NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

Editor's Note: The following Notice of Exempt Rulemaking was reviewed per Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 2688.) The Governor's Office authorized the notice to proceed through the rulemaking process on August 16, 2012.

[R12-194]

PREAMBLE

1. **Article, Part, or Section Affected (as applicable)** | **Rulemaking Action**

   R9-22-710 | Amend

2. **Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific), and the statute or session law authorizing the exemption:**

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

   Implementing statute: A.R.S. § 36-2907; Arizona Laws 2012, Ch. 299, § 18

   Statute or session law authorizing the exemption: Arizona Laws 2012, Ch. 299

3. **The effective date of the rule and the agency's reason it selected the effective date:**

   October 1, 2012

4. **A list of all notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the exempt rulemaking:**

   Notice of Proposed Exempt Rulemaking: 18 A.A.R. 2230, September 7, 2012

5. **The agency's contact person who can answer questions about 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

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   E-mail: AHCCCSrules@azahcccs.gov

   Web site: www.azahcccs.gov

6. **An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**

   The recently enacted Health Budget Reconciliation Bill, Senate Bill 1528 (Arizona Laws 2012, Ch. 299), amended A.R.S. § 36-2239 such that reimbursement of ambulances is no longer tied to rates established by the Arizona Department of Health Services (section 3). However, for the contract year beginning October 1, 2012, the bill requires that AHCCCS reimburse ambulance services at 68.59% of the rates established by ADHS (section 18). The bill also exempted rules regarding revisions to ambulance reimbursement from the rulemaking requirements of A.R.S. Title 41 (section 25). The bill becomes effective August 2, 2012.

   As part of this rulemaking, AHCCCS describes the reimbursement methodology that the program will employ as of the effective date of the Health BRB.

7. A reference to any study relevant to the rule that the agency reviewed and either to 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 any analysis of each study and other supporting material:

A study was not relied upon for this rulemaking.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

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

Not applicable

10. A description of any changes between the proposed rulemaking, including any supplemental proposed rulemaking, and the final rulemaking package (if applicable):

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

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments, if applicable:

The following comments were received by the close of the comment period, September 21, 2012, 5 p.m.

[See top of next page for comments table]

#	Comment From	Comment	Analysis/ Recommendation
1.	Roy Ryals Ambulance Association	AHCCCS initiated a new regulatory scheme—exempt from the State's rule-making procedures laws—which will force the ambulance industry into some form of rate-setting obligations at AHCCCS for Title XIX clients—an obligation which will be ***on top of*** the significant requirements of ADHS. This decoupling from the ADHS rate setting process will result in the Arizona ambulance industry being double-regulated by two different State agencies regarding rates and charges, and likely facing conflicts between AHCCCS and ADHS on overlapping matters. We find this untenable, wasteful and ultimately not in the best interest of the population that we both serve. We also will never be certain that the legislature really understood the implications of the surprising last minute changes to the SB 1528, and what alternatives might have been pursued had ADHS, industry, insurer, consumer and general public involvement been allowed. Unlike other health care providers, we cannot simply increase rates to other payers to make up for the loss on AHCCCS patients—our rates and charges are subject to government approval. As a result, the continued reductions to ambulance service reimbursement place us in a most untenable position of actually having to fund a portion of the provision of services to AHCCCS patients out of our own operating budgets. Continuing along this path is damaging to our businesses and places the public we serve in a vulnerable position if reducing or eliminating vital emergency medical services to parts of the State becomes our only viable option. We object to the further (relative to A.R.S. § 36-2239 before the effect of Chapter 299) decoupling of rates/rate-setting from the rates approved, and process overseen, by ADHS. We request that AHCCCS support the recoupling of the process. We request that AHCCCS meet with the industry annually, or more often if needed, to determine any percentage discount (beyond the 20% that had been in § 36-2239) that Arizona government may require to address fiscal challenges facing the State. We stand ready at such meeting(s) to work with AHCCCS and ADHS to address the impacts of changes in compensated care resulting from the federal Affordable Care Act as well as other concerns AHCCCS raised during a very recent meeting with industry.	AHCCCS appreciates your comments which will be taken into consideration as we propose rules for ambulance reimbursement for the October 1, 2013 through September 30, 2014 time-frame. However, this rulemaking is specific to ambulance reimbursement for the time period of October 1, 2012 through September 30, 2013. Your comments do not appear to address the proposed rule language. This rulemaking is to effectuate session law. The agency has ensured the public has the opportunity to comment on the rulemaking and has taken into account comments received. This rulemaking uses the methodology that has been in effect since October 1, 2011, consistent with recent enactments by the Arizona legislature. This rulemaking formalizes the same percentage for dates of services beginning October 1, 2012. AHCCCS has already engaged the Ambulance industry in discussions regarding ambulance reimbursement and will continue to do so.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules. When applicable, matters shall include, but not be limited to:

None

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than the federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

An analysis was not submitted.

13. A list of any incorporated by reference material and its location in the rule:

None

14. Whether the rule was previously made, amended, repealed or renumbered as an emergency rule. If so, the agency shall state where the text changed between the emergency and the exempt rulemaking packages:

None

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

R9-22-710. Payments for Non-hospital Services

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-710. Payments for Non-hospital Services

A. Capped fee-for-service. The Administration shall provide notice of changes in methods and standards for setting payment rates for services in accordance with 42 CFR 447.205, December 19, 1983, incorporated by reference and on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

1. Non-contracted services. In the absence of a contract that specifies otherwise, a contractor shall reimburse a provider or noncontracting provider for non-hospital services according to the Administration's capped-fee-for-service schedule.
2. Procedure codes. The Administration shall maintain a current copy of the National Standard Code Sets mandated under 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004), incorporated by reference and on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
   a. A person shall submit an electronic claim consistent with 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004).
   b. A person shall submit a paper claim using the National Standard Code Sets as described under 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004).
   c. The Administration may deny a claim for failure to comply with subsection (A)(2)(a) or (b).
3. Fee schedule. The Administration shall pay providers, including noncontracting providers, at the lesser of billed charges or the capped fee-for-service rates specified in subsections (A)(3)(a) through ~~(A)(3)(d)~~ (d) unless a different fee is specified in a contract between the Administration and the provider, or is otherwise required by law.
   a. Physician services. Fee schedules for payment for physician services are on file at the central office of the Administration for reference use during customary business hours.
   b. Dental services. Fee schedules for payment for dental services are on file at the central office of the Administration for reference use during customary business hours.
   c. Transportation services. Fee schedules for payment for transportation services are on file at the central office of the Administration for reference use during customary business hours. For dates of service beginning October 1,

2012, through September 30, 2013, the Administration and its contractors shall reimburse ambulance services at 68.59 percent of the ADHS rates that are in effect as of August 2, 2012.

d. Medical supplies and durable medical equipment (DME). Fee schedules for payment for medical supplies and DME are on file at the central office of the Administration for reference use during customary business hours. The Administration shall reimburse a provider once for purchase of DME during any two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless prior authorized by the Administration, no more than one repair and adjustment of DME shall be reimbursed during any two-year period.

B. Pharmacy services. The Administration shall not reimburse pharmacy services unless the services are provided by a pharmacy having a subcontract with a Pharmacy Benefit Manager (PBM) contracted with AHCCCS. Except as specified in subsection (C), the Administration shall reimburse pharmacy services according to the terms of the contract.

