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 6. ECONOMIC SECURITY

CHAPTER 5. DEPARTMENT OF ECONOMIC SECURITY SOCIAL SERVICES

Editor's Note: The following Notice of Exempt Rulemaking was exempt from Executive Order 2011-05 as issued by Governor Brewer. (See the text of the executive order on page 1368.)

[R11-81]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

Appendix A	Repeal
Appendix A	New Section

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

Authorizing statute: A.R.S. §§ 41-1005(A)(25), 41-1954(A)(3), 46-134(A)(12), 46-805

Implementing statute: A.R.S. §§ 46-801 through 46-810

Statute authorizing the exemption: A.R.S. § 41-1005(A)(25)

3. The effective date of the rules:

July 1, 2011. This date is consistent with statutory requirements regarding eligibility levels.

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 rule:

Name:	Beth A. Broeker
Address:	1789 W. Jefferson St., Site Code 837A Phoenix, AZ 85007
	or
	P.O. Box 6123, Site Code 837A Phoenix, AZ 85005
Telephone:	(602) 542-6555
Fax:	(602) 542-6000
E-mail:	bbroeker@azdes.gov

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

A.R.S. § 41-1005(A)(25) gives the Department an exemption from the Administrative Procedure Act to develop rules under A.R.S. § 46-805. This statute gives the Department the authority to establish payment rates for child care assistance and a sliding fee scale and formula for determining child care assistance. The Department is adopting a new Child Care Assistance Gross Monthly Income Eligibility Chart and Fee Schedule to adjust the eligibility limits for child care assistance, to reflect updated Federal Poverty Guidelines.

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

9. The summary of the economic, small business, and consumer impact:
Because these rules are exempt from the Administrative Procedure Act under A.R.S. § 41-1005(A)(25), the Department did not prepare an economic impact statement.

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

11. A summary of the principle comments 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 adopted as an emergency rule?
No

15. The full text of the rules follows:

TITLE 6. ECONOMIC SECURITY

CHAPTER 5. DEPARTMENT OF ECONOMIC SECURITY SOCIAL SERVICES

ARTICLE 49. CHILD CARE ASSISTANCE

Section
~~Appendix A. Child Care Assistance Gross Monthly Income Eligibility Chart & Fee Schedule~~
Appendix A. Child Care Assistance Gross Monthly Income Eligibility Chart & Fee Schedule

ARTICLE 49. CHILD CARE ASSISTANCE

~~**Appendix A. Child Care Assistance Gross Monthly Income Eligibility Chart and Fee Schedule**~~
~~**ARIZONA DEPARTMENT OF ECONOMIC SECURITY**~~
~~**CHILD CARE ASSISTANCE GROSS MONTHLY INCOME ELIGIBILITY CHART AND FEE SCHEDULE**~~
~~**EFFECTIVE JULY 1, 2009**~~

~~Family Size ⇓~~	~~FEE LEVEL 1 (L1) INCOME MAXIMUM EQUAL TO OR LESS THAN 85% FPL*~~	~~FEE LEVEL 2 (L2) INCOME MAXIMUM EQUAL TO OR LESS THAN 100% FPL*~~	~~FEE LEVEL 3 (L3) INCOME MAXIMUM EQUAL TO OR LESS THAN 135% FPL*~~	~~FEE LEVEL 4 (L4) INCOME MAXIMUM EQUAL TO OR LESS THAN 145% FPL*~~	~~FEE LEVEL 5 (L5) INCOME MAXIMUM EQUAL TO OR LESS THAN 155% FPL*~~	~~FEE LEVEL 6 (L6) INCOME MAXIMUM EQUAL TO OR LESS THAN 165% FPL*~~
~~1~~	~~0 – 768~~	~~769 – 903~~	~~904 – 1,220~~	~~1,221 – 1,310~~	~~1,311 – 1,400~~	~~1,401 – 1,490~~
~~2~~	~~0 – 1,033~~	~~1,034 – 1,215~~	~~1,216 – 1,641~~	~~1,642 – 1,762~~	~~1,763 – 1,884~~	~~1,885 – 2,005~~
~~3~~	~~0 – 1,298~~	~~1,299 – 1,526~~	~~1,527 – 2,061~~	~~2,062 – 2,213~~	~~2,214 – 2,366~~	~~2,367 – 2,518~~
~~4~~	~~0 – 1,563~~	~~1,564 – 1,838~~	~~1,839 – 2,482~~	~~2,483 – 2,666~~	~~2,667 – 2,849~~	~~2,850 – 3,033~~
~~5~~	~~0 – 1,828~~	~~1,829 – 2,150~~	~~2,151 – 2,903~~	~~2,904 – 3,118~~	~~3,119 – 3,333~~	~~3,334 – 3,548~~
~~6~~	~~0 – 2,092~~	~~2,093 – 2,461~~	~~2,462 – 3,323~~	~~3,324 – 3,569~~	~~3,570 – 3,815~~	~~3,816 – 4,061~~
~~7~~	~~0 – 2,358~~	~~2,359 – 2,773`~~	~~2,774 – 3,744~~	~~3,745 – 4,021~~	~~4,022 – 4,299~~	~~4,300 – 4,576~~
~~8~~	~~0 – 2,623~~	~~2,624 – 3,085~~	~~3,086 – 4,165~~	~~4,166 – 4,474~~	~~4,475 – 4,782~~	~~4,783 – 5,091~~

~~9~~	~~0 – 2,887~~	~~2,888 – 3,396~~	~~3,397 – 4,585~~	~~4,586 – 4,925~~	~~4,926 – 5,264~~	~~5,265 – 5,604~~
~~10~~	~~0 – 3,152~~	~~3,153 – 3,708~~	~~3,709 – 5,006~~	~~5,007 – 5,377~~	~~5,378 – 5,748~~	~~5,749 – 6,119~~
~~11~~	~~0 – 3,417~~	~~3,418 – 4,020~~	~~4,021 – 5,427~~	~~5,428 – 5,829~~	~~5,830 – 6,231~~	~~6,232 – 6,633~~
~~12~~	~~0 – 3,682~~	~~3,683 – 4,331~~	~~4,332 – 5,847~~	~~5,848 – 6,280~~	~~6,281 – 6,714~~	~~6,715 – 7,102**~~

~~**MINIMUM REQUIRED CO-PAYMENTS**~~

~~Per child in care~~	~~full day = $1.00 part day = $ .50~~	~~full day = $2.00 part day = $1.00~~	~~full day = $3.00 part day = $1.50~~	~~full day = $5.00 part day = $2.50~~	~~full day = $7.00 part day = $3.50~~	~~full day = $10.00 part day = $5.00~~

~~**For families receiving Transitional Child Care (TCC) there is no co-pay assigned beyond the third child in the family.**~~
~~Full day = Six or more hours; Part day = Less than six hours.~~
~~Families receiving Child Care Assistance based on Child Protective Services/Foster Care, the Jobs Program or those who are receiving Cash Assistance (CA) and are employed, may not have an assigned fee level and may not have a minimum required co-payment. However, all families may be responsible for charges above the minimum required co-payments if a provider's rates exceed allowable state reimbursement maximums and/or the provider has other additional charges.~~
~~*Federal Poverty Level (FPL) =US DHHS 2009 poverty guidelines. The Arizona state statutory limit for child care assistance is 165% of the Federal Poverty Level.~~
~~**This amount is equal to the Federal Child Care and Development Funds statutory limit (for eligibility for child care assistance) of 85% of the state median income.~~

Appendix A. Child Care Assistance Gross Monthly Income Eligibility Chart and Fee Schedule

