NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

Editor's Note: The following Notice of Proposed Rulemaking was reviewed per Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 955.) The Governor's Office authorized the notice to proceed through the rulemaking process on June 13, 2012.

[R13-58]

PREAMBLE

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

R9-22-101	Amend
R9-22-711	Amend
R9-22-712.01	Amend
R9-22-712.20	Amend
R9-22-712.30	Amend
R9-22-712.40	Amend

2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):

Authorizing statutes: A.R.S. §§ 36-2903.01; 36-2903.01(F); Laws 2011, Ch. 31, § 34
Implementing statutes: A.R.S. §§ 36-2903.01; 36-2903.01(H); Laws 2012, Ch. 122, § 7; Laws 2012, Ch. 299, §§ 19, 20, 32, 34

3. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the proposed rule:

Notice of Proposed Exempt Rulemaking: 17 A.A.R. 2456, December 9, 2011
Notice of Exempt Rulemaking: 18 A.A.R. 212, January 27, 2012
Notice of Proposed Exempt Rulemaking: 18 A.A.R. 1644, July 6, 2012
Notice of Exempt Rulemaking: 18 A.A.R. 1914, August 10, 2012
Notice of Rulemaking Docket Opening: 19 A.A.R. 943, May 3, 2013 *(in this issue)*

4. The agency's contact person who can answer questions about the rulemaking:

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Administrative Legal Services 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@azahcccs.gov
Web site:	www.azahcccs.gov

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

AHCCCS finalized rules for Non-Emergency transportation co-payments and Hospital rates in 2012 under exemption from the requirements of Title 41, Chapter 6, Arizona Revised Statutes pursuant to Laws 2011, Ch. 31, § 34. The Administration is required to repromulgate these rulemakings since Laws 2012, Ch. 299, § 7 repealed the rulemaking exemption authority of Laws 2011, Ch. 31, § 34, and § 8 of Laws 2012, Ch. 299 further stipulated that the Administration may not continue any program changes made pursuant to Laws 2011 Ch. 31, § 34 after December 31, 2013, absent specific statutory authority for those rules.

After an evaluation of the Agency's overall statutory authority regarding rates and co-payments, AHCCCS has determined to repromulgate these rules specifying specific statutory authority to continue measures it previously enacted consistent with Laws 2012 Ch. 299, § 8.

The intent of the rulemakings has not changed as what was described in the rulemakings posting listed under item 3 remains applicable.

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

A study was not referenced or relied upon when revising these regulations.

7. 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.

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

No estimated impact is expected due to the repromulgation of existing rules.

9. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Administrative Legal Services 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@azahcccs.gov
Web site:	www.azahcccs.gov

10. The time, place, and nature of the proceedings to make, amend, repeal, or renumber the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Proposed rule language will be available on the AHCCCS web site www.azahcccs.gov the week of April 15, 2013. Please send written or e-mail comments to the above address by the close of the comment period, 5:00 p.m., June 3, 2013.

Date:	June 3, 2013
Time:	2 p.m.
Location:	AHCCCS 701 East Jefferson Phoenix, AZ 85034
Nature:	Public Hearing
Date:	June 3, 2013
Time:	2 p.m.
Location:	ALTCS: Arizona Long-Term Care System 1010 N. Finance Center Dr., Suite 201 Tucson, AZ 85710
Nature:	Public Hearing
Date:	June 3, 2013

Time: 2 p.m.
Location: 2717 N. 4th St., STE 130
Flagstaff, AZ 86004
Nature: Public Hearing

11. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters have been prescribed.

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 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:

No analysis was submitted.

12. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section
R9-22-101. Location of Definitions

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-711. Copayments
R9-22-712.01. Inpatient Hospital Reimbursement
R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule
R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-for-service Schedule
R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

ARTICLE 1. DEFINITIONS

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition	Section or Citation
"Accommodation"	R9-22-701
"Act"	R9-22-101
"ADHS"	R9-22-101
"Administration"	A.R.S. § 36-2901
"Adverse action"	R9-22-101
"Affiliated corporate organization"	R9-22-101
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501
"Aggregate"	R9-22-701
"AHCCCS"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-701
"AHCCCS registered provider"	R9-22-101
"Ambulance"	A.R.S. § 36-2201

"Ancillary department"	R9-22-701
"Ancillary service"	R9-22-701
"Anticipatory guidance"	R9-22-201
"Annual enrollment choice"	R9-22-1701
"APC"	R9-22-701
"Appellant"	R9-22-101
"Applicant"	R9-22-101
"Application"	R9-22-101
"Assessment"	R9-22-1101
"Assignment"	R9-22-101
"Attending physician"	R9-22-101
"Authorized representative"	R9-22-101
"Authorization"	R9-22-201
"Auto-assignment algorithm"	R9-22-1701
"AZ-NBCCEDP"	R9-22-2001
"Baby Arizona"	R9-22-1401
"Behavior management services"	R9-22-1201
"Behavioral health adult therapeutic home"	R9-22-1201
"Behavioral health therapeutic home care services"	R9-22-1201
"Behavioral health evaluation"	R9-22-1201
"Behavioral health medical practitioner"	R9-22-1201
"Behavioral health professional"	A.A.C. R9-20-1201
"Behavioral health recipient"	R9-22-201
"Behavioral health service"	R9-22-1201
"Behavioral health technician"	A.A.C. R9-20-1201
"Benefit year"	R9-22-201
"BHS"	R9-22-1401
"Billed charges"	R9-22-701
"Blind"	R9-22-1501
"Burial plot"	R9-22-1401
"Business agent"	R9-22-701 and R9-22-704
"Calculated inpatient costs"	R9-22-712.07
"Capital costs"	R9-22-701
"Capped fee-for-service"	R9-22-101
"Caretaker relative"	R9-22-1401
"Case management"	R9-22-1201
"Case record"	R9-22-101
"Case review"	R9-22-101
"Cash assistance"	R9-22-1401
"Categorically eligible"	R9-22-101
"CCR"	R9-22-712
"Certified psychiatric nurse practitioner"	R9-22-1201
"Charge master"	R9-22-712
"Child"	R9-22-1503 and R9-22-1603
"Children's Rehabilitative Services" or "CRS"	R9-22-201
"Claim"	R9-22-1101
"Claims paid amount"	R9-22-712.07
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-22-201
"CMDP"	R9-22-1701
"CMS"	R9-22-101
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contract year"	R9-22-101
"Contractor"	A.R.S. § 36-2901
"Copayment"	R9-22-701, R9-22-711 and R9-22-1603
"Cost avoid"	R9-22-1201
"Cost-To-Charge Ratio"	R9-22-701
"Covered charges"	R9-22-701
"Covered services"	R9-22-101
"CPT"	R9-22-701
"Creditable coverage"	R9-22-2003 and 42 U.S.C. 300gg(c)
"Critical Access Hospital"	R9-22-701
"CRS"	R9-22-1401