C. FQHC Pharmacy reimbursement.

1. For purposes of this Section the following terms are defined:
   a. "340B Drug Pricing Program" means the discount drug purchasing program described in Section 256b of Title 42 of the United States Code.
   b. "340B Ceiling Price" means the maximum price that drug manufacturers can charge covered entities participating in the 340B Drug Pricing Program as reported by the drug manufacturer to HRSA.
   c. "340B entity" means a covered entity, eligible to participate in the 340B Drug Pricing Program, as defined by the Health Resources and Human Services Administration.
   d. "Actual Acquisition Cost (AAC)" means the purchase price of a drug paid by a pharmacy net of discounts, rebates, chargebacks and other adjustments to the price of the drug. The AAC excludes dispensing fees.
   e. "Contracted Pharmacy" means an arrangement through which a 340B entity may contract with an outside pharmacy to provide comprehensive pharmacy services utilizing medications subject to 340B pricing.
   f. "Dispensing Fee" means the amount paid for the professional services provided by the pharmacist for dispensing a prescription. The Dispensing Fee does not include any payment for the drugs being dispensed.
   g. "Federally Qualified Health Center" means a public or private non-profit health care organization that has been identified by HRSA and certified by CMS as meeting the criteria under ~~Sections~~ sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receives funds under Section 330 of the Public Health Service Act.
   h. "Federally Qualified Health Center Look-Alike" means a public or private non-profit health care organization that has been identified by HRSA and certified by CMS as meeting the definition of "health center" under ~~Section~~ section 330 of the Public Health Service Act, but does not receive grant funding under ~~Section~~ section 330.
   i. "FQHC or FQHC Look-Alike pharmacy" means a pharmacy that dispenses drugs to FQHC or FQHC-LA patients and that is owned and/or operated by an FQHC/FQHC-LA or by an entity that reports the costs of an FQHC/FQHC-LA on its Medicare Cost Report, whether or not collocated with an FQHC or an FQHC Look-Alike.
2. Effective the later of February 1, 2012, or CMS approval of a State Plan Amendment, an FQHC or FQHC Look-Alike shall:
   a. Notify the AHCCCS provider registration unit of its status as a 340B covered entity no later than:
      i. 30 days after the effective date of this Section;
      ii. 30 days after registration with the Health Resources and Services Administration (HRSA) for participation in the 340B program; or
      iii. The time of application to become an AHCCCS provider.
   b. Provide the 340B pricing file to the AHCCCS Administration upon request. The 340B pricing file shall be provided in the file format as defined by AHCCCS.
   c. Identify 340B drug claims submitted to the AHCCCS FFS PBM or the Managed Care Contractors' PBMs for reimbursement. The 340B drug claim identification and claims processing for a drug claim submission shall be consistent with claim instructions issued and required by AHCCCS to identify such claims.
3. The FQHC and the FQHC Look-Alike pharmacies shall submit claims for AHCCCS members for drugs that are identified in the 340B pricing file, whether or not purchased under the 340B pricing file, with the lesser of:
   a. The actual acquisition cost, or
   b. The 340B ceiling price.
4. The AHCCCS Fee-for-Service and Managed Care Contractors' PBMs shall reimburse claims for drugs which are identified in the 340B pricing file dispensed by FQHC and FQHC Look-Alike pharmacies, whether or not purchased under the 340B pricing file, at the amount submitted under subsection ~~(3)~~ (C)(3) plus a dispensing fee listed in the AHCCCS Capped Fee-For-Service Schedule unless a contract between the 340B entity and a Managed Care Contractor's PBM specifies a different dispensing fee.
5. Contracted pharmacies shall not submit claims for drugs dispensed under an agreement with the 340B entity as part of the 340B drug pricing program, and the AHCCCS Administration and Managed Care Contractors shall not reimburse such claims.

6. The AHCCCS Administration and Managed Care Contractors shall reimburse contracted pharmacies for drugs not dispensed under an agreement with the 340B entity as part of the 340B program at the price and dispensing fee set forth in the contract between the contracted pharmacy and the AHCCCS or its Managed Care Contractors' PBMs. Neither the Administration nor its Managed Care Contractors will reimburse a contracted pharmacy that does not have a contract with the Administration or MCO's PBM.
7. The AHCCCS Administration and its Managed Care Contractors shall reimburse FQHC and FCHC Look-Alike pharmacies for drugs that are not eligible under the 340B Drug Pricing Program at the price and dispensing fee set forth in their contract with the AHCCCS or its Managed Care Contractors' PBMs.
8. AHCCCS may periodically conduct audits to ensure compliance with this Section.