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

PREAMBLE

1. Sections Affected — **Rulemaking Action**
R9-22-712 — Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):
Authorizing statute: Laws 2004, Ch. 279, § 18.

Implementing statute: A.R.S. § 36-2903.01(H)(3), as amended by Laws 2004, Ch 279, § 3.

3. The effective date of the rules:
August 25, 2004

4. A list of all previous notices appearing in the Register addressing the exempt rule:
Notice of Rulemaking Docket Opening: 10 A.A.R. 1894, May 7, 2004

5. 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) 417-4693
Fax:	(602) 253-9115
Email:	proposedrules@ahcccs.state.az.us

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:
A.R.S. 36-2903.01 was amended by Laws 2004, Ch. 279, § 3, imposing a rule that AHCCCS will pay a hospital covered outpatient service using a specific outpatient cost-to-charge ratio.

In the event the hospital increases its charges for outpatient covered services by more than 4.7% on, or after, date of service July 1, 2004, AHCCCS shall reduce the specific cost-to-charge ratio as detailed in the promulgated rule attached.

Laws 2004, Ch. 279, § 18 exempts AHCCCS from the regular rulemaking procedure.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:
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 previous 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 principal comments and the agency response to them:
None received

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

13. Incorporations by reference and their location in the rules:
There are no incorporations by reference.

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

ARTICLE 7. STANDARDS FOR PAYMENTS

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

A. No change
1. No change
   a. No change
   b. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
2. No change
   a. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
   b. No change
      i. No change
      ii. No change
      iii. No change
   c. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
      v. No change
      vi. No change
   d. No change
   e. No change
3. No change
   a. No change
   b. No change
   c. No change

i. No change
ii. No change
iii. No change
iv. No change
v. No change
vi. No change
vii. No change

4. No change
   a. No change
   b. No change
   c. No change
5. No change
6. No change
   a. No change
   b. No change
7. No change
8. No change
   a. No change
   b. No change
   c. No change
   d. No change
      i. No change
      ii. No change
      iii. No change
   e. No change
   f. No change
   g. No change
9. No change
10. No change
11. No change
12. No change

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

1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs shall be included in the computation but outpatient medical education costs that are included in the inpatient medical education component shall be excluded. To calculate the outpatient hospital cost-to-charge ratio for the initial prospective rate year for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in subsections (A)(1)(a) and (A)(1)(b). The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
   a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters for outpatient hospital services. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
   b. Cost-to-charge limit. To comply with federal regulation, 42 CFR 447.325, the Administration may limit cost-to-charge ratios at 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hos-

pital services in specialty facilities.

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

   CCR*[1.047/(1+ % increase)]

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

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

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

C. No change
D. No change
E. No change
F. No change
G. No change
H. No change
I. No change
J. No change