"Cryotherapy"	R9-22-2001
"Customized DME"	R9-22-212
"Day"	R9-22-101 and R9-22-1101
"Date of the Notice of Adverse Action"	R9-22-1441
"DBHS"	R9-22-201
"DCSE"	R9-22-1401
"De novo hearing"	42 CFR 431.201
"Dentures" and "Denture services"	R9-22-201
"Department"	A.R.S. § 36-2901
"Dependent child"	A.R.S. § 46-101
"DES"	R9-22-101
"Diagnostic services"	R9-22-101
"Director"	R9-22-101
"Disabled"	R9-22-1501
"Discussion"	R9-22-101
"Disenrollment"	R9-22-1701
"DME"	R9-22-101
"DRI inflation factor"	R9-22-701
"E.P.S.D.T. services"	42 CFR 440.40(b)
"Eligibility posting"	R9-22-701
"Eligible person"	A.R.S. § 36-2901
"Emergency behavioral health condition for the non-FES member"	R9-22-201
"Emergency behavioral health services for the non-FES member"	R9-22-201
"Emergency medical condition for the non-FES member"	R9-22-201
"Emergency medical services for the non-FES member"	R9-22-201
"Emergency medical or behavioral health condition for a FES member"	R9-22-217
"Emergency services costs"	A.R.S. § 36-2903.07
"Encounter"	R9-22-701
"Enrollment"	R9-22-1701
"Enumeration"	R9-22-101
"Equity"	R9-22-101
"Existing outpatient service"	R9-22-701
"Expansion funds"	R9-22-701
"Experimental services"	R9-22-203
"FAA"	R9-22-1401
"Facility"	R9-22-101
"Factor"	R9-22-701 and 42 CFR 447.10
"FBR"	R9-22-101
"Federal financial participation" or "FFP"	42 CFR 400.203
"Federal poverty level" or "FPL"	A.R.S. § 36-2981
"Fee-For-Service" or "FFS"	R9-22-101
"FES member"	R9-22-101
"FESP"	R9-22-101
"First-party liability"	R9-22-1001
"File"	R9-22-1101
"Fiscal agent"	R9-22-210
"Fiscal intermediary"	R9-22-701
"Foster care maintenance payment"	42 U.S.C. 675(4)(A)
"FQHC"	R9-22-101
"Free Standing Children's Hospital"	R9-22-701
"Fund"	R9-22-712.07
"Graduate medical education (GME) program"	R9-22-701
"Grievance"	A.A.C. R9-34-202
"GSA"	R9-22-101
"HCPCS"	R9-22-701
"Health care practitioner"	R9-22-1201
"Hearing aid"	R9-22-201
"HIPAA"	R9-22-701
"Home health services"	R9-22-201

"Homebound"	R9-22-1401
"Hospital"	R9-22-101
"ICU"	R9-22-701
"IHS"	R9-22-101
"IHS enrolled" or "enrolled with IHS"	R9-22-708
"IMD" or "Institution for Mental Diseases"	42 CFR 435.1010 and R9-22-201
"Income"	R9-22-1401 and R9-22-1603
"Indigent"	R9-22-1401
"Individual"	R9-22-211
"In-kind income"	R9-22-1420
"Inmate of a public institution"	42 CFR 435.1010
"Inpatient covered charges"	R9-22-712.07
"Interested party"	R9-22-101
"Intermediate Care Facility for the Mentally Retarded" or "ICF-MR"	42 U.S.C. 1396d(d)
"Intern and Resident Information System"	R9-22-701
"LEEP"	R9-22-2001
"Legal representative"	R9-22-101
"Level I trauma center"	R9-22-2101
"License" or "licensure"	R9-22-101
"Licensee"	R9-22-1201
"Liquid assets"	R9-22-1401
"Mailing date"	R9-22-101
"Medical education costs"	R9-22-701
"Medical expense deduction" or "MED"	R9-22-1401
"Medical record"	R9-22-101
"Medical review"	R9-22-701
"Medical services"	A.R.S. § 36-401
"Medical supplies"	R9-22-201
"Medical support"	R9-22-1401
"Medically necessary"	R9-22-101
"Medicare claim"	R9-22-101
"Medicare HMO"	R9-22-101
"Member"	A.R.S. § 36-2901
"Mental disorder"	A.R.S. § 36-501
"Milliman study"	R9-22-712.07
"Monthly equivalent"	R9-22-1421 and R9-22-1603
"Monthly income"	R9-22-1421 and R9-22-1603
"National Standard code sets"	R9-22-701
"New hospital"	R9-22-701
"NICU"	R9-22-701
"Noncontracted Hospital"	R9-22-718
"Noncontracting provider"	A.R.S. § 36-2901
"Non-FES member"	R9-22-201
"Non-IHS Acute Hospital"	R9-22-701
"Nonparent caretaker relative"	R9-22-1401
"Notice of Findings"	R9-22-109
"Nursing facility" or "NF"	42 U.S.C. 1396r(a)
"OBHL"	R9-22-1201
"Observation day"	R9-22-701
"Occupational therapy"	R9-22-201
"Offeror"	R9-22-101
"Operating costs"	R9-22-701
"Organized health care delivery system"	R9-22-701
"Outlier"	R9-22-701
"Outpatient hospital service"	R9-22-701
"Ownership change"	R9-22-701
"Ownership interest"	42 CFR 455.101
"Parent"	R9-22-1603
"Partial Care"	R9-22-1201
"Participating institution"	R9-22-701
"Peer group"	R9-22-701
"Peer-reviewed study"	R9-22-2001

