

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 ADMINISTRATION

[R07-06]

PREAMBLE

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|------------------------------------|---------------------------------|
| 1. <u>Sections Affected</u> | <u>Rulemaking Action</u> |
| R9-22-701 | Amend |
| R9-22-712.05 | New Section |
- 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
Implementing statute: A.R.S. § 36-2903.01
- 3. A list of all previous notices appearing in the Register addressing the proposed rule:**
Notice of Rulemaking Docket Opening: 12 A.A.R. 41, January 5, 2007
- 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) 417-4693 |
| Fax: | (602) 253-9115 |
| E-mail: | AHCCCSRules@azahcccs.gov |
- 5. An explanation of the rule, including the agency's reasons for initiating the rule:**
The 47th Legislative 2006 session approved additional funds for distribution to training hospitals for graduate medical education (GME) programs. The funds are in addition to the funds allocated yearly to teaching hospitals, and are designated to support programs that have expanded, and will expand, their educational efforts. The proposed rule establishes the methodology for distributing the funds. In general, the proposed rule: (i) defines hospitals eligible to receive distributions, (ii) defines residency positions on which distributions will be based, (iii) requires reporting of information necessary to determine distributions, (iv) describes the process of calculating allocations to programs, and (v) describes the process for distributing allocated amounts among eligible hospitals.
- 6. A reference to any study relevant to the rules that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rules, 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 study was reviewed during this rulemaking and the Agency does not anticipate reviewing any studies.
- 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

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

It is anticipated that the rulemaking will have a minimal to moderate economic impact on graduate medical education programs (GME) that are currently in place and any newly created GME programs as of July 1, 2006.

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) 417-4693
Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS web site www.azahcccs.gov the week of January 15, 2007. Please send written comments to the above address by 5:00 p.m., March 5, 2007. 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 5, 2007
Time: 1:00 p.m.
Location: AHCCCS
701 E. Jefferson
Phoenix, AZ 85034
Nature: Public Hearing

Date: March 5, 2007
Time: 1:00 p.m.
Location: ALTCS: Arizona Long-Term Care System
110 S. Church, Ste. 1360
Tucson, AZ 85701
Nature: Public Hearing

Date: March 5, 2007
Time: 1:00 p.m.
Location: ALTCS: Arizona Long-Term Care System
3480 E. Rte. 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:

Not applicable

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
ADMINISTRATION**

ARTICLE 7. STANDARDS FOR PAYMENTS

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

R9-22-712.05. ~~Reserved~~ Graduate Medical Education Fund Allocation

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-701. Standard for Payments Related Definitions

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

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

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

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

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

“APC” means the Ambulatory Payment Classification system under 42 CFR 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 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) and displayed for verification of the member’s eligibility.

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

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

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

“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 Hospital” means a separately standing hospital with at least 120 pediatric beds that is dedicated

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to provide the majority of the hospital's services to children.

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

“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 codes 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.

“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 for a graduate medical education program.

“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.

R9-22-712.05. Reserved Graduate medical education fund allocation

- A.** Graduate medical education (GME) reimbursement as of September 30, 1997. Subject to legislative appropriation, the Administration shall make a distribution based on direct graduate medical education costs as described in A.R.S. § 36-2903.01(H)(9)(a).
- B.** Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for the expansions of GME programs approved by the Administration to hospitals for direct program costs eligible for funding under A.R.S. § 36-2903.01(H)(9)(b). A GME program approved by the Administration means a GME program that has been approved by a national organization as described in 42 CFR 415.152. A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (E).
- C.** Eligible health care facilities. A health care facility is eligible for distributions under subsection (B) if all of the following apply:
1. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona;
 2. It incurs direct costs for the training of residents in the GME programs, which costs are or will be reported on the hospital’s Medicare Cost Report;
 3. It is not administered by or does not receive its primary funding from an agency of the federal government.
- D.** Eligible resident positions. For purposes of determining program allocation amounts under subsection (F) the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (C)(3):
1. Filled resident positions in approved programs established as of October 1, 1999 at hospitals that receive funding as described in A.R.S. § 36-2903.01(H)(9)(a) that are additional to the number of resident positions that were filled as of October 1, 1999; and
 2. All filled resident positions in approved programs other than GME programs described in A.R.S. § 36-2903.01(H)(9)(a); and
 3. For approved programs established on or after July 1, 2006 that have been established for less than one year as of the date of reporting under subsection (E) and have not yet filled their first-year resident positions, all prospective resi-

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dents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match.

- E. Annual reporting.** By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (B) shall provide to the Administration:
1. A GME program shall provide all of the following:
 - a. The program name and number assigned by the accrediting organization;
 - b. The original date of accreditation;
 - c. The names of the sponsoring institution and all participating institutions current as of the date of reporting;
 - d. The number of approved resident positions and the number of filled resident positions current as of the date of reporting;
 - e. For programs described under subsection (D)(3), the number of residents expected to be enrolled as a result of the most recently completed annual resident match;
 - f. For programs established as of October 1, 1999, the number of resident positions that were filled as of October 1, 1999, if the program has not prior provided this information to the Administration;
 - g. For programs established on or after July 1, 2006, the academic year rotation schedule on file with the program current as of the date of reporting.
 2. A hospital seeking a distribution under subsection (B) shall provide all of the following that apply:
 - a. If the hospital uses the Intern and Resident Information System (IRIS) for tracking and reporting its resident activity to the fiscal intermediary, copies of the IRIS master and assignment files for the hospital's two most recently completed Medicare cost reporting years as filed with the fiscal intermediary;
 - b. If the hospital does not use the IRIS or has less than two cost reporting years available in the form of the IRIS master and assignment files, the information normally contained in the IRIS master and assignment files in an alternative format for the hospital's two most recently completed Medicare cost reporting years;
 - c. At the request of the Administration, a copy of the hospital's Medicare Cost Report or any part thereof for the most recently completed cost reporting year.
- F. Allocation of expansion funds.** Annually the Administration shall allocate available funds to each approved GME program in the following manner:
1. Information provided by hospitals under subsection (E)(2) shall be used to determine the program in which each eligible resident is enrolled and the number of days that each eligible resident worked in any area of the hospital complex or in a non-hospital setting under agreement with the reporting hospital during the period of assignment to that hospital. For this purpose, the Administration shall use data relating to the most recent 12-month period that is common to all information provided under subsections (E)(2)(a) and (b).
 2. For approved programs established on or after July 1, 2006 whose first-year resident positions have been filled but whose first year of operation is not complete as of the date of reporting under subsection (E)(2), information provided by GME programs under subsection (E)(1) shall be used to determine the number of days that each eligible resident is assigned to work at each participating institution.
 3. For eligible residents described by subsection (D)(3), information provided by GME programs under subsection (E)(1) shall be used to determine a number of days that each prospective first-year resident is expected to work at each participating institution.
 4. The number of eligible residents allocated to each participating institution for each approved GME program shall be determined by totaling the number of days determined under subsections (F)(1) through (F)(3) and dividing the totals by 365.
 5. The number of allocated residents determined under subsection (F)(4) shall be adjusted for Arizona Medicaid utilization using the most recent Medicare Cost Report information on file with the Administration as of the date of reporting under subsection (E) and the Administration's inpatient hospital claims and encounter data for the time period corresponding to the Medicare Cost Report information for each hospital. The Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were adjudicated by the Administration as of the date of reporting under subsection (E). The Medicaid-adjusted eligible residents shall be determined as follows:
 - a. For each hospital, the total AHCCCS inpatient hospital days of care shall be divided by the total Medicare Cost Report inpatient hospital days, multiplied by 100 and rounded up to the nearest multiple of 5 percent.
 - b. The number of allocated residents determined for each participating hospital under subsection (F)(4) shall be multiplied by the percentage derived under subsection (F)(5)(a) for that hospital. The number of allocated residents determined under subsection (F)(4) for a participating institution that is not a hospital and not a health care facility made ineligible under subsection (C)(3) shall be multiplied by the percentage derived under subsection (F)(5)(a) for the program's sponsoring institution or, if the sponsoring institution is not a hospital, the sponsoring institution's affiliated hospital. The number of allocated residents determined under subsection (F)(4) for a participating institution that is made ineligible under subsection (C)(3) shall be multiplied by 0 percent.
 6. The total allocation for each approved program shall be determined by multiplying the Medicaid-adjusted eligible residents determined under subsection (F)(5)(b) by the per resident conversion factor determined below and totaling

the resulting dollar amounts for all participating institutions in the program. The per resident conversion factor shall be determined as follows:

- a. Calculate the total direct GME costs from the most recent Medicare Cost Reports on file with the Administration for all hospitals that have reported such costs.
- b. Calculate the total allocated residents determined under subsection (F)(4) for those hospitals described under subsection (F)(6)(a).
- c. Divide the total GME costs calculated under subsection (F)(6)(a) by the total allocated residents calculated under subsection (F)(6)(b).

G. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (F) in the following manner:

1. The allocated amounts shall be distributed in the following order of priority:
 - a. To eligible hospitals that do not receive funding in accordance with A.R.S. § 36-2903.01(H)(9)(a) for the direct costs for programs established prior to July 1, 2006;
 - b. To eligible hospitals that receive funding in accordance with A.R.S. § 36-2903.01(H)(9)(a) for the direct costs for programs established prior to July 1, 2006;
 - c. To any eligible hospital for the direct costs for programs established on or after July 1, 2006.
2. The allocated amounts shall be distributed to the eligible hospitals in each approved program in proportion to the number of Medicaid-adjusted eligible residents allocated to each within that program under subsection (F)(5)(b).
3. Where funds are insufficient to cover all distributions within any priority group described under subsection (G)(1), the Administration shall adjust the distributions proportionally within that priority group.