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

[R07-366]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-701	Amend
R9-22-712.05	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

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

3. The effective date of the rules:

November 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

Fax: (602) 253-9115

E-mail: AHCCCSrules@azahcccs.gov

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 as amended by Laws 2007, Ch. 263, § 9 have required the Administration to implement and describe in rule how GME appropriated funds will be distributed to hospitals for direct costs of the GME programs established or expanded on or after July 1, 2006. In addition the rule describes how indirect GME costs for programs located in a county with a population of less than 500,000 will be calculated and distributed and how funds and certified public expenditures shall apply to other indirect program costs.

Laws 2007, Ch. 263, § 29 exempts the Administration from rulemaking requirements of A.R.S. Title 41, Chapter 6, 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 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 comments made regarding rule, and the agency response to them:

	Date:	Commenter:	Comment/Questions:	AHCCCS Response:	Response Date:
1	09/28/07	Norma Peal UPH – University Physicians Healthcare	We urge AHCCCS to modify its proposed regulations to permit local, county and tribal government funds to be used as the non-federal share of reimbursements for direct program costs to the extent that these costs are not reimbursed by state general appropriations.	The distribution methodology created by the proposed rule is a cost-based calculation that accounts for the whole Medicaid portion of direct GME costs for each hospital having GME programs. The Administration may not make payments in excess of costs. Based on the FY 2007 distributions, the Administration believes that available funds will be adequate to cover the calculated Medicaid costs.	10/24/07
2	09/28/07	Norma Peal UPH – University Physicians Healthcare	We urge AHCCCS to permit local, county and tribal governments to provide the non-federal share of supplemental GME payments to non-institutional providers. The maximum amount of these payments should be the Medicaid-related share of direct and indirect program costs incurred by these providers, as verified in a manner acceptable to both AHCCCS and CMS.	Statute 36-2903.01(H) specifically establishes that payments are to be made to hospitals. A.R.S. § 36-2903.01(H), states: "For inpatient hospital admissions and outpatient hospital services on and after March 1, 1993 the administration shall adopt rules for the reimbursement of hospitals according to the following procedures:" (Emphasis added.) All parts of subsection (H) are subject to the same limitation. Therefore, distributions of local, county, and tribal funds authorized by A.R.S. § 36-2903.01(H)(9)(f) are limited to reimbursement of hospitals.	10/24/07
3	09/28/07	Norma Peal UPH – University Physicians Healthcare	HB2789 authorizes AHCCCS to make administrative GME payments when the non-federal share is provided by local, county or tribal governments.	Under A.R.S. § 36-2903.01(H), the Administration's authority is limited to reimbursement of hospitals. The distributions made under the proposed rule cover both direct and indirect costs, which together make up the whole cost associated with graduate medical education at a hospital.	10/24/07

				Therefore, the costs of medical activities and administrative activities are addressed by the distribution methodology created by the proposed rule.	
4	09/24/07	James Haynes AZHHA – AZ Hospital and Healthcare Association	AZHHA requests that the Administration share the detailed methodology behind the rules. For example, how are the participation and Medicaid percentages calculated? How are eligible residents determined?	Medicaid Percentage In accordance with proposed subsection (C)(4)(d), allocated residents will be adjusted for Arizona Medicaid utilization using the methodology described at subsection (B)(4)(c). Accordingly, the Medicaid utilization percentage for each participating hospital will be determined by the methodology described at subsection (B)(4)(c)(i), which states: "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." Eligible Residents The definition of eligible residents is provided at proposed subsection (C)(2). The number of filled resident positions in each program will be reported by the programs in accordance with proposed subsection (C)(3). The number of eligible residents in a program will be determined by the program reporting. Participation Percentage The "participation percentage" is not a part of the proposed rule. It is a statistic whose existence is incidental to the process created by the proposed rule, calculated as the number of program residents allocated to a participating hospital divided by the total number of program residents.	10/24/07