"Penalty"	R9-22-1101
"Pharmaceutical service"	R9-22-201
"Physical therapy"	R9-22-201
"Physician"	R9-22-101
"Physician assistant"	R9-22-1201
"Post-stabilization services"	R9-22-201 or 42 CFR 422.113
"PPC"	R9-22-701
"PPS bed"	R9-22-701
"Practitioner"	R9-22-101
"Pre-enrollment process"	R9-22-1401
"Premium"	R9-22-1603
"Prescription"	R9-22-101
"Primary care provider" or "PCP"	R9-22-101
"Primary care provider services"	R9-22-201
"Prior authorization"	R9-22-101
"Prior period coverage" or "PPC"	R9-22-701
"Procedure code"	R9-22-701
"Proposal"	R9-22-101
"Prospective rates"	R9-22-701
"Psychiatrist"	R9-22-1201
"Psychologist"	R9-22-1201
"Psychosocial rehabilitation services"	R9-22-201
"Public hospital"	R9-22-701
"Qualified alien"	A.R.S. § 36-2903.03
"Qualified behavioral health service provider"	R9-22-1201
"Quality management"	R9-22-501
"Radiology"	R9-22-101
"RBHA" or "Regional Behavioral Health Authority"	R9-22-201
"Reason to know"	R9-22-1101
"Rebase"	R9-22-701
"Referral"	R9-22-101
"Rehabilitation services"	R9-22-101
"Reinsurance"	R9-22-701
"Remittance advice"	R9-22-701
"Resident"	R9-22-701
"Residual functional deficit"	R9-22-201
"Resources"	R9-22-1401
"Respiratory therapy"	R9-22-201
"Respite"	R9-22-1201
"Responsible offeror"	R9-22-101
"Responsive offeror"	R9-22-101
"Revenue Code"	R9-22-701
"Review"	R9-22-101
"Review month"	R9-22-101
"RFP"	R9-22-101
"Rural Contractor"	R9-22-718
"Rural Hospital"	R9-22-712.07 and R9-22-718
"Scope of services"	R9-22-201
"Section 1115 Waiver"	A.R.S. § 36-2901
"Service location"	R9-22-101
"Service site"	R9-22-101
"SOBRA"	R9-22-101
"Specialist"	R9-22-101
"Specialty facility"	R9-22-701
"Speech therapy"	R9-22-201
"Spendthrift restriction"	R9-22-1401
"Sponsor"	R9-22-1401
"Sponsor deemed income"	R9-22-1401
"Sponsoring institution"	R9-22-701
"Spouse"	R9-22-101
"SSA"	42 CFR 1000.10
"SSDI Temporary Medical Coverage"	R9-22-1603
"SSI"	42 CFR 435.4
"SSN"	R9-22-101

"Stabilize"	42 U.S.C. 1395dd
"Standard of care"	R9-22-101
"Sterilization"	R9-22-201
"Subcontract"	R9-22-101
"Submitted"	A.R.S. § 36-2904
"Substance abuse"	R9-22-201
"SVES"	R9-22-1401
"Taxi"	A.R.S. § 28-2515
"Therapeutic foster care services"	R9-22-1201
"Third-party"	R9-22-1001
"Third-party liability"	R9-22-1001
"Tier"	R9-22-701
"Tiered per diem"	R9-22-701
"Title IV-D"	R9-22-1401
"Title IV-E"	R9-22-1401
"Total Inpatient payments"	R9-22-712.07
"Trauma and Emergency Services Fund"	A.R.S. § 36-2903.07
"TRBHA" or "Tribal Regional Behavioral Health Authority"	R9-22-1201
"Treatment"	R9-22-2004
"Tribal Facility"	A.R.S. § 36-2981
"Unrecovered trauma center readiness costs"	R9-22-2101
"Urban Contractor"	R9-22-718
"Urban Hospital"	R9-22-718
"USCIS"	R9-22-1401
"Utilization management"	R9-22-501
"WWHP"	R9-22-2001

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

"Act" means the Social Security Act.

"ADHS" means the Arizona Department of Health Services.

"Adverse action" means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

"Affiliated corporate organization" means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation.

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS registered provider" means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A), and

Meets license or certification requirements to provide covered services.

"Appellant" means an applicant or member who is appealing an adverse action by the Department or Administration.

"Applicant" means a person who submits or whose authorized representative submits a written, signed, and dated application for AHCCCS benefits.

"Application" means an official request for AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a Fee-For-Service member.

"Authorized representative" means a person who is authorized to apply for medical assistance or act on behalf of another person.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific covered service or equipment provided to a member. A payment is made in accordance with an upper or capped limit established by the Director. This capped limit can either be a specific dollar amount or a percentage of billed charges.

"Case record" means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.

"Case review" means the Administration's evaluation of an individual's or family's circumstances and case record in a review month.

"Categorically eligible" means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) or 36-2934.

"Children's Rehabilitative Services" or "CRS" means the program that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means a period during which a member receives inpatient hospital services without interruption

beginning with the date of admission and ending with the date of discharge or date of death.
"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.
"Contract year" means the period beginning on October 1 of a year and continuing until September 30 of the following year.
"Covered services" means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.
"Day" means a calendar day unless otherwise specified.
"DBHS" means the Division of Behavioral Health Services within the Arizona Department of Health Services.
"DES" means the Department of Economic Security.
"Diagnostic services" means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.
"Director" means the Director of the Administration or the Director's designee.
"Discussion" means an oral or written exchange of information or any form of negotiation.
"DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.
"Enumeration" means the assignment of a nine-digit identification number to a person by the Social Security Administration.
"Equity" means the county assessor full cash value or market value of a resource minus valid liens, encumbrances, or both.
"Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.
"FBR" means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.
"Fee-For-Service" or "FFS" means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a member not enrolled with a contractor.
"FES member" means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.
"FESP" means the federal emergency services program under R9-22-217 which covers services to treat an emergency medical or behavioral health condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).
"FQHC" means federally qualified health center.
"GSA" means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with the contractor.
"Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.
"IHS" means Indian Health Service.
"IMD" or "Institution for Mental Diseases" means an Institution for Mental Diseases as described in 42 CFR 435.1010 that is licensed by ADHS.
"Interested party" means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.
"Legal representative" means a custodial parent of a child under 18, a guardian, or a conservator.
"License" or "licensure" means a nontransferable authorization that is granted based on established standards in law by a state or a county regulatory agency or board and allows a health care provider to lawfully render a health care service.
"Mailing date" when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:
Shown on the postmark;
Shown on the postage meter mark of the envelope, if no postmark; or
Entered as the date on the document, if there is no legible postmark or postage meter mark.
"Medical record" means a document that relates to medical or behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that is kept at the site of the provider.
"Medical supplies" means consumable items that are designed specifically to meet a medical purpose.
"Medically necessary" means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or

their progression, or to prolong life.
"Medicare claim" means a claim for Medicare-covered services for a member with Medicare coverage.
"Medicare HMO" means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid Services for participation in the Medicare program under 42 CFR 417(L).
"Non-FES member" means an eligible person who is entitled to full AHCCCS services.
"Offeror" means an individual or entity that submits a proposal to the Administration in response to an RFP.
"Physician" means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.
"Practitioner" means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a registered nurse practitioner certified under A.R.S. Title 32, Chapter 15.
"Prescription" means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.
"Primary care provider" or "PCP" means an individual who meets the requirements of A.R.S. § 36-2901(12) or (13), and who is responsible for the management of a member's health care.
"Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services contingent on the medical necessity of the services.
"Prior period coverage" means the period prior to the member's enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, whichever is later, and continues until the day the member is enrolled with a contractor.
"Proposal" means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.
"Radiology" means professional and technical services rendered to provide medical imaging, radiation oncology, and radioisotope services.
"Referral" means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.
"Rehabilitation services" