the outlier analysis and was consistent with what was used for the rule.	08/15/07
2	08/15/07	Ethel Hoffman PCH	3. Page 15, language added in regard to the phase in, some hospitals will be impacted much more significantly than others. Was there any thought put into capping or putting in a maximum impact number to that in terms of a particular hospital? The overall change represents an impact in the 20% range. Even cut down into 3 years it is a huge hit to us.	When this was debated in the legislature, there was a lot of discussion regarding the fiscal impact on hospitals. The legislation did not include any mitigating impact for the hospitals other than the phase-in. The rule is written to mirror the statute.	08/15/07
3	08/15/07	Marcia Leblanc Pima Health Systems	Will the new legislation allow for medical review of the claims and will the review allow for cutbacks or for any lines to be determined not medically necessary.	Nothing changes with the existing processes for claims review. What is changing is the CCR ratios used to qualify for outlier and the CCR used to calculate payment. However, per statute routine maternity claims are an exception and will not qualify for outlier.	08/15/07
4	08/15/07	Marcia Leblanc Pima Health Systems	There is no opportunity to impact anything more at this point?	The scope of the legislative change is limited to implementation of the new CCR. To make any changes to other aspects of the rule the Administration would be required to initiate another formal rulemaking process and/or propose legislative changes. AHCCCS will also look at other potential carve outs within the next five months.	08/15/07

5	08/15/07	Catholic Healthcare West (CHW)	There is ample room for regulatory and reimbursement policy changes that will improve the efficiency, cost effectiveness, and fairness of the AHCCCS payment system.	The purpose of this rulemaking was to implement the Medicare CCR as prescribed in statute. The legislation gave the Administration discretion to use an alternative methodology approved by CMS, if necessary. This discretion was not required since CMS approved the original proposal of using the Medicare CCRs. The Administration does not agree that there is ample room for regulatory and reimbursement changes. AHCCCS reimbursement is set by statute and payments are made according to statute.	08/31/07
6	08/15/07	Catholic Healthcare West (CHW)	AHCCCS is still paying less than cost for its members in the aggregate – as little as 80%.	The Administration is currently conducting a cost study with various hospitals including CHW. This comment is not germane to this rulemaking.	08/31/07
7	08/15/07	Catholic Healthcare West (CHW)	AHCCCS should consider in the next steps for legislative activity: 1. Consideration of a separate payment mechanism for specific high acuity services. 2. Underfunding analysis with possible reimbursement rebase or redesign.	The Administration is currently conducting a cost study. Any changes to reimbursement for areas other than outlier will require legislative action and statutory changes.	08/31/07
8	08/15/07	Catholic Healthcare West (CHW)	The "Covered Charges" Used for Qualification and Payment must be standardized in R9-22-712.01(6)(a)	There are standard disallowed charges that are appropriate, but there are also other charges that may be inappropriate in one instance and appropriate in another. The Administration pays for care that is medically necessary, since what is medically necessary for one person may not be medically necessary for another. A standardized list would not be appropriate.	08/31/07
9	08/15/07	Catholic Healthcare West (CHW)	We want practice of declaring charges non-covered on the grounds they are "included in another charge" to end now, with these regulations. Plans should not be allowed the opportunity to further enhance their finances by manipulating "covered charges" without foundation. Add to R9-22-712(6)(a): For purposes of this Section, neither the Administration or Contractor shall consider a charge to be non-covered on the grounds that the charge is included in another charge or service unless the Administration has established a schedule of such non-covered charges in consultation with providers, including evaluation of the impact of such a schedule on hospital reimbursement.	This rule change will require legislative action and statutory changes.	08/31/07

10	08/15/07	Catholic Healthcare West (CHW)	Limitation on Unanticipated Reductions in Revenue. The impetus has been to isolate single components of the system, such as outlier payments or implants, because individual components can be traced to high outlays by the payers. This approach undermines the financial viability for the reimbursement system and will end up decreasing the availability and accessibility of services to the sickest of the sick. Each hospital should be subject to an overall limitation of 15% reduction in outlier payments.	The statute does not allow for any limitation on reductions for future growth. This comment is outside the scope of the exemption provided for this rulemaking. The exemption only authorizes changes that are related to the CCR.	08/31/07
11	08/15/07	Catholic Healthcare West (CHW)	Components of the AHCCCS payments system must be reviewed. We have identified 11 DRGs at St.Josephs – primarily for sophisticated, tertiary services that are reimbursed significantly below cost and contribute substantially to the overall underfunding by AHCCCS. Claims in these DRGs rarely meet current outlier criteria. None of these services are "optional."	This comment is outside the scope of the exemption provided for this rulemaking. The exemption only authorizes changes that are related to the CCR. In addition, the Administration does not have the authority to pay DRGs.	08/31/07
12	08/15/07	Arizona Hospital and Healthcare Association (AZHHA)	Consider Code 61. the provider must resubmit the entire stay on a single claim form as a replacement with a condition code 61. This process is redundant, increases provider costs and ultimately delays claim payments. Hospitals should not be required to pre-identify claims as outliers nor be required to submit Replacement claims.	This recommendation will be forwarded to the responsible Division. However, this comment is outside of the scope of this rulemaking.	08/31/07
13	08/15/07	Arizona Hospital and Healthcare Association (AZHHA)	Consider Unbundled Charge Denials. Prohibit, or at least restrict and/or standardize the practice of plans disallowing charges they declare "unbundled." Hospitals are subject to more than a dozen set of rules, one for each plan. These rules are applied erratically and change with turnover and are not disclosed. The "non-covered charges" are charges (and costs) that are accounted for in the development of hospital Medicare and AHCCCS cost to charge ratios. Disallowing charges result in payment less than cost and violates the integrity of the methodology. We request the following language be added to R9-22-712(6)(a): <u>For purposes of this Section, neither the Administration or Contractor shall consider a charge to be non-covered on the grounds that the charge is included in another charge or service unless the Administration has established a schedule of such non-covered charges in consultation with providers, including evaluation of the impact of such a schedule on hospital reimbursement.</u>	This comment is outside the scope of the exemption provided for in this rulemaking. The exemption only authorizes changes that are related to the CCR.	08/31/07

14	08/15/07	University Medical Center (UMC)	The proposed mechanism used to determine a claim qualifies for outlier will continue to permit a hospital to "game" their chargemaster, arbitrarily and materially increase their charges.	The Administration is implementing a process to monitor chargemasters filed with DHS.	08/31/07
15	08/15/07	University Medical Center (UMC)	The proposed formulae illogically disqualify most high-cost cases that require extraordinarily long hospital stays. This formula will qualify the lower cost cases as outliers and underpay the higher cost cases.	This comment is outside the scope of the exemption provided for in this rulemaking. The exemption only authorizes changes that are related to the CCR. The proposed rule does not change the 2-3 standard deviations methodology used for the original outlier calculation.	08/31/07
16	08/15/07	University Medical Center (UMC)	UMC opposes the excessive cuts in the proposed outlier rule and request that it be withdrawn. Outlier payments are essential and should be structured properly to pay hospitals for the higher cost cases that routinely occur at UMC.	The Administration does not have the statutory authority to withdraw the rule changes. This would be in violation of the statute.	08/31/07
17	08/15/07	Phoenix Children's Hospital (PCH)	The payment methodology for non-outlier cases is flawed. The calculation of annual increases in per diem rates based on the Global Insights does not match the cost increases experienced by providers.	The payment methodology is delineated in statute. This comment is beyond the scope of this rulemaking.	08/31/07
18	08/15/07	Phoenix Children's Hospital (PCH)	PCH proposes that the change in the cost to charge ratio be limited to 2% per year.	The statute explicitly requires the Administration to implement this ratio within 3 years.	08/31/07
19	08/15/07	Phoenix Children's Hospital (PCH)	Savings from the outlier implementation should be directed to increase the per diem payment for non-outlier cases.	The Administration does not have the authority to use funds from one area for another. According to statute, the Administration is only authorized to increase the per diem by the Global Insights adjustment.	08/31/07

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

None

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

None

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-701. Standard for Payments Related Definitions

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

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

"Aggregate" means the combined amount of hospital payments for covered services provided within and outside the GSA.

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

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

"APC" means the Ambulatory Payment Classification system under 42 CFR Part 419.31 used by Medicare for grouping clinically and resource-similar procedures and services.

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

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

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

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

"Cost-To-Charge Ratio" (CCR) means a hospital's costs for providing covered services divided by the hospital's charges for the same services. The CCR is the percentage derived from the cost and charge data for each revenue code provided to AHCCCS by each hospital.

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

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

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

"DRI inflation factor" means Global Insights Prospective Hospital Market Basket.

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

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

"Existing outpatient service" means a service provided by a hospital before the hospital files an increase in its charge master as defined in R9-22-712(G), regardless of whether the service was explicitly described in the hospital charge master before filing the increase.

"Expansion funds" means funds appropriated to support GME program expansions as described under A.R.S. § 36-2903.01(H)(9)(b).

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

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

"Free Standing Children's Hospital" means a separately standing hospital with at least 120 pediatric beds that is dedicated to provide the majority of the hospital's services to children.

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

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

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

"ICU" means the intensive care unit of a hospital.

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

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

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

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

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

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

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

"Non-IHS Acute Hospital" means a hospital that is not run by Indian Health Services, is not a free-standing psychiatric hospital, such as an IMD, and is paid under ADHS rates.

"Observation day" means a physician-ordered evaluation period of less than 24 hours to determine whether a person needs treatment or needs to be admitted as an inpatient.

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

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

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

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

"Ownership change" means a change in a hospital's owner, lessor, or operator under 42 CFR 489.18(a).

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

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

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

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

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

"Prospective rates" means inpatient or outpatient hospital rates set by AHCCCS in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-

party payments regardless of billed charges or individual hospital costs.

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

"Rebase" means the process by which the most currently available and complete Medicare Cost Report data for a year and AHCCCS claim and encounter data for the same year, are collected and analyzed to reset the Inpatient Hospital Tiered per diem rates, or the Outpatient Hospital Capped Fee-For-Service Schedule.

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

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

"Resident" means a physician engaged in postdoctoral training in an accredited graduate medical education program, including an intern and a physician who has completed the requirements for the physician's eligibility for board certification.

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

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

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

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

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

R9-22-712.01. 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 represent payment in full, excluding quick-pay discounts, slow-pay penalties, and third-party payments for both accommodation and ancillary department services. The rates include reimbursement for operating and capital costs. The Administration shall make reimbursement for direct graduate medical education as described in A.R.S. § 36-2903.01. For payment purposes, the Administration shall classify each AHCCCS inpatient hospital day of care into one of several tiers appropriate to the services rendered. The rate for a tier is referred to as the tiered per diem rate of reimbursement. The number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier claims, transplant claims, or payment to out-of-state hospitals, freestanding psychiatric hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.

1. Tier rate data. The Administration shall base tiered per diem rates effective on and after October 1, 1998 on Medicare Cost Reports for Arizona hospitals for 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. A hospital shall submit information to assist the Administration in this allocation.
    b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed for rates effective on and after October 1, 1998. The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude from the database or adjust claims and encounters that fail these edits. The Administration shall also exclude from the database the following claims and encounters:
        i. Those missing information necessary for the rate calculation,
        ii. Medicare crossovers,
        iii. Those submitted by freestanding psychiatric hospitals, and
        iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.
2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on

the sum of the operating and capital components. The rate for the operating component is a statewide rate for each tier except for the NICU and Routine tiers, which are based on peer groups. The rate for the capital component is a blend of statewide and hospital-specific values, as described in A.R.S. § 36-2903.01. The Administration shall use the following methodologies to establish the rates for each of these components ~~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 Administration shall compute the rate for the operating component as follows:
   i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.
   ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports are grouped. The ancillary department cost-to-charge ratios for a particular hospital are multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters are multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day do not include medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1996, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs. The Administration shall further inflate operating costs to the midpoint of the rate year (March 31, 1999).
   iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these. For the NICU tier, the Administration shall further assign claims and encounters to NICU Level II or NICU Level III peer groups, based on the hospital's certification by the Arizona Perinatal Trust. For the Routine tier, the Administration shall further assign claims and encounters to the general acute care hospital or rehabilitation hospital peer groups, based on state licensure by the Department of Health Services. For claims and encounters assigned to more than one tier, the Administration shall allocate ancillary department costs to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (6).
   iv. Operating rate calculation. The Administration shall set the rate for the operating component for each tier by dividing total statewide or peer group hospital costs identified in this subsection within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.

b. Capital component. For rates effective October 1, 1999 the capital component is calculated as described in A.R.S. § 36-2903.01.

c. Statewide inpatient hospital cost-to-charge ratio. For dates of service prior to October 1, 2007, ~~The~~ the statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, as described in subsections (4), (5), and (6), and out-of-state hospitals, as described in R9-22-712(B). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (1) and used to determine the tiered per diem rates. For each hospital, the covered inpatient days of care on the claims and encounters are multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters are multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital are determined in the same way described in subsection (2)(a) but include costs for operating and capital. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.

d. Unassigned tiered per diem rates. If a hospital has an insufficient number of claims to set a tiered per diem rate, the Administration shall pay that hospital the statewide average rate for that tier.

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

a. Tier hierarchy. In assigning claims for AHCCCS inpatient hospital days of care to a tier, the Administration shall follow the Hierarchy for Tier Assignment in R9-22-712.09. The Administration shall not pay a claim for inpatient hospital services unless the claim meets medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that are submitted by the hospital.
b. Tier exclusions. The Administration shall not assign to a tier or pay AHCCCS inpatient hospital days of care that do not occur during a period when the person is eligible. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. The Administration shall pay same day admit and discharge claims that qualify for either the maternity or nursery tiers based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.
c. Seven tiers. The seven tiers are:
i. Maternity. The Administration shall identify the Maternity Tier by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the Administration shall pay the AHCCCS inpatient hospital days of care on the claim at the maternity tiered per diem rate.
ii. NICU. The Administration shall identify the NICU Tier by a revenue code. A hospital does not qualify for the NICU tiered per diem rate unless the hospital is classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier and have a NICU revenue code at the NICU tiered per diem rate. The Administration shall pay any remaining AHCCCS inpatient hospital day on the claim that does not meet NICU Level II or NICU Level III medical review criteria at the nursery tiered per diem rate.
iii. ICU. The Administration shall identify the ICU Tier by a revenue code. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meets the medical review criteria for the ICU tier and has an ICU revenue code at the ICU tiered per diem rate. The Administration may classify any AHCCCS inpatient hospital days on the claim without an ICU revenue code, as surgery, psychiatric, or routine tiers.
iv. Surgery. The Administration shall identify the Surgery Tier by a revenue code and a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list identifies minor procedures such as sutures that do not require the same hospital resources as other procedures. The Administration shall only split a surgery tier with an ICU tier. AHCCCS shall pay at the surgery tier rate only when the surgery occurs on a date during which the member is eligible.
v. Psychiatric. The Administration shall identify the Psychiatric Tier by either a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the psychiatric tier with any tier other than the ICU tier.
vi. Nursery. The Administration shall identify the Nursery Tier by a revenue code. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the nursery tier with any tier other than the NICU tier.
vii. Routine. The Administration shall identify the Routine Tier by revenue codes. The routine tier includes AHCCCS inpatient hospital days of care that are not classified in another tier or paid under any other provision of this Section. The Administration shall not split the routine tier with any tier other than the ICU tier.

4. Annual update. The Administration shall annually update the inpatient hospital tiered per diem rates in accordance with A.R.S. § 36-2903.01.
5. New hospitals. For rates effective on and after October 1, 1998, the Administration shall pay new hospitals the statewide average rate for each tier, as appropriate. The Administration shall update new hospital tiered per diem rates annually under A.R.S. § 36-2903.01.
6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers under this Section by multiplying the covered charges on a claim by the ~~statewide inpatient hospital cost-to-charge ratio.~~ Medicare Urban or Rural cost-to-Charge Ratio. The Urban cost-to-charge ratio will be used for hospitals located in a county of 500,000 residents or more. The Rural cost-to-charge ratio will be used for hospitals located in a county of fewer than 500,000 residents.
a. Outlier criteria. For rates effective on and after October 1, 1998, the Administration ~~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 is 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.~~ If the covered costs per day on a claim exceed the urban or rural cost threshold for a tier, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the applicable Medicare Urban or Rural CCR. The resulting amount will be the outlier payment. If there are two tiers on a claim, the Administration shall determine whether the claim is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying each tier rate by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital. Routine maternity stays shall be excluded from outlier reimbursement. A routine maternity is any one-day stay with a delivery of one or two babies. A routine maternity stay will be paid at tier.

b. Update. The CCR is updated annually by the Administration for dates of service beginning October 1, using the most current Medicare cost-to-charge ratios published or placed on display by CMS by August 31 of that year. The Administration shall update the outlier cost thresholds for each hospital as described under A.R.S § 36-2903.01.

c. Medicare Cost-to-Charge Ratio Phase-In. AHCCCS shall phase in the use of the Medicare Urban or Rural Cost-to-Charge Ratios for outlier determination, calculation and payment. The three year phase-in does not apply to out of state or new hospitals.

i. Medicare Cost-to-Charge Ratio Phase-In outlier determination and threshold calculation. For outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. For outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. The adjusted hospital specific inpatient cost-to-charge ratios shall be used for all calculations using the Medicare Urban or Rural Cost-to-Charge Ratios, including outlier determination, and threshold calculation.

ii. Medicare Cost-to-Charge Ratio Phase-In calculation for payment. For payment of outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio. For payment of outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio.

iii. Medicare Cost-to-Charge Ratio for outlier determination, threshold calculation, and payment. For outlier claims with dates of service on or after October 1, 2009, the full Medicare Urban or Rural Cost-to-Charge Ratios shall be utilized for all outlier calculations.

7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered transplant as described in R9-22-206 is performed through the terms of the relevant contract. As described in R9-22-716, if the Administration and a hospital that performs transplant surgery on an eligible person do not have a contract for the transplant surgery, the Administration shall not reimburse the hospital more than what would have been paid to the contracted hospital for that same surgery.
8. Ownership change. The Administration shall not change any of the components of a hospital's tiered per diem rates upon an ownership change.
9. Psychiatric hospitals. The Administration shall pay freestanding psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Department of Health Services.
10. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section as provided by A.R.S. § 36-2903.01. For purposes of this subsection, "specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.
11. Outliers for out-of-state and new hospitals. Outliers for out-of-state hospitals will be calculated using the Medicare urban cost-to-charge ratio times covered charges. If the resulting cost is equal to or above the urban outlier threshold, the claim will be paid at the Medicare Urban Cost-to-Charge Ratio times covered charges. Outliers for new hospitals will be calculated using the Medicare Urban or Rural Cost-to-Charge Ratio times covered charges. If the resulting cost is equal to or above the cost threshold, the claim will be paid at the Medicare Urban or Rural Cost-to-Charge ratio.

R9-22-718. Urban Hospital Inpatient Reimbursement Program

A. Definitions. The following definitions apply to this Section:
1. "Noncontracted Hospital" means an urban hospital which does not have a contract under this Section with an urban contractor in the same county.

2. "Rural Contractor" means a contractor or program contractor as defined in A.R.S. Title 36, Chapter 29 that does not provide services to members residing in either Maricopa or Pima County.
3. "Urban Contractor" means a contractor or program contractor as defined in A.R.S. Title 36, Chapter 29, that provides services to members residing in Maricopa or Pima County and may also provide services to members who reside in other counties. An urban contractor does not include BHS, CRS, CMDP, HCG or a Tribal government.
4. "Rural Hospital" means a hospital, as defined in Article 1, that is physically located in Arizona but in a county other than Maricopa and Pima County.
5. "Urban Hospital" means a hospital, as defined in Article 1, that is physically located in Maricopa or Pima County.

B. General Provisions.
1. This Section applies to an urban hospital who receives payment for inpatient hospital services under A.R.S. §§ 36-2903.01 and 36-2904.
2. AHCCCS shall operate an inpatient hospital reimbursement program under A.R.S. § 36-2905.01 and this Section.
3. Residency of the member receiving inpatient AHCCCS covered services is not a factor in determining which hospitals are required to contract with which contractors.
4. An urban contractor shall enter into a contract for reimbursement for inpatient AHCCCS covered services with one or more urban hospitals located in the same county as the urban contractor.
5. A noncontracted urban hospital shall be reimbursed for inpatient services by an urban contractor ~~based on the tiered per diem rates for that hospital~~ at 95% of the amount calculated as defined in A.R.S. § 36-2903.01 and ~~R9-22-712~~ this Article, ~~multiplied by 95%~~ unless otherwise negotiated by both parties.

C. Contract Begin Date. A contract under this Article shall cover inpatient acute care hospital services for members with hospital admissions on and after October 1, 2003.

D. Outpatient urban hospital services. Outpatient urban hospital services, including observation days and emergency room treatments that do not result in an admission, shall be reimbursed either through an urban hospital contract negotiated between a contractor and an urban hospital, or the reimbursement rates set forth in A.R.S. § 36-2903.01. Outpatient services in an urban hospital that result in an admission shall be paid as inpatient services in accordance with this Section.

E. Urban Hospital Contract.
1. Provisions of an urban hospital contracts. The urban hospital contract shall contain but is not limited to the following provisions:
   a. Required provisions as described in the Request for Proposals (RFP);
   b. Dispute settlement procedures. If the AHCCCS Grievance System prescribed in A.R.S. § 36-2903.01(B) and rule is not used, then arbitration shall be used.
   c. Arbitration procedure. If arbitration is used, the urban hospital contract shall identify:
      i. The parties' agreement on arbitrating claims arising from the contract,
      ii. Whether arbitration is nonbinding or binding,
      iii. Timeliness of arbitration,
      iv. What contract provisions may be appealed,
      v. What rules will govern arbitrations,
      vi. The number of arbitrators that shall be used,
      vii. How arbitrators shall be selected, and
      viii. How arbitrators shall be compensated.
   d. Timeliness of claims submission and payment;
   e. Prior authorization;
   f. Concurrent review;
   g. Electronic submission of claims;
   h. Claims review criteria;
   i. Payment of discounts or penalties such as quick-pay and slow-pay provisions;
   j. Payment of outliers;
   k. Claim documentation specifications under A.R.S. § 36-2904.
   l. Treatment and payment of emergency room services; and
   m. Provisions for rate changes and adjustments.
2. AHCCCS review and approval of urban hospital contracts.
   a. AHCCCS may review, approve, or disapprove the hospital contract rates, terms, conditions, and amendments to the contract.
   b. An urban contractor shall submit urban hospital contracts and amendments as specified in the RFPs for the contract year beginning October 1, 2003, or as specified in the RFP for a new urban hospital contract negotiated after October 1, 2003.
   c. The AHCCCS evaluation of each urban hospital contract shall include but not be limited to the following areas:
      i. Availability and accessibility of services to members,
      ii. Related party interests,

iii. Inclusion of required terms pursuant to this Section, and
iv. Reasonableness of the rates.

3. Evaluation of urban contractor's use of a noncontracted hospital. AHCCCS shall evaluate the contractor's use of a contracted versus noncontracted hospital.

~~F. Outlier Policy. When there is no hospital contract between an urban contractor and an urban hospital, reimbursement of an outlier is based upon the effective FFS outlier thresholds at 95% of the statewide average cost-to-charge ratio in effect.~~

~~G.~~**F.** Quick-Pay/Slow-Pay. A payment made by urban contractor to a noncontracted hospital shall be subject to quick-pay discounts and slow-pay penalties under A.R.S. § 36-2904.