5	09/24/07	James Haynes AZHHA – AZ Hospital and Healthcare Association	Clarify section related to Indirect Program costs (IME) with: 1. How much total funding will be set aside for IME reimbursement? 2. Based on IRIS data received, which hospitals will qualify for the rural rotations and reimbursement? 3. How is the one-month rotation determined in rural counties, (four weeks, 31 days)? Must the time be consecutive?	1. The legislature appropriated $9 million for the direct GME distributions described at proposed subsection (C) and indirect ME distributions described at proposed subsection (D). Proposed subsection (E) provides that the distributions under proposed subsections (C) and (D) will be adjusted proportionally if funds are insufficient to cover all calculated distributions under both. 2. Due to the nature of the IRIS data, the existence of rural rotations cannot be determined from that source. The Administration's source of information on rural rotations will be the program-reported academic year rotation schedules. The Administration is not yet in possession of the rotation schedules on which the first distribution will be based. Therefore, it is not known which hospitals will qualify. 3. In accordance with proposed subsection (D)(4)(a), the number of months per year that residents will perform rural rotations will be determined by the academic year rotation schedules submitted by the programs under proposed subsection (D)(3)(a)(ii). The Administration will account for the resident time by the time periods stated on the rotation schedules. The typical academic year rotation schedule indicates the required resident time at a given location in whole or half months. The Administration does not intend by this rule to impose a time requirement inconsistent with the educational requirements determined by the program faculty and the accrediting body. Therefore, eligibility does not depend on the time period spent at the rural educational venue being consecutive.	10/24/07

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
R9-22-701. Standard for Payments Related Definitions
R9-22-712.05. 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" 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 a uniform language to accurately designate medical, surgical, and diagnostic

services.

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

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

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

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

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

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

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

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

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

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

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

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

"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.

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

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

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

"Medical review" means a clinical evaluation of documentation conducted by AHCCCS or a contractor for purposes of prior authorization, concurrent review, post-payment review, or determining medical necessity. The criteria for 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 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. 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)~~ (B)(3).

~~C.~~1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (B) if all of the following apply:

~~1.~~a. 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.~~b. 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.~~c. It is not administered by or does not receive its primary funding from an agency of the federal government.

~~D.~~2. Eligible resident positions. For purposes of determining program allocation amounts under subsection ~~(F)~~ (B)(4) 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)~~ (B)(1)(c):

~~1.~~a. 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.~~b. All filled resident positions in approved programs other than GME programs described in A.R.S. § 36-2903.01(H)(9)(a)~~; and~~ that were established before July 1, 2006.

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

~~E.~~3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (B) shall provide the applicable information listed in this subsection to the Administration:

~~1.~~a. A GME program shall provide all of the following:

~~a.~~i. The program name and number assigned by the accrediting organization;

~~b.~~ii. The original date of accreditation;

~~c.~~iii. The names of the sponsoring institution and all participating institutions current as of the date of reporting;

~~d.~~iv. 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.~~v. 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 already 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.~~b. A hospital seeking a distribution under subsection (B) shall provide all of the following that apply:

~~a.~~i. 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.~~ii. 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.~~iii. At the request of the Administration, a copy of the hospital's Medicare Cost Report or any part of the report for the most recently completed cost reporting year.

~~F.~~4. Allocation of expansion funds. Annually the Administration shall allocate available funds to each approved GME program in the following manner:

~~1.~~a. Information provided by hospitals under subsection ~~(E)(2)~~ (B)(3)(b) 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)~~ (B)(3)(b)(i) and (ii).

~~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.~~b. The number of eligible residents allocated to each participating institution within each approved GME program shall be determined ~~by totaling the number of days determined for each participating institution under subsections (F)(1) through (F)(3) and dividing each total by 365.~~ as follows:

i. Total the number of days determined for each participating institution under subsection (B)(4)(a) and divide each total by 365.

ii. Proportionally adjust the result of subsection (B)(4)(b)(i) for each participating institution within each program according to the number of residents determined to be eligible under subsection (B)(2).

~~5.~~c. The number of allocated eligible residents determined under subsection ~~(F)(4)~~ (B)(4)(b)(ii) 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)~~ (B)(3) 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)~~ (B)(3). The Medicaid-adjusted eligible residents shall be determined as follows:

~~a.~~i. 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~~ five percent.

~~b.~~ii. The number of allocated eligible residents determined for each participating hospital under subsection ~~(F)(4)~~ (B)(4)(b)(ii) shall be multiplied by the percentage derived under subsection ~~(F)(5)(a)~~ (B)(4)(c)(i) for that hospital. The number of allocated eligible residents determined under subsection ~~(F)(4)~~ (B)(4)(b)(ii) for a participating institution that is not a hospital and not a health care facility made ineligible under subsection ~~(C)(3)~~ (B)(1)(c) shall be multiplied by the percentage derived under subsection ~~(F)(5)(a)~~ (B)(4)(c)(i) 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 eligible residents determined under subsection ~~(F)(4)~~ (B)(4)(b)(ii) for a participating institution that is made ineligible under subsection ~~(C)(3)~~ (B)(1)(c) shall be multiplied by ~~0~~ zero percent.

~~6.~~d. The total allocation for each approved program shall be determined by multiplying the Medicaid-adjusted eligible residents determined under subsection ~~(F)(5)(b)~~ (B)(4)(c)(ii) 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.~~i. 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.~~ii. Calculate the total allocated residents determined under subsection ~~(F)(4)~~ (B)(4)(b)(i) for those hospitals described under subsection ~~(F)(6)(a)~~ (B)(4)(d)(i).

~~c.~~iii. Divide the total GME costs calculated under subsection ~~(F)(6)(a)~~ (B)(4)(d)(i) by the total allocated residents calculated under subsection ~~(F)(6)(b)~~ (B)(4)(d)(ii).

~~G.~~5. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection ~~(F)~~ (B)(4) in the following manner:

~~1.~~a. The allocated amounts shall be distributed in the following order of priority:

~~a.~~i. To eligible hospitals that do not receive funding in accordance with A.R.S. § 36-2903.01(H)(9)(a) for the direct costs of programs established before July 1, 2006;

~~b.~~ii. To eligible hospitals that receive funding in accordance with A.R.S. § 36-2903.01(H)(9)(a) for the direct costs of programs established before July 1, 2006;

~~c. To any eligible hospital for the direct costs of programs established on or after July 1, 2006.~~

~~2.~~b. 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 hospital within that program under subsection ~~(F)(5)(b)~~ (B)(4)(c)(ii).

~~3.~~c. If funds are insufficient to cover all distributions within any priority group described under subsection ~~(G)(1)~~

(B)(5)(a), the Administration shall adjust the distributions proportionally within that priority group.

C. 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)(c)(i). 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 (C)(3).

1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (C) if it meets all the conditions of subsections (B)(1)(a) through (c).
2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (C)(4), 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 (B)(1)(c):
   a. All filled resident positions in approved programs established on or after July 1, 2006; and
   b. 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 (C)(3) and have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match.
3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (C) shall provide to the Administration:
   a. A GME program shall provide all of the following:
      i. The requirements of subsections (B)(3)(a)(i) through (iv);
      ii. The academic year rotation schedule on file with the program current as of the date of reporting; and
      iii. For programs described under subsection (C)(2)(b), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
   b. A hospital seeking a distribution under subsection (C) shall provide the requirements of subsection (B)(3)(b).
4. Allocation of expansion funds. Annually the Administration shall allocate available funds to approved GME programs in the following manner:
   a. Information provided by hospitals in accordance with subsection (B)(3)(b) 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 in accordance with subsections (B)(3)(b)(i) and (ii).
   b. For approved programs whose resident activity is not represented in the information provided in accordance with subsection (B)(3)(b), information provided by GME programs under subsection (C)(3)(a) shall be used to determine the number of days that each eligible resident is expected to work at each participating institution.
   c. 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 (C)(4)(a) and (b) and dividing the totals by 365.
   d. The number of allocated residents determined under subsection (C)(4)(c) shall be adjusted for Arizona Medicaid utilization in accordance with subsection (B)(4)(c).
   e. The total allocation for each approved program shall be determined in accordance with subsection (B)(4)(d).
5. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (C)(4) 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 (C)(4)(d).

D. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for GME programs approved by the Administration to hospitals for indirect program costs eligible for funding under A.R.S. § 36-2903.01(H)(9)(c)(ii). 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 (D)(3).