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

CHILD CARE ASSISTANCE GROSS MONTHLY INCOME ELIGIBILITY CHART AND FEE SCHEDULE

EFFECTIVE JULY 1, 2011

Family Size ⇓	FEE LEVEL 1 (L1) INCOME MAXIMUM EQUAL TO OR LESS THAN 85% FPL*	FEE LEVEL 2 (L2) INCOME MAXIMUM EQUAL TO OR LESS THAN 100% FPL*	FEE LEVEL 3 (L3) INCOME MAXIMUM EQUAL TO OR LESS THAN 135% FPL*	FEE LEVEL 4 (L4) INCOME MAXIMUM EQUAL TO OR LESS THAN 145% FPL*	FEE LEVEL 5 (L5) INCOME MAXIMUM EQUAL TO OR LESS THAN 155% FPL*	FEE LEVEL 6 (L6) INCOME MAXIMUM EQUAL TO OR LESS THAN 165% FPL*
1	0 – 772	773 – 908	909 – 1,226	1,227 – 1,317	1,318 – 1,408	1,409 – 1,499
2	0 – 1,043	1,044 – 1,226	1,227 – 1,656	1,657 – 1,778	1,779 – 1,901	1,902 – 2,023
3	0 – 1,314	1,315 – 1,545	1,546 – 2,086	2,087 – 2,241	2,242 – 2,395	2,396 – 2,550
4	0 – 1,584	1,585 – 1,863	1,864 – 2,516	2,517 – 2,702	2,703 – 2,888	2,889 – 3,074
5	0 – 1,854	1,855 – 2,181	2,182 – 2,945	2,946 – 3,163	3,164 – 3,381	3,382 – 3,599
6	0 – 2,125	2,126 – 2,500	2,501 – 3,375	3,376 – 3,625	3,626 – 3,875	3,876 – 4,125
7	0 – 2,396	2,397 – 2,818	2,819 – 3,805	3,806 – 4,087	4,088 – 4,368	4,369 – 4,650
8	0 – 2,666	2,667 – 3,136	3,137 – 4,234	4,235 – 4,548	4,549 – 4,861	4,862 – 5,175
9	0 – 2,937	2,938 – 3,455	3,456 – 4,665	4,666 – 5,010	5,011 – 5,356	5,357 – 5,701
10	0 – 3,208	3,209 – 3,773	3,774 – 5,094	5,095 – 5,471	5,472 – 5,849	5,850 – 6,226
11	0 – 3,478	3,479 – 4,091	4,092 – 5,523	5,524 – 5,932	5,933 – 6,342	6,343 – 6,751
12	0 – 3,749	3,750 – 4,410	4,411 – 5,954	5,955 – 6,395	6,396 – 6,836	6,837 – 7,277

MINIMUM REQUIRED CO-PAYMENTS

Per child in care	full day = $1.00 part day= $.50	full day= $2.00 part day= $1.00	full day = $3.00 part day= $1.50	full day = $5.00 part day = $2.50	full day = $7.00 part day = $3.50	full day = $10.00 part day = $5.00

For families receiving Transitional Child Care (TCC) there is no co-pay assigned beyond the third child in the family.

Full day = Six or more hours; Part day = Less than six hours.

Families receiving Child Care Assistance based on Child Protective Services/Foster Care, the Jobs Program or those who are receiving Cash Assistance (CA) and are employed, may not have an assigned fee level and may not have a minimum required co-payment. However, all families may be responsible for charges above the minimum required co-payments if a provider's rates exceed allowable state reimbursement maximums and/or the provider has other additional charges.

*Federal Poverty Level (FPL) =US DHHS 2011 poverty guidelines. The Arizona state statutory limit for child care assistance is 165% of the Federal Poverty Level.

The Federal Child Care & Development Funds statutory limit (for eligibility for child care assistance) of 85% of the state median income.

NOTICE OF 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 Executive Order 2011-05 as issued by Governor Brewer. (See the text of the executive order on page 1368.) The Governor's Office authorized the notice to proceed through the rulemaking process on May 4, 2011.

[R11-83]

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:

Notice of Proposed Exempt Rulemaking: 17 A.A.R. 1182, June 17, 2011

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

Close of the comment period was, June 27, 2011 at 5:00 p.m.

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Administrative and Legal Services 701 E. Jefferson St., 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 regular rulemaking procedures:

The purpose of this 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 promulgating 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 either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study and other supporting material:

Studies related to provider reimbursement, provider costs, and AHCCCS members' access to covered healthcare will be available 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):

No changes were made between the proposed rulemaking and the final exempt rulemaking.

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 comment period closed June 27, 2011 at 5:00 p.m.

The following comments and responses have been made:

Outlier 2011 Rulemaking
Public Comments

Numb:	Date/Commentor:	Comment:	Response:
1.	06/17/11 James Haynes AZHHA	We have concerns about the proposed rules' financial impact to hospitals, and are strongly opposed to the promulgation of any rule that affects hospital payments without sufficient opportunity to assess the rule's impact. First, the language in the proposed rule explicitly contradicts your assertion in a June 2 e-mail that the outlier changes are designed to keep total outlier expenditures flat. According to section 6 of the proposal: ***"… the agency proposes to increase the thresholds used to qualify claims by 5%".*** Although we anticipate that a threshold increase could have the impact of reducing overall payments by more than 5%, we cannot determine the impact by hospital without data provided by AHCCCS. In addition, it is unlikely that this change would impact all hospitals equally. ***"… and to reduce the cost-to-charge ratios used to qualify and pay outliers by 5% …"*** From this language, it appears that the total outlier payments will decrease by 5%. If hospitals have the ability to separately identify outlier payments they could model this impact, and we believe that many do. It sounds like the intent of this rule is to reduce payments by 5%, not to keep payments flat, as your previous correspondence suggests. According to section 9 of the proposal: "… If, as intended, the proposed rulemaking results in a 5% reduction in outlier payments…" Again, it sounds like the outlier changes are designed to reduce payments, not keep them flat. Since two changes are proposed the impact could be far greater than 5%, but without a complete model we cannot tell. We urge AHCCCS to prepare a model showing the estimated impact by hospital. We also recommend that once the model has been developed, AHCCCS should meet with hospital representatives to explain the proposal and any other future outlier changes that AHCCCS Administration is contemplating.	The Arizona Legislature struck the statutory language that explicitly authorized outlier payments; however, the Legislature also provided AHCCCS with the authority to establish reimbursement methodologies "notwithstanding any other law." AHCCCS is exercising the latter authority to maintain a modified outlier reimbursement methodology albeit a methodology that is likely to reduce aggregate payments for outliers in CYE 2012. It is AHCCCS' intent, through this modified methodology, to eliminate the historically steep growth trend and reduce the outlier payments. The proposed rule attempts to implement this by (1) reducing CCR's by five percent in accordance with legislatively authorized provider rate reduction, (2) increasing cost thresholds by five percent in an effort to address past increases in charge masters, and (3) reducing CCR's by a percentage equal to a hospital's increase to its charge master to offset any future increases in hospital charges. A five percent reduction in CCRs would, in isolation, have the effect of reducing aggregate outlier payments by five percent assuming hospitals do not increase their charge masters. However, hospitals have historically made changes to their charge masters and are expected to do so in the future. As the degree of increases to charge masters are unregulated and solely within the discretion of the hospitals, those changes cannot be predicted or modeled. As such, the financial estimates in the preamble are based on the assumption that charge masters stay constant. The June 2, 2011 e-mail was intended to address the aspect of the proposed rule that decreased CCRs when charge masters are increased. If hospitals do not increase their charge masters, all other things being equal, hospitals in aggregate would not see a change to outlier reimbursement as the result of this one change to the rule. A spreadsheet including the CYE 2009 outlier payments to individual hospitals will be forthcoming. Please note that encounter data does not indicate when a claim is paid at outlier, thus AHCCCS estimated those claims that have been paid at outlier. Therefore this data may not exactly match hospitals' records. Hospitals can compare this data to their own records and complete their own modeling. AHCCCS will soon begin work to end outlier payments and include payment for extraordinary expenses in the tiered per diem rates, with an effective date of October 1, 2012. We plan to have stakeholder involvement in these efforts. When we begin this project, AzHHA will be notified along with other stakeholders.

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. 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 accommodation costs. Before calculating the rate for the operating component, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (6).
      iv. Operating rate calculation. The Administration shall set the rate for the operating component for each tier by dividing total statewide or peer group hospital costs identified in this subsection within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.
   b. Capital component. For rates effective October 1, 1999 the capital component is calculated as described in A.R.S. § 36-2903.01.
   c. Statewide inpatient hospital cost-to-charge ratio. For dates of service prior to October 1, 2007, the 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 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

Editor's Note: The following Notice of Exempt Rulemaking was reviewed per Executive Order 2011-05 as issued by Governor Brewer. (See the text of the executive order on page 1368.) The Governor's Office authorized the notice to proceed through the rulemaking process on April 28, 2011.

[R11-82]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-1443 — 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, 36-2903.01

Implementing statute: A.R.S. § 36-2901.01; Arizona Laws 2010, 7th Special Session, Ch. 10, § 34; Arizona Laws 2011, 1st Special Session, Ch. 1, § 1(B); Arizona Laws 2011, 1st Regular Session, Ch. 31, § 34

3. The proposed effective date of the rules:

July 8, 2011

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

Notice of Proposed Exempt Rulemaking: 17 A.A.R. 1023, May 20, 2011

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 St., 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 regular rulemaking procedures:

The AHCCCS Administration is initiating this exempt rulemaking to comply with the legislative requirement that the Administration adopt rules regarding eligibility necessary to implement a program within available appropriations. Specifically, the Administration is proposing to establish through rule 1) closing all new eligibility beginning July 8 for persons in AHCCCS Care not designated as eligible in the Arizona State Plan under Title XIX of the Social Security Act; and, 2) flexibility and a methodology for the Director to: delay closure of the AHCCCS Care program, reopen the AHCCCS Care program, or terminate coverage for some or all persons in the AHCCCS Care Program. These changes will be predicated on the most current information and estimates of available resources to support the

Medicaid program. The proposed rule also sets forth the means by which changes in eligibility and their effective dates will be communicated to the public. Approval of this methodology by the Center for Medicare and Medicaid Services is required.

The proposed methodology will apply to persons in the "AHCCCS Care" population; that is, persons who are not designated as eligible in the Arizona State Plan for Medicaid under specific provisions of Title XIX of the Social Security Act. The State Plan is the agreement between the state and federal government that entitles the state to federal participation in the cost of providing medical care through AHCCCS. In general terms, the people affected by this rule have household income at or below 100% of the federal poverty level and are not pregnant, under age 18, a specified caretaker relative of a deprived child, age 65 or older, blind, or disabled. Operationally, AHCCCS refers to this waiver population as the "AHCCCS Care" eligibility expansion group. The federal government refers to this group (along with the MED eligibility group) as a "Waiver Population" or an "expansion population" (because they are not listed in the Arizona State Plan for Medicaid, but are listed in a separate agreement known as the Waiver or the Demonstration Project). Informally, and somewhat imprecisely, this group is also referred to as "childless adults."

Arizona Laws 2010, 7th Special Session, Ch. 10, § 34, provides that AHCCCS is exempt from the rulemaking requirements of Title 41, Chapter 6, Arizona Revised Statutes, for two years after the effective date of this Act, for the following purpose of "establishing and maintaining rules regarding standards, methods and procedures for determining eligibility necessary to implement a program within the available appropriation." That Act also requires the agency to provide public notice and an opportunity for public comment on proposed rules at least 30 days before rules are adopted or amended. Subsequently, the Arizona Legislature reiterated its directive. Arizona Laws 2011, 1st Special Session, Ch. 1, § 1(B), provides that:

> "… the Arizona health care cost containment system administration shall adopt rules regarding standards, methods and procedures for determining eligibility necessary to implement a program within the monies available from the Arizona tobacco litigation settlement fund established by section 36-2901.02, Arizona Revised Statutes, the proposition 204 protection account established by section 36-778, Arizona Revised Statutes, and any other legislative appropriation and federal monies made available for the support of the program. To the extent that monies available for the program established pursuant to this subsection are insufficient to fund all existing programs, the administration, subject to approval by the secretary of the United States department of health and human services, may suspend any programs or eligibility for any persons or categories of persons established under title 36, chapter 29, Arizona Revised Statutes."

During its most recent session, the Arizona Legislature again directed AHCCCS to establish and maintain "rules regarding standards, methods and procedures for determining eligibility necessary to implement a program within the available appropriation." Arizona Laws 2011, 1st Regular Session, Ch. 31, § 34.

For the State Fiscal Year ending June 30, 2012, AHCCCS has projected that maintaining eligibility standards as they exist today would cost $9,981,831,300 in total funds. Of those total funds, $3,178,180,700 would be the nonfederal funds that the state and political subdivisions of the state would be required to contribute toward the cost of the program. The difference is provided through federal matching funds. The SFY12 budget recently signed into law appropriates $2,636,350,700 in nonfederal funds (including funds in the Arizona Tobacco Litigation Settlement fund under A.R.S. § 36-2901.02). This is $541,830,000 short of the amount of non-federal funds that are projected to be necessary to maintain the status quo with respect to eligibility.

There are three primary drivers of cost in the Arizona Health Care Cost Containment System: eligibility standards, the scope of covered healthcare services, and the rates of reimbursement to healthcare providers. During recent fiscal years, AHCCCS has already implemented significant changes to reduce costs in each of these areas and has pursued opportunities to increase program revenues. Nevertheless, there are legal and practical constraints on the ability of AHCCCS to continue to reduce costs with respect to eligibility standards, the scope of services, and reimbursement rates. As a condition of receiving federal financial support for the AHCCCS program, the state must comply with the requirements of the Medicaid Act, unless those requirements are waived by the Secretary of the United States Department of Health & Human Services ("the Secretary") under section 1115 of the Social Security Act, 42 U.S.C. 1315.

Regarding reimbursement to healthcare providers, section 1902(a)(30)(A) of the Medicaid Act, 42 U.S.C. 1396a(a)(30)(A), requires the state to provide assurances to the Secretary that the state has established:

> "methods and procedures relating to … the payment for … care and services available under the plan … 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 plan at least to the extent that such care and services are available to the general population in the geographic area."

The United States Court of Appeals for the 9th Circuit has ruled that, in most cases, the reimbursement rates established by the state must bear a reasonable relationship to efficient and economical costs of providing quality services. *Indep. Living Ctr. of S. Cal., Inc.* v. *Maxwell-Jolly*, 572 F.3d 644, 652 (9th Cir. Cal. 2009). Therefore, the state cannot reduce provider reimbursement indefinitely and continue to attract a number of providers reasonably sufficient to assure access comparable to the general population. During recent fiscal years (including the current fiscal year) AHCCCS has implemented reductions in its capped fee-for-service provider rates, and the legislature has directed that inflationary adjustments otherwise required by statute be suspended. During the most recent session, the Legislature reset inpatient hospital rates, continued the suspension of inflationary increases to rates, eliminated reimburse-

ment for certain hospital claims with extraordinary costs per stay, and granted AHCCCS authority to reduce rates further. Within the constraints imposed on the program by law and by market forces, AHCCCS continues to explore methodologies that provide fair and reasonable reimbursement to health care providers consistent with the provision of efficient quality care while reducing costs to the system. Based on this analysis, the program is anticipating the implementation of additional rate reductions on October 1, 2011.

Regarding the scope of covered healthcare services, the Medicaid Act lists the categories of medical services that are eligible for federal matching dollars. 42 U.S.C. 1396d(a)(1) – (29). As a condition of participation in the Medicaid program, every state must cover certain services - such as hospital services and physician services - unless the requirement is waived by the Secretary. Other types of services - such as prescription drugs, dental services, and physical therapy - can, at the state's option, be covered by the State Medicaid program, and the cost of those services are eligible for federal matching funds. 42 U.S.C. 1396a(a)(10). In addition, the Medicaid Act permits states to place limits on the amount, duration, and scope of both mandatory and optional services, so long as the services are offered in an amount adequate to meet the intended purpose. During recent fiscal years, AHCCCS has eliminated or limited the scope of services for adults with respect to the services of podiatrists, dental care, physical therapy, preventative care services, orthotics and medical supplies and equipment. AHCCCS is currently reviewing the impact and potential cost savings associated with limits on the number of hours of respite care that will be covered for persons in home and community based settings, and the number of inpatient hospital days and emergency department visits that will be covered per year. AHCCCS will also be requesting that CMS approve the elimination of non-emergency transportation services for select populations in certain geographic locations.

Regarding eligibility standards, the Medicaid Act as amended by the Affordable Care Act, now codified as 42 U.S.C. 1396a(gg), mandates that the state must maintain the eligibility standards established by the state as of March 2010. This is referred to as the "maintenance of effort" requirement (MOE). However, by letter dated February 15, 2011 from the Secretary to the Governor of Arizona, the state was informed that it could, consistent with that federal requirement, eliminate eligibility for the categories covered not through the Arizona State Plan for Medicaid, but solely under the authority in the current Demonstration Project by not renewing its request to cover those expansion populations under a new Demonstration Project. By doing so, the Secretary stated, the state would not violate the MOE requirements of the Medicaid Act. In the same letter the Secretary expressed uncertainty about her legal ability to waive the MOE requirements for State Plan populations.

The 2000 Arizona Ballot Propositions included Proposition 204 which added section 36-2901.01 to the Arizona Revised Statutes. Specifically, the first subsection of that statute requires AHCCCS to cover all residents with income at or below the federal poverty level. To accomplish this objective the second subsection dedicated the funds received through the Arizona Tobacco Litigation Settlement fund plus "any other *available* sources including legislative appropriations and federal monies" (emphasis added). As stated in greater detail below, the funds in the Arizona Tobacco Litigation Settlement Fund and the Proposition 204 Protection Account of the Tobacco Products Tax Fund are inadequate to pay for the cost of covering everyone defined as an eligible person by A.R.S. § 36-2901.01. As stated above, the other funds appropriated by the Arizona legislature are inadequate to cover the cost of services to populations subject to the maintenance of effort requirements of 42 U.S.C. 1396a(gg) and the full cost of continuing services to everyone included in the expanded definition of eligible person in A.R.S. § 36-2901.01.

Immediately prior to the passage of Proposition 204, AHCCCS covered families with income below an amount that is equal to about 23% of the current federal poverty level. At that time, AHCCCS also covered Supplemental Security Income recipients (and similar cases) whose income was below the federal benefit rate. As a result, Proposition 204 required AHCCCS to add eligibility for: (1) families between approximately 23% and 100% of the federal poverty level, (2) Supplemental Security Income recipients with income between the federal benefit rate and the federal poverty level, and (3) individuals eligible under the AHCCCS Care program. AHCCCS amended its agreement with the Secretary (known as "the State Plan" for Medicaid) to extend coverage to the first two expansion groups. As categories covered under the Medicaid State Plan, those first two categories are subject to the maintenance of effort requirements of 42 U.S.C. 1396a(gg). In accordance with the Secretary's letter of February 15, 2011, the third expansion category covered under Proposition 204 is not because it is a "Waiver Population." Therefore, closing new eligibility beginning July 8 for persons in AHCCCS Care who are not otherwise eligible under the State Plan is consistent with federal authority.

For the State Fiscal Year ending June 30, 2012, the estimated non-federal contributions for the cost of providing coverage to the first two groups is $234,704,700. The total funds in the Arizona Tobacco Litigation Settlement Fund and the Proposition 204 Protection Account of the Tobacco Products Tax Fund for that same period are forecast to be $148,579,200. This represents a shortfall in the voter designated fund of $86,125,500 for the anticipated cost of just the first two Proposition 204 eligibility groups listed above (both of which are subject to the federal maintenance of effort requirements discussed above). If allocated in this manner, no funds remain from the voter designated fund for purposes of providing the non-federal funds necessary to support the AHCCCS Care "Waiver Population." For the State Fiscal Year beginning July 1, 2011, AHCCCS will use the other funds appropriated by the Legislature to cover: (1) the remainder of the costs associated with the first two Proposition 204 State Plan expansion categories listed above, (2) the costs associated with other eligibility groups listed in the State Plan that are subject to the MOE requirements unless those requirements are waived by the Secretary, and (3) to fund continuation of the AHCCCS Care program if it is closed to new enrollment.

The state is electing not to seek authority under future Demonstration Projects for coverage of the AHCCCS Care population as described in the current Demonstration Project. Instead, AHCCCS is requesting waiver authority to claim federal financial participation for a non-entitlement program for persons not otherwise covered under the state Plan (non-disabled childless adults) at an income level that can be adjusted as necessary to maintain a program within state appropriations. In addition, certain persons in this new waiver expansion population would be required to pay an enrollment premium to discourage controllable behaviors adverse to health such as smoking and obesity.

Budgeting and financial planning for the AHCCCS program is a dynamic process. A budget is predicated on a series of estimates such as projected enrollment, projected costs per enrollee and projected savings associated with cost containment strategies. While, absent further legislative action, the amount of available state funding is set in law, there are a number of other factors that affect the estimate of the availability of funds in support of the AHCCCS program. To state the obvious, AHCCCS cannot predict with absolute certainty, the number of persons who will apply and be determined eligible in the future. As mentioned above, AHCCCS has implemented, and plans to implement, changes to eligibility, to the scope of benefits, and to reimbursement rates to address the state's continuing fiscal shortfall. There is some uncertainty with respect to the cost savings associated with each of these and with the timing of those cost savings. For instance, the estimates of the cost savings associated with closing MED to new enrollment assumes that MED enrollment will decline at a fixed rate; however, there may be fewer or more persons who retain eligibility late into the phase out time-frame. Estimated savings associated with limitations in benefits are still being finalized. As a result of the Affordable Care Act, AHCCCS, beginning in the Spring of this year, is able to participate in the Medicaid Drug Rebate program. While AHCCCS expects to collect significant rebates from drug manufacturers as a result, the precise amount and the amount of the federal share of those rebates are unknown at this time. CMS also must approve components of the Governor's Medicaid Reform Plan and there may be elements of that Plan that do not receive federal government approval. In addition, while AHCCCS is confident that its plan of action is within its legal authority, it is anticipated that there will be litigation regarding aspects of the AHCCCS plan to reduce costs. Judicial intervention, in the form of preliminary or permanent injunctions, could impose additional constraints on the use of available funds and/or require AHCCCS to consider changes to other aspects of the program not subject to any such court order. As a result, this rulemaking establishes an expeditious and flexible approach to the management of eligibility as one of the primary drivers of cost with the goal of minimizing the number of persons losing coverage. While AHCCCS anticipates the need to close the AHCCCS Care program to new enrollment beginning July 8, it proposes through this rulemaking to provide flexibility to the Director to implement changes to the AHCCCS Care program based on the most current fiscal data. The AHCCCS Administration is committed to regular review of the program's financial status and prompt adjustment of eligibility standards to respond to budgetary changes. Through this rulemaking, AHCCCS proposes a means to operate the program within available funding while retaining health coverage for as many Arizonans as is reasonably possible.

Under the Special Terms and Conditions of the current Demonstration Project, if the state does not seek authority to continue coverage for the waiver expansion populations" (such as AHCCCS Care) beyond September 30, 2011, the state must stop enrolling new individuals and families into that program during such period as specified in the Demonstration phase-out plan. As a result, this rule prohibits the AHCCCS Administration or the Department of Economic Security (which also determines eligibility for AHCCCS Care) from making any new determinations of AHCCCS Care eligibility beginning July 8, 2011 except for redeterminations for persons who were determined eligible prior to that date and have remained continuously eligible. With respect to applications that are pending as of that date, the AHCCCS Administration and the Department will complete the eligibility determination process, but will only approve AHCCCS Care eligibility for persons that meet all eligibility criteria before July 8, 2011.

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

None

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:

The Administration will not be making any new eligibility determinations for the AHCCCS Care population. There are currently about 221,000 members in the AHCCCS Care program. Due to turnover or movement on and off the program (sometimes referred to as "churn"), AHCCCS estimates that, because of this turnover, closing new enrollment for this program will result in a decrease in the AHCCCS Care population of about 50% one year after closing eligibility. Absent a change in circumstances, these persons would not be eligible under any other category of AHCCCS eligibility. This action is expected to save the State General Fund approximately $190 million over a 12 month period.

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

No changes have been made between the proposed rule and final rules.

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

The following comments were received by the close of the comment period June 20, 2011:

The Arizona Legislature has directed the AHCCCS Administration to establish a program within legislative appropriation. Due to the State's severe budget crisis, the Legislature has not appropriated sufficient funds to maintain the AHCCCS program at current eligibility levels. Reducing eligibility standards involves difficult decisions which the Administration realizes will have significant impacts on the lives of some Arizona residents. The Freeze of the Childless Adult Program is one of several steps the Administration must take to establish a program within appropriated funds. The AHCCCS Administration has previously limited or eliminated optional services and continues to explore other service limitations. In addition, the AHCCCS Administration has previously reduced provider rates, and additional provider rate reductions are planned for October 1, 2011.

Absent a waiver from the Secretary of the U.S. Department of Health & Human Service, AHCCCS, as the State's Medicaid program, is required as a matter of federal law to maintain eligibility standards relating to most pregnant women, children, certain caretakers of children, the elderly, and persons who are blind or disabled. However, the childless adult program and the MED program are not subject to the federal Maintenance of Eligibility requirements which prohibit reduction of the eligibility standards. Because AHCCCS does not have a sufficient appropriation to provide health care coverage to all persons who qualify for the Childless Adult program on and after July 8, 2011, AHCCCS is implementing a freeze on July 8, 2011 with the goal of preserving coverage to the greatest extent possible for this population. Childless Adult members who are eligible prior to July 8, 2011 and who continue to remain eligible will retain their AHCCCS coverage. To minimize the number of persons losing eligibility, AHCCCS and DES have undertaken a review of a significant number of childless adult cases to ensure that they are not entitled to continued eligibility under another eligibility category.

Numb:	Date/ Commentor:	Comment:	Response:
1.	05/08/11 Cindy Vlosic	I have read repeatedly in *The Republic* that childless adults will be dropped from the AHCCCS program in October. What was the criteria used in making this decision? Do childless adults suffer from more diseases? Do they incur higher costs for ACCCHS? Please help me to understand how and why this group of enrollees has been singled out.	AHCCCS' current plan is to close the AHCCCS Care program to new enrollment effective July 8, 2011, not to disenroll all childless adults in October. The Childless Adult population is a waiver program for adults who have not been determined Medicaid eligible with a categorical link (aged, blind, disabled, pregnant, under 18 or parent of a deprived child). Members in the childless adult program like members in the MED program are not subject to the Maintenance of Eligibility requirements in the Affordable Care Act and therefore AHCCCS can implement a freeze for this population.
2.	06/20/11 Reuben Howard Pascua Yaqui Tribe	The Pascua Yaqui Tribe does not agree with the proposal to freeze the enrollment into AHCCCS for Childless adults, effective July 1. We believe it does not meet the "maintenance of effort" of the Medicaid Act requirement for adolescence that are aging out of the CPS system or individuals that have been diagnosed with a mental health illness, or Native Americans. Excluding these individuals will cause irreparable harm to their health and well-being. Not covering the adolescent aging out of the CPS system is not the ethical or moral thing to do to a group of individuals that have little or no support to meet the challenges of adulthood. We believe that not covering individuals diagnosed with a Mental Health Illness needing psychotropic medications is placing society at risk and shifting the cost to the legal system. The State Behavioral Health Services Department has not adequately developed a transition plan on how the SMI population will be handled. The transition plan needs to be presented to the RHBAs and TRBHAs for review and comment with meaning full consultation.	Upon federal approval of the Childless Adult Phase Out Plan, the AHCCCS Administration will implement a freeze to the childless adult population. Because this is a waiver population they are not subject to the Maintenance of Eligibility requirements. Any Seriously Mentally Ill (SMI) adult, who is eligible under the Childless Adult program will be moved into the SSI MAO program. AHCCCS currently has a request pending with the federal government for a demonstration project that would exclude persons receiving services through the Indian Health Service and 638 facilities from the freeze. Children who are aging out of Section 1931 of the Social Security Act, Sixth Omnibus Budget Reconciliation Act (SOBRA), Young Adult Transition Insurance (YATI) and KidsCare will continue to be considered for AHCCCS Care after July 7, 2011.

Numb:	Date/ Commentor:	Comment:	Response:
2. *continued*		The potential negative impact to the AI/AN population and the Indian health care system is of great concern to the tribal leaders. Approximately half of the American Indian population in Arizona is enrolled in the state's Medicaid program. The majority is enrolled in the American Indian Health Program (AIHP) and obtains their health care at IHS and tribally operated facilities, but there are significant numbers who are enrolled in the managed care health plans in order to access other provider networks of which the new Demonstration Waiver may have a more serious impact. As a result American Indians who are enrolled in the AHCCCS managed care health plans will fall off the AHCCCS program and will highly likely end up needing to access direct care at IHS and tribally operated clinics. It has been noted that the impact of proposed AHCCCS changes will immediately affect about 27,000 American Indians in the state who could lose eligibility. The impacts on IHS and tribal health programs is a decrease of approximately 23% [1] in Medicaid revenue affecting services, purchasing of equipment, medical and pharmacy supplies, facility repairs/renovations and reductions in staffing. Approximately half of IHS funding is obtained through total third party revenue – Medicare, Medicaid and Private Insurance. IHS relies on outside hospitals for referred care for AHCCCS members. Reduction in eligibility limits ability to refer patients to non IHS providers due to lack of Medicaid coverage, therefore access to care is greatly reduced. The loss of Medicaid revenue will have a ripple effect throughout the system. Most concerning is the ability of IHS/Tribal hospitals to maintain their accreditation status. The budget shortfalls of the State of Arizona should not be passed onto IHS and tribal facilities who receive 100% federal pass through funds for providing services to Medicaid eligible patients. The receipt of the 100% federal pass through funds should continue for both mandatory and optional services delivered at an IHS and tribal facility and not be arbitrarily reduced by parties that do not fully understand the impact of their decisions. **This action will not cost the State of Arizona any state funds but will add to the economic recovery directly because a large portion of the FMAP dollars are spent for supplies and services with businesses off reservation**.	

Numb:	Date/ Commentor:	Comment:	Response:
3.	06/20/11 Ellen S. Katz William Morris Institute	The Institute is a non-profit program that advocates on behalf of low-income Arizonans. As part of our work, we focus on public benefit programs, such as Medicaid. The Institute objects to AHCCCS' proposed rulemaking because the proposed rulemaking violates the Arizona Constitution and state law. AHCCCS wants the authority to close enrollment on July 1, 2011, for childless adults not otherwise in the State Plan as a mandatory or optional category and the additional flexibility to delay closure, reopen eligibility or terminate coverage for some or all childless adults. AHCCCS proposes to review available resources on a monthly basis. AHCCCS claims it is initiating this rulemaking in response to the "legislative requirement that the Administration adopt rules regarding eligibility necessary to implement a program within available appropriations." Paragraph 6 of Preamble to Proposed Rule. AHCCCS notes the Legislature appropriated approximately $550 million less in state funds than needed for the AHCCCS program. It also notes that the federal government informed AHCCCS that childless adults who are not in the State Plan are not subject to the federal Maintenance of Effort ("MOE") requirement in 42 U.S.C. 1396a(gg). AHCCCS' claim that "closing new eligibility" for childless adults is "consistent with federal authority" is both incorrect and not relevant. The federal government took no position on whether closing enrollment is appropriate and regardless, whatever the federal government's interpretation of the MOE requirements in federal law, that interpretation is not relevant to the mandatory requirements in Proposition 204 and the Voter Protection Act. Finally, AHCCCS claims it is not seeking federal authority to continue the childless adult population as "described in the current Demonstration Project." Rather, AHCCCS seeks unlimited authority to reduce income eligibility for a "non-enrollment" program. AHCCCS expects the freeze to reduce childless adult enrollment by 50% in one year and to save the State $190 million. Paragraph 9 of Preamble. For the following reasons, AHCCCS must withdraw this rule: **A. AHCCCS' Proposed Rule for Authority to Freeze Enrollment or Reduce Eligibility for Persons Under 100% of the Federal Poverty Level Violates State Law and the Arizona Constitution**	The William Morris Institute filed a Petition for Special Action challenging the AHCCCS Administration's freeze of the Proposition 204 population effective July 8, 2011. The AHCCCS Administration has addressed the Institute's arguments in its Response to the Petition for Special Action filed with the Supreme Court on June 21, 2011, setting forth the reasons why AHCCCS has the legal authority to implement the freeze for the childless adult population. The Governor and Director cannot provide services to the childless adult population in excess of funds that have been appropriated for the childless adult population. A.R.S. § 36-2901.01(B) appropriates monies only from the tobacco litigation settlement fund. The statute does not authorize AHCCCS to use money other than the tobacco litigation settlement fund. Because the funds from the tobacco litigation settlement fund are not sufficient to support new member enrollment in the childless adult program on and after July 8, 2011, AHCCCS has proposed rules to freeze the childless adult population consistent with the available funding. Only the Legislature has the authority to appropriate funds to AHCCCS for this program, therefore, AHCCCS must institute the freeze until additional monies are appropriated by the Legislature for this purpose.

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3. *continued*		In November 2000, the citizens of Arizona passed Proposition 204 that expanded AHCCCS coverage to all persons with incomes up to 100% of the federal poverty level. A.R.S. § 36-2901.01. Proposition 204 provides that the Legislature can only change financial eligibility "to a percentage of the federal poverty guidelines that is *even more inclusive*." A.R.S. § 36-2901.01(A) (emphasis added). In addition, the initiative prohibits any cap on the number of eligible persons who can enroll in AHCCCS. *Id.* Because it was approved by a majority of the votes cast, the Voter Protection Act in the Arizona Constitution provides that the Governor cannot veto and the Legislature cannot repeal Proposition 204. *See* Ariz. Const., Art. IV, Part 1, Section 1, Subsections 6(A) and (B). Pursuant to the Voter Protection Act, legislative amendments are limited to ones that further the purpose of the voter initiative and are approved by 3/4 of the members of each legislative branch. *Id*. Subsection 6(C). Thus, by state law and Constitution, Arizona is required to provide AHCCCS coverage to all persons whose incomes are at or below 100% of the federal poverty level. Proposition 204 also mandated that the Director of AHCCCS shall use Arizona Tobacco Litigation Settlement Funds first "to fully implement and fully fund the programs and services required as a result of the expanded definition of an eligible person pursuant to Section 36-2901.01." A.R.S. § 36-2901.02(B). Moreover, "[t]o ensure sufficient monies are available to provide benefits to <u>all</u> persons who are eligible," Proposition 204 directed that funding "shall" come from the Arizona Tobacco Litigation Fund and "shall be supplemented <u>as necessary</u>, by any other available sources <u>including legislative appropriations</u> and federal monies." A.R.S. § 36-2901.01(B). (emphasis added). These provisions are straightforward that the voters who approved Proposition 204 intended all Arizonans with incomes up to 100% of the federal poverty level would receive AHCCCS and the state would fund their coverage. AHCCCS' claim that if the Legislature fails to appropriate sufficient funds, that ends the inquiry, is simply wrong. To make this claim, AHCCCS adopts a statutory construct that conflicts with the rules of statutory construction adopted by the courts.	The Arizona Legislature has directed the AHCCCS Administration to establish a program within legislative appropriation. Due to the state's severe budget crisis, the Legislature has not appropriated sufficient funds to maintain the AHCCCS program at current eligibility levels. Reducing eligibility standards involves difficult decisions which the Administration realizes will have significant impacts on the lives of some Arizona residents. The Freeze of the Childless Adult Program is one of several steps the Administration must take to establish a program within appropriated funds. The AHCCCS Administration has previously limited or eliminated optional services and continues to explore other service limitations.

Numb:	Date/ Commentor:	Comment:	Response:
3. *continued*		1. **AHCCCS' Interpretation Violates the Rules of Statutory Construction** The plain language of Proposition 204 is that the state is obligated to provide health care benefits to all individuals with incomes at or below the federal poverty level. The "primary objective in construing statutes adopted by initiative is to give effect to the intent of the electorate." *Arizona Early Childhood*, 221 Ariz. at 470, 212 P. 3d 808 quoting *State* v. *Gomez*, 212 Ariz. 55, 57, 127 P.3d 873, 875 (2006). *See also, Jett* v. *City of Tucson,* 180 Ariz. 115, 119, 882 P.2d 426, 430 (1994) ("Our primary purpose is to effectuate the intent of those who framed the provision and, in the case of an [initiative], the intent of the electorate that adopted it"). If the language is clear and unambiguous, a court can apply it without using other means of statutory construction. *See Hayes* v. *Continental Ins. Co.,* 178 Ariz. 264, 268, 872 P.2d 668, 672 (1994). In addition, when construing a statute, courts interpret the provisions in the context of the entire statute. *Ariz. Dep't of Econ. Sec.* v. *Superior Court,* 186 Ariz. 405, 408, 923 P.2d 871, 874 (App. 1996). It is also important that the court "give each word, phrase, clause and sentence meaning so that no part of the [statute] is rendered superfluous, void, insignificant, redundant or contradictory." *Patterson* v. *Maricopa County Sheriff's Office,* 177 Ariz. 153, 156, 865 P.2d 814, 817 (App. 1993). To claim that "available" funds is limited to whatever the Legislature decides to appropriate, nullifies all the other provisions in Proposition 204 and thwarts the clear intent and purpose of the initiative. 1. **AHCCCS' Interpretation Conflicts with the Statements in the Voting Materials** Initiatives are "fundamental to Arizona's scheme of government." *Calik* v. *Kongable,* 195 Ariz. 496, 500, 990 P.2d 1055, 1059 (1999). When interpreting an initiative, the court must "identify the reasonable interpretation that is most consistent with the intent of the voters in adopting the measure." *Gomez*, 212 Ariz. at 58-59, 127 P 3d at 876-77. To determine the voters' intent, the court will examine, among other things, the materials included in the Secretary of State's publicity pamphlet that is available to all voters before a general election. *See, e.g. id.* (examining findings in publicity pamphlet to determine purpose of an initiative measure); *Calik,* 195 Ariz. at 501, 990 P.2d at 1061 (relying upon Legislative Council's analysis in publicity pamphlet in determining voters' intent); *Jett,* 180 Ariz. at 119-20, 882 P.2d at 430-31 (holding that publicity pamphlet material entitled to "some weight"); *Laos* v. *Arnold*, 141 Ariz. 46, 48, 685 P.2d 111, 113 (1984) (finding that Legislative Council's analysis, contained in publicity pamphlet, provided intent of framers and electorate).	In addition, the AHCCCS Administration has previously reduced provider rates, and additional reductions are planned for October 1, 2011. Absent a waiver from the Secretary of the U.S. Department of Health & Human Service, AHCCCS, as the State's Medicaid program, is required as a matter of federal law to maintain eligibility standards relating to most pregnant women, children, certain caretakers of children, the elderly, and persons who are blind or disabled. While it is unfortunate that the state can no longer afford to provide health care coverage to all persons who may qualify for the Childless Adult program in the future, AHCCCS is implementing a freeze effective July 8, 2011 with the goal of preserving coverage to the greatest extent possible. AHCCCS will continue to cover all persons who are determined eligible for the Childless Adult program prior to July 8, 2011. Furthermore, we are transitioning some members to other eligibility categories, such as the elderly and those with serious mental illnesses.

Numb:	Date/ Commentor:	Comment:	Response:
3. *continued*		The Publicity Pamphlet provided to every voter for the 2000 election contained an analysis by the Arizona Legislative Council about Proposition 204. Publicity Pamphlet at 160 available at www.azsos.gov/election2000/info/pubphamplet/ English/prop204.htm. The Pamphlet noted that Proposition 204 would require Arizona to deposit all of the money it receives over the next 25 years from the Tobacco Litigation Settlement into a specific account and use the funds to increase the number of people who are eligible for coverage in the AHCCCS program. The Legislative Council observed that "[i]f Proposition 204 passes, people who earn up to 100% of the federal poverty level will qualify to receive health care under AHCCCS." *Id*. According to the Legislative Council, future Legislatures could change the eligibility requirements to allow more people to qualify to receive health care under AHCCCS but that the Legislature and the AHCCCS administration could not reduce or limit the number of persons who would be able to enroll in AHCCCS. *Id*. The Legislative Council analysis in the publicity pamphlet regarding Proposition 204 was quite clear that coverage for eligible individuals was mandatory. It stated that without limitation: Future Legislatures could change the eligibility requirements to allow more people to qualify to receive health care under AHCCCS *but the Legislature and the AHCCCS administration could not reduce or limit the number of persons who would be able to enroll in AHCCCS.* (emphasis added). *Id.* There were two ballot initiatives in 2000 that wanted to use the Tobacco Litigation Settlement Funds. The Proposition 204 Fiscal Impact Summary included as part of the publicity pamphlet discussed the competing ballot proposition, Proposition 200, called Healthy Children, Healthy Families, and noted that the competing proposition also fully spent the Tobacco Litigation Settlement Funds. The Proposition 204 fiscal impact summary provides that: A second ballot proposition, Healthy Children, Healthy Families (Proposition 200), also fully spends the Tobacco Settlement. If both initiatives pass, and Healthy Children, Healthy Families receives more votes than this initiative, this initiative would still go into effect. *However, the entire projected state cost of the program would need to be paid from its general or other revenues*. (emphasis added).	

Numb:	Date/ Commentor:	Comment:	Response:
3. *continued*		*Id*. Thus, Legislative Council fully understood the impact of Proposition 204 and took pains to point out that if both propositions passed, but Proposition 200 received more votes, then all the funding for Proposition 204 would have to come from the general fund. The Legislative Council Analysis and the Fiscal Impact Summary made it clear that if Tobacco Litigation Settlement Funds were insufficient to support the expanded population, then the projected state cost of expanding the AHCCCS eligible population would have to be paid from the state's general fund or other revenues. At the time Arizona voters were asked to approve the voter-initiated legislation, neither the measure's proponents nor its opponents thought that the Governor, the Legislature or AHCCCS had any discretion to decide whether to provide health care benefits to the individuals protected by Proposition 204. It was understood to be a mandatory obligation and that fact was conveyed forcefully to the voting public. It was that fact the opponents of Proposition 204 prominently used to try to defeat the measure. In November 2000, Proposition 204 was approved by 63% of the voters. The arguments in the publicity pamphlet also leave no doubt about the intended purpose of the initiative and the impact of its passage on the AHCCCS program. AHCCCS is required to provide health care coverage to the Proposition 204 population. By proposing this rule, AHCCCS is violating Proposition 204 and the Voter Protection Act. The persons the citizens of Arizona mandated eligible for the State Medicaid program include childless adults, the very persons upon whom AHCCCS seeks to impose an enrollment freeze and/or reduced eligibility. Proposition 204 and the Arizona Constitution require AHCCCS to cover these persons. AHCCCS cannot ignore the Arizona state law and Constitution. Therefore based on Proposition 204 and the Voter Protection Act, AHCCCS must withdraw its proposed rule.	

Numb:	Date/ Commentor:	Comment:	Response:
3. *continued*		**B. The State Failed to Consider Other Proposals** As explained above, a purported budget deficit cannot be a proper basis for a freeze on enrollment or reduced eligibility. But even if it did, Arizona's request is unsupported factually. The premise of the proposed rulemaking is that the State has no other option except to balance its budget by radical cuts to the health care provided to its low-income citizens. This is the only rationale given for the proposed rulemaking. The rationale is not supported by the facts. The Arizona Hospital and Healthcare Association submitted a proposal to the Governor and the Legislature to impose a hospital provider assessment, a nursing facility assessment, and a nursing home quality assessment to generate additional matching federal Medicaid funds. The legislative leadership rejected the proposal. The Legislature and the Governor also failed to propose any other assessments that might bridge the financial gap described. The legislative leadership took the position that it would not entertain discussion of new sources of revenue because these would be "taxes" and many legislators had taken a "no tax" pledge. The Institute notes the proposal and the no tax pledge solely as evidence that the State has other options, options it chose to reject. For this reason, as well, AHCCCS must withdraw its proposed rule.	The Legislature has directed the agency to establish a program within available appropriations. Just as AHCCCS does not have the authority to appropriate additional funds for the administration of the program, AHCCCS does not have the authority to impose provider assessments.
		C. Recent Financial Predictions do not Support the Claim of Insufficient Funds The state expects to save only $190 million by freezing enrollment for the Proposition 204 population. Paragraph 9 of the Preamble. Recent revenue forecasts for the current fiscal year 2011 are estimated to be $252 million higher than anticipated. *See* JLCB Staff Report – Preliminary May Review Update, June 8, 2011, available at www.azleg.gov/jlbc/preliminarymayrevenueupdate.pdf. Thus, it appears there are sufficient funds for the AHCCCS program. Based on the recent fiscal predictions, AHCCCS must withdraw its proposed rule.	Although recent revenue forecasts are estimated to be $250M higher than anticipated, only the legislature-not AHCCCS-can make a determination whether funds other than the tobacco funds are available from other sources. In the absence of an additional appropriation, AHCCCS must implement this freeze to establish a program within existing appropriations. In the event that the legislature does make a supplemental appropriation to AHCCCS this rule provides the Director with the flexibility to modify eligibility standards.
		D. The History of the KidsCare Freeze Shows AHCCCS will Continue the Freeze. AHCCCS' claim that it wants/needs the flexibility to assess resources on a monthly basis is belied by AHCCCS' handling of KidsCare. In December 2009, AHCCCS requested permission to amend its Children's Health Insurance Program ("CHIP") State Plan to freeze enrollment on KidsCare. Pursuant to the approval, AHCCCS amended Section 4.3.1 of the State Plan and put a retroactive enrollment freeze on KidsCare effective January 1, 2010. The enrollment cap is in place "until such time that the AHCCCS Administration is able to verify that funding is sufficient, and the Governor agrees that the AHCCCS Administration may begin processing new applications." As of today, the KidsCare freeze is still in place and there are almost 102,000 children on the wait list. There is no reason to think the childless adult freeze will be lifted either.	AHCCCS has continued the freeze on the KidsCare program due to a lack of legislative appropriation for that program.

Numb:	Date/ Commentor:	Comment:	Response:
3. *continued*		**E. The Proposed Rule Fails to Satisfy the Federal Requirements for a Section 1115 Demonstration Waiver** Section 1115 of the Social Security Act, 42 U.S.C. § 1315(a) authorizes the Secretary under certain conditions to approve "experimental, pilot or demonstration projects" that are "likely to assist in promoting the objectives of the Medicaid Act." The changes AHCCCS proposes to make to health care coverage for childless adults in the proposed rule are part of its March 31, 2011, amended request for a demonstration waiver. While the Institute submitted comprehensive and detailed comments and objections to the amended waiver request, the Institute reiterates its objections to the portion of the request that is encompassed by the proposed rule. This portion of the amended request violates the federal requirements for a Section 11115 demonstration project. The hallmark of Section 1115 is its requirement of research or experimentation. Thus, section 1115 was not enacted to enable states to save money or to evade federal requirements but to 'test out new ideas and ways of dealing with problems of public welfare recipients.' [citation omitted]. A simple benefit cut, which might save money, but has no research or experimental goal, would not satisfy this requirement. Rather, the 'experimental or demonstration project' language strongly implies that the Secretary must make at least some inquiry into the merits of the experiment. She must determine that the project is likely to yield useful information or demonstrate a novel approach to program administration. *Beno* v. *Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994). In *Beno*, the Ninth Circuit held Section 1315(a) "plainly obligates the Secretary to evaluate the merits of a proposed state project, including its scope and potential impact" on recipients. *Id.* at 1068. Under *Beno*, there are three main parts to the required analysis. First, the Secretary must determine that the project has research or demonstration value. *Id*. at 1069. Second, the proposed project must assist in promoting the objectives of the Act. *Id.* As part of this assessment, the Secretary must consider the impact the demonstration project has on the persons the Medicaid Act was intended to protect. *Id.* Part of this assessment implies the collection of data. *Id.* at 1070-71 and fn. 30. Finally, the Secretary can only approve Section 1315 projects for the "extent and period" necessary. *Id.* at 1071. The only rationale for the proposed changes to the State Medicaid program in the proposed rule is to save state funds. The state seeks permission to manage its Medicaid program within budgetary constraints. This rationale does not satisfy the statutory requirements for a Section 1115 waiver. In addition, there is no research or experimental purpose to the changes in the proposed rule. Because it is an improper section 1115 request, AHCCCS should withdraw the proposed rule.	At this time the proposed rule is intended to implement the phase out of the childless adult population described in the demonstration project due to expire September 30, 2011. Any continuation of the childless adult population or any population similar to the current childless adult population will depend upon federal approval of a new demonstration project effective October 1, 2011. AHCCCS recognizes that an amendment of this proposed rule may be necessary depending on the precise nature of any terms and conditions of any new demonstration project.

Numb:	Date/ Commentor:	Comment:	Response:
3. *continued*		**F. AHCCCS Improperly Seeks Unlimited Authority to Determine Eligibility for Childless Adults** In the proposed administrative rule AHCCCS seeks unlimited authority to set any eligibility standard it wants subject to what it determines are "available" state funds. There are no defined parameters or objective standards of eligibility.This type of request for undefined and overreaching authority must be withdrawn. There is no authority for such a request under federal law. In addition, this request nullifies any public notice and meaningful input requirements in 42 U.S.C. 1315(d)(1). AHCCCS must withdraw this proposed rule. **G. AHCCCS' Proposal to Give Public Notice of Program Changes on its Web Site is Inadequate** Coupled with the unlimited authority AHCCCS seeks, AHCCCS proposes to provide limited public notice of any changes to the childless adult coverage by only posting the change on its web site 30 days prior to the change unless it determines a shorter notice is necessary to "maintain [the program] within available funding." AHCCCS does not intend to have a public comment period or public meeting prior to any determinations. This type of process fails to comply with the public notice and meaningful input requirements of 42 U.S.C. 1315(d)(1). For this reason, as well, AHCCCS must withdraw its proposed rulemaking.	At this time the proposed rule is intended to implement the phase out of the childless adult population described in the demonstration project due to expire September 30, 2011. Any continuation of the childless adult population or any population similar to the current childless adult population will depend upon federal approval of a new demonstration project effective October 1, 2011. AHCCCS recognizes that an amendment of this proposed rule may be necessary depending on the precise nature of any terms and conditions of any new demonstration project. The freeze on enrollment is part of AHCCCS' plan for the phase out of the Childless Adult population as provided for in the demonstration project due to expire September 30, 2011, and as such, the public notice requirements of 42 U.S.C. 1315 do not apply to the phase out. Continuation of federal financial participation for any population similar to the current childless adult population, including any less inclusive population, will depend upon federal approval of a new demonstration project beginning October 1, 2011. AHCCCS is complying with requirements regarding public notice and input with respect to the application for new waiver authority as required by the federal agency that ensures that the Medicaid program is administered consistent with federal requirements. State law does require a 30 day notice and comment period prior to final rulemaking. AHCCCS is in compliance with that requirement by virtue of this solicitation of comments on its proposed rule. Consistent with Arizona Laws 2010, 7th Special Session, Ch. 10, § 34, AHCCCS provided public notice of this 30 day comment period prior to promulgating any final rules. Public hearings are not required by the state law.
4.	06/20/11 Janice York	I think u should not cut heathlcare, a lot of sick people that dont have jobs are very effected by this. I understand that some people abuse it but thank of all the people that is really sick and they need it to get medcine or be treated, I think u really should re consider your decision. *(sic)*	As described in the introduction the AHCCCS Administration's goal is to preserve the agency's core program within the available appropriations.

Numb:	Date/ Commentor:	Comment:	Response:
5.	06/20/11 Jesus Diaz	I just wanted to take the time to write this e-mail to express my opinion about the proposed childless adult law that would disqualify them for AHCCCS benefits. I want to express first of all that I am a current student at NAU pursuing a degree in Masters of Administration emphasized in Health Sciences and Public Management. With that stated, I feel that this proposed law would adversely affect the citizens of Arizona and the overall health of the population. This will negatively impact the workforce with a major increase in chronic illnesses and diseases. Medical facilities will have to treat these conditions with no medical insurance to reimburse these facilities for their services forcing them to make major cuts and decreasing quality of care. In the long-run, this is going to cause a greater problem in both the business and health aspect of Arizona; considering its current financial issues due to economic reasons. There has to be a better solution that our leadership at the Legislature can conjure up with that will not affect the citizen health. I think Arizona government is forgetting the main purpose and that is to be public servants and work for the people and not against them. I hope that my opinion in this matter is taken into consideration and not just another e-mail.	As described in the introduction the AHCCCS Administration's goal is to preserve the agency's core program within the available appropriations.
6.	06/20/11 SouthMountain Concrete	What can we do to change this new law starting July 1st. I work in a hospital where there are at least 1/3 of clients that are homeless. Leaving them without health insurance is going to effect staff and patients. Pts wont get treated and will be able to spread more disease. The hospitals will not collect on bills. We are all going to go down hill. *(sic)*	As described in the introduction the AHCCCS Administration's goal is to preserve the agency's core program within the available appropriations.

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:
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 14. AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS

Section
R9-22-1443. Closing New Eligibility for Persons Not Covered under the State Plan

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS

R9-22-1443. Closing New Eligibility for Persons Not Covered under the State Plan

A. Neither the Department nor the Administration shall approve as eligible for coverage individuals who apply on or after July 8, 2011 who do not otherwise meet the eligibility criteria for an optional or mandatory Title XIX coverage group described in the Arizona State Plan for Medicaid: that is, neither the Department nor the Administration shall approve eligibility with an effective date on or after July 8, 2011 for the population described in A.R.S. § 36-2901.01 and R9-22-1428(4), referred to in this Section as "AHCCCS Care."

1. With respect to any applications that are pending as of July 8, 2011, the Department shall not approve any individual as eligible for AHCCCS Care who has not met all eligibility requirements prior to July 8, 2011.
2. This Section does not prohibit the redetermination of an individual as eligible for AHCCCS Care on or after July 8, 2011, if the individual was determined eligible for AHCCCS Care prior to July 8, 2011 and has remained continuously eligible since the date of the determination of eligibility that occurred prior to July 8, 2011.

B. At least monthly, the Director shall review the most recent estimate of the anticipated expenditures for the remainder of the state fiscal year as compared to funds remaining in the appropriations made to the agency for the state fiscal year as well as any other known or reasonably anticipated sources of other funding. Based on that review and subject to approval by the Center for Medicare and Medicaid Services, the Director may:

1. Delay implementation of the closure of new enrollment into the AHCCCS Care program.
2. Re-open the AHCCCS Care program to new enrollment following the closure of the AHCCCS Care program.
3. Terminate coverage for some or all persons eligible for the AHCCCS Care program based on date of eligibility and/or such other factors that the Director determines are equitable and consistent with the objective of ensuring coverage for as many persons as possible within available funding.

C. Public notice of any changes to the AHCCCS Care program described under subsection (B) shall be provided 30 days prior to the effective date of the change via publication on the AHCCCS web site unless shorter notice is necessary to maintain a program that is reasonably anticipated to remain within available funding.