# 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 PROPOSED EXEMPT RULEMAKING

### TITLE 9. HEALTH SERVICES

### CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

*Editor's Note: The following Notice of Exempt Rulemaking was reviewed per Laws 2010, Ch. 287, § 18. (See the text of § 18 on page 1193.) The Governor's Office authorized the notice to proceed through the rulemaking process on May 4, 2011.*

[R11-54]

### PREAMBLE

**1. Sections Affected** — **Rulemaking Action**

| | |
|---|---|
| R9-22-712 | Amend |
| R9-22-712.01 | Amend |

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

Authorizing statute and laws: A.R.S. § 36-2903.01 and Arizona Laws 2011, Ch. 31, § 34

Implementing statute and laws: A.R.S. § 36-2903.01 as amended by Arizona Laws 2011, Ch. 31, §§ 11 and 32

**3. The proposed effective date of the rules:**

October 1, 2011

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

None

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

Please submit any comments by the close of the comment period, June 27, 2011 at 5:00 p.m.

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|---|---|
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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 regular rulemaking procedures:**

The purpose of the proposed rulemaking is to implement changes to the methodology for qualifying and paying claims for inpatient hospital services with extraordinary operating costs per day, commonly referred to as "outlier" claims. Specifically, the agency proposes to increase the thresholds used to qualify claims by 5% and to reduce the cost-to-charge ratios used to qualify and pay outliers by 5% plus by a like percentage of any increase in a hospital's charge master as filed with the Arizona Department of Health Services. In addition, the rulemaking clarifies that all inpatient services provided by out of state hospitals are not paid using the tiered per diem methodology, but are paid by multiplying billed charges by a cost-to-charge ratio. As such, there is no outlier methodology for payments to out of state hospitals.

In general, Arizona hospitals are reimbursed for inpatient services based on a per diem basis that varies by "tier"; that is, by the general type of service delivered on any particular day of an inpatient admission. Those tiered per diem payments were based on a calculation of the average per diem costs associated with each tier, and the payments have been adjusted for inflation since the base year in which the calculation was done. See A.R.S. § 36-2903.01(H). Prior to the 50th Legislature, 1st Regular Session of 2011, Arizona law also permitted the agency to establish a different methodology for the reimbursement of inpatient services with extraordinary operating costs per day; however, Arizona Laws 2011, Ch. 31, § 11, eliminated subsection (H)(10) regarding establishment of an outlier payment methodology separate from tiered per diem payments.

As a condition of the receipt of federal financial participation toward the cost of inpatient services for persons eligible under the Medicaid program, the agency is required to establish "methods and procedures relating to … the payment for, care and services … as may be necessary … to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the [State Medicaid] plan at least to the same extent that such care and services are available to the general population in the geographic area." 42 U.S.C. 1396a(a)(30)(A). In the preamble to a recent Notice of Proposed Rulemaking published by the federal government to establish standards related to the "access to care" requirement of this provision of the Medicaid Act, the Center for Medicare and Medicaid Services (CMS) set forth its position that, if eligible persons have appropriate access to care, the standard has been met regardless of other factors including payment levels. However, where issues exist with respect to access, factors such as rates of provider participation and retention as well as payment levels may be relevant. Therefore, CMS is proposing standards for reporting payment level information. 76 F.R. 26350 (May 6, 2011). In addition, CMS stated that in evaluating payment levels, it is important to consider total provider reimbursement – both base and supplemental payments. *Id.* at 26351.

Relating this recent statement of the federal government's to this agency rulemaking, it is important to note that the outlier payment methodology is merely one aspect of total reimbursement for inpatient hospital services – one designed to address inpatient stays with extraordinary operating costs per day, which by their nature are statistically small in number. In addition to outlier payments, hospitals receive tiered per diem payments for most inpatient stays and may receive supplemental payments in the form of disproportionate share payments, graduate medical education payments, critical access hospital payments, trauma/emergency department payments, and rural hospital payments. Adjustments to the outlier payment methodology do not, in and of themselves, imply that there will be impacts on access to care as payment levels are not the test for compliance with federal standards and, even where access issues may arise, payment levels are only one factor, and outlier payments are but a fraction of all payments.

Nevertheless, it is the intention of AHCCCS to establish and maintain a comprehensive payment methodology that protects the integrity of the delivery system consistent with market conditions and available funding for the AHCCCS program. During its recent session, the Arizona Legislature authorized the AHCCCS Administration to reduce payments to providers by up to 5%. Arizona Laws 2011, Ch. 31, § 32. In addition, the Legislature authorized the agency to adopt rules, including rules relating to reimbursement for services, to the extent necessary to maintain a program within the legislative appropriation notwithstanding any other law. Arizona Laws 2011, Ch. 31, § 34. Through this rulemaking, the agency is exercising the discretion granted by the Legislature.

For the present, the agency is proposing this rulemaking in an effort to implement changes to the methodology for the payment of outliers that will approximate a net savings to the system of 5% relative to the historical expenditure for outlier claims. In the future, the agency may develop a different methodology designed to include the historical cost of outliers into payments made through the tiered per diem methodology. Any such changes will be made through separate rulemaking after public notice and an opportunity for comment.

**7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to 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:**

Studies related to provider reimbursement, provider costs, and AHCCCS members' access to covered healthcare will be available in June 2011 at www.azahcccs.gov.

**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:**

For the 12 month period ending September 30, 2009 (the most recent year for which complete data is available), the Arizona Health Care Cost Containment System paid $2,320,471,989 for inpatient and outpatient hospital services. Of that total, $1,545,012,785 was for inpatient services, $600,999,735 was for outpatient services, and supplemental payments of $174,519,469 were made. Of the total payments for inpatient services, outlier payments for that same period were $195,941,472. If, as intended, the proposed rulemaking results in a 5% reduction in outlier payments (approximately $9,797,000), the reduction would represent a reduction of less than 1% (0.6341%) of total inpatient payments (not including supplemental payments) and less than half a percent (0.4222%) of total payments for hospital services.

**10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**

Not applicable. Final rules have not been filed yet.

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

Arizona Law 2011, Ch. 31, § 34, which authorizes this exempt rulemaking, requires public notice with an opportunity for public comment of at least 30 days. Public notice of this rulemaking is being accomplished through publication on the agency web site on May 27, 2011. A supplemental notice will also appear in the *Arizona Administrative Register* in advance of the close of the comment period. In addition, notice will be directed to those individuals who, prior to this proposed rulemaking have notified the agency of their desire to receive such notices directly pursuant to A.R.S. § 36-2903.01(B)(6).

The close of the comment period is June 27, 2011 at 5:00 p.m.

**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 made as an emergency rule? If so, please indicate the *Register* citation:**

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. Reimbursement: General
R9-22-712.01. Inpatient Hospital Reimbursement

### ARTICLE 7. STANDARDS FOR PAYMENTS

**R9-22-712. Reimbursement: General**

**A.** Inpatient and outpatient discounts and penalties. If a claim is pended for additional documentation required under A.R.S. § 36-2903.01(H)(4), the period during which the claim is pended is not used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § 36-2903.01(H)(5).

**B.** Inpatient and outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in ~~R9-22-712.01(6)(b)~~ R9-22-712.01(6)(d). In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse an out-of-state hospital for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the Administration shall pay the claim by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio.

**C.** Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or the Administration's designated representative in performance of the Administration's utilization control activities. The Administration shall deny a claim for failure to cooperate.

**D.** Prior authorization. Failure to obtain prior authorization as required under R9-22-210 is a basis for denial of payment.

**E.** Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers, to prepayment medical review or post-payment review, or both. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims. If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more appropriate level of care, effective on the date when the different level of care was medically appropriate.

**F.** Claim receipt.

1. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number.
2. Hospital claims are considered paid on the date indicated on disbursement checks.

3. A denied claim is considered adjudicated on the date the claim is denied.
4. Claims that are denied and are resubmitted are assigned new receipt dates.
5. For a claim that is pending for additional supporting documentation specified in A.R.S. §~~§~~ 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation.
6. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. §~~§~~ 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.

**G.** Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons with dates of service from March 1, 1993 through June 30, 2005, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the amount of 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 are included in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calculate the outpatient hospital cost-to-charge ratio annually 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 R9-22-712.01. 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 for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. 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 by 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 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 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 hospital services in a specialty facility.
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~~ zero. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. Services provided in the emergency room, observation area, 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 four years but no more than once a year 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 represents an aggregate increase in charges of more than ~~4.7 percent~~ 4.7%, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through ~~(G)(5)~~ (5) by applying the following formula:
   CCR*[1.047/(1+ % increase)]
   Where "CCR" means the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through ~~(G)(5)~~ (5) 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 as described under A.R.S. § 36-436 and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services

**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.
    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 accommo-

dation 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 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 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 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. 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. For the rate year effective October 1, 2011, to September 30, 2012, AHCCCS will increase the outlier cost thresholds by 5% of the thresholds that were effective on September 30, 2011.
   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.
   d. Cost-to-Charge Ratio used for qualification and payment of outlier claims.
      i. For qualification and payment of outlier claims with begin dates of service on or after April 1, 2011 through

September 30, 2011, the CCR will be equal to 95% of the ratios in effect on October 1, 2010.

ii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011 through September 30, 2012, the CCR will be equal to 90.25% of the most recent published Urban or Rural Medicare CCR as of August 31, 2011.

iii. In addition, for qualification and payment of outlier claims with begin dates of service on or after October 1, 2011 through September 30, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after April 1, 2011 by an additional percentage equal to the total percent increase reported on the charge master.

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.

# NOTICE OF EXEMPT RULEMAKING

## TITLE 12. NATURAL RESOURCES

## CHAPTER 4. GAME AND FISH COMMISSION

*Editor's Note: The following Notice of Exempt Rulemaking was reviewed per Laws 2010, Ch. 287, § 18. (See the text of § 18 on page 1193.) The Governor's Office authorized the notice to proceed through the rulemaking process on May 23, 2011.*

[R11-53]

### PREAMBLE

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

R12-4-517 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. §§ 5-302 and 5-311(A)(1)

Implementing statute: A.R.S. §§ 5-311(A)(2) and 5-311(A)

Exempt from the requirements of A.R.S. Title 41, Chapter 6, Article 3 under Laws 2011, 1st Regular Session, Ch. 113, § 5

**3. The effective date of the rules:**

May 24, 2011

The Commission requests an immediate effective date. Under A.R.S. § 41-1032(A)(4), an agency may request an immediate effective date when the proposed rulemaking will provide a benefit to the public and a penalty is not associated with a violation of the rule. The Commission believes that the public will benefit from a rule that authorizes the limited use of non-motorized watercraft on Rose Canyon Lake.

**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: Celeste Cook

Address: 5000 W. Carefree Hwy.
Phoenix, AZ 85086

Telephone: (623) 236-7390

Fax: (623) 236-7677

E-mail: ccook@azgfd.gov

Please visit the AZGFD web site to track progress of this rule and any other agency rulemaking matters at http://www.azgfd.gov/inside_azgfd/rules/rulemaking_updates.shtml.

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

Laws 2009, 3rd Special Session, Ch. 7, § 28(B)(3) allows an agency to pursue rulemaking for an authorization enacted by the Legislature after January 1, 2009.

On May 23, 2011, the Governor's office approved the Department's request to pursue rulemaking to amend R12-4-517 to implement Laws 2011, 1st Regular Session, Ch. 113, § 5.

The Commission proposes to amend R12-4-517 to allow a person to operate non-motorized watercraft, such as a canoe, inflatable raft, or kayak. The person must first apply for and receive a permit from the U.S. Forest Service. The proposed rule will not exempt the person from complying with all applicable requirements imposed by federal or state laws, rules, regulations, or orders.

This rulemaking is exempt from the regular rulemaking process under Laws 2011, 1st Regular Session, Ch. 113, effective April 14, 2011.

**7. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the rules and where the public may obtain or review the study, all data underlying each study, any analysis of the study, and other supporting material:**

Not applicable

**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:**

Exempt under Laws 2011, 1st Regular Session, Ch. 113.

**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 the rule and the agency response to them:**

Not applicable

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

Not applicable

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

Not applicable

**14. Was this rule previously made as an emergency rule? If so, please indicate the *Register* citation:**

Not applicable

**15. The full text of the rules follows:**

**TITLE 12. NATURAL RESOURCES**

**CHAPTER 4. GAME AND FISH COMMISSION**

**ARTICLE 5. BOATING AND WATER SPORTS**

Section
R12-4-517. Watercraft Motor and Engine Restrictions

**ARTICLE 5. BOATING AND WATER SPORTS**

**R12-4-517. Watercraft Motor and Engine Restrictions**

**A.** No change

**B.** No change

**C.** A person shall not operate a watercraft on Frye Mesa Reservoir, Rose Canyon Lake, or Snow Flat Lake, except as authorized under subsection (D).

**D.** A person who possesses a valid use permit issued by the U.S. Forest Service may operate a non-motorized watercraft only on Rose Canyon Lake on any Tuesday, Wednesday, or Thursday during June and July from 9:30 a.m. to 4:30 p.m. Mountain Time Zone. This subsection does not exempt the person from complying with all applicable requirements imposed by federal or state laws, rules, regulations, or orders.

~~**D.**~~**E.** This ~~rule~~ Section does not apply to watercraft of governmental agencies or to Department-approved emergency standby watercraft operated by lake concessionaires if operating to address public safety or public welfare.