1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (D) if all of the following apply:
   a. It is a hospital in Arizona that is the sponsoring institution of one or more of the GME programs in Arizona or the base hospital for one or more of the GME programs in Arizona whose sponsoring institutions are not hospitals;
   b. It incurs indirect program costs for the training of residents in the GME programs;
   c. It is not administered by or does not receive its primary funding from an agency of the federal government.
2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (D)(4) 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 (D)(1)(c):

a. Any filled resident position in an approved program that includes a rotation of at least one month per year in a county other than Maricopa or Pima whose population was less than 500,000 persons at the time the residency rotation was added to the academic year rotation schedule;
b. For approved programs that have been established for less than one year as of the date of reporting under subsection (D)(3) and have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match who will perform rotations of at least one month per year in a county other than Maricopa or Pima whose population was less than 500,000 persons at the time the residency rotation was added to the academic year rotation schedule.

3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (D) shall provide to the Administration:
   a. A GME program shall provide all of the following:
      i. The requirements of subsections (B)(3)(a)(i) through (iv);
      ii. The academic year rotation schedule on file with the program current as of the date of reporting;
      iii. For programs described under subsection (D)(2)(c), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
   b. A hospital seeking a distribution under subsection (D) shall provide the requirements of subsection (B)(3)(b)(iii).
4. Allocation of funds for indirect program costs. Annually the Administration shall allocate available funds to approved GME programs in the following manner:
   a. Using the information provided by programs under subsection (D)(3), the Administration shall determine for each program the number of residents in the program who are eligible under subsection (D)(2) and the number of months per year that each eligible resident will perform rotations in counties described by subsection (D)(2), multiply the number of eligible residents by the number of months and multiply the result by the per resident per month conversion factor determined under subsection (D)(4)(b).
   b. Using the most recent Medicare Cost Reports on file with the Administration for all hospitals that have calculated a Medicare indirect medical education payment, the Administration shall determine a per resident per month conversion factor as follows:
      i. Calculate each hospital's Medicaid share by dividing the AHCCCS inpatient hospital days of care by the total inpatient hospital days from the Medicare Cost Report. For this purpose, the Administration shall use the information described by subsection (B)(4)(c) for adjusting allocated residents for Arizona Medicaid utilization.
      ii. Calculate each hospital's Medicare share by dividing the Medicare inpatient days on the Medicare Cost Report by the total inpatient hospital days on the Medicare Cost Report.
      iii. Divide the Medicaid share by the Medicare share and multiply the resulting ratio by the indirect medical education payment calculated on the Medicare Cost Report.
      iv. Total the results for all hospitals, divide the result by the total allocated residents determined under subsection (B)(4)(b)(i) for these hospitals, and divide that result by 12.
5. Distribution of funds for indirect program costs. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (D)(4) to the program's sponsoring hospital or the program's base hospital if the sponsoring institution is not a hospital, up to but not exceeding:
   a. The amount calculated for the hospital at subsection (D)(4)(b)(iii), or
   b. The median of all amounts calculated at subsection (D)(4)(b)(iii) if no amount was calculated for the hospital.

E. Reallocation of funds. If funds appropriated for subsection (B) are not allocated by the Administration and funds appropriated for subsections (C) and (D) are insufficient to cover all distributions under subsections (C)(5) and (D)(5), the funds not allocated under subsection (B) shall be allocated under subsections (C) and (D) to the extent of the calculated distributions. If funds are insufficient to cover all distributions under subsections (C)(5) and (D)(5), the Administration shall adjust the distributions proportionally. If funds appropriated for subsections (C) and (D) are not allocated by the Administration and funds appropriated for subsection (B) are insufficient to cover all distributions under subsection (B)(5), the funds not allocated under subsections (C) and (D) shall be allocated under subsection (B) to the extent of the calculated distributions.

F. The Administration may enter into intergovernmental agreements with local, county, and tribal governments wherein local, county and tribal governments may transfer funds or certify public expenditures to the Administration. Such funds or certification, subject to approval by CMS, will be used to qualify for additional federal funds. Those funds will be used for the purposes of reimbursing hospitals specified by the local, county, or tribal government for indirect program costs other than those reimbursed under subsection (D). Funds transferred and available under this subsection shall be distributed in accordance with subsection (D) except that reimbursement with such funds is not limited to resident positions or rotations in counties with populations of less than 500,000 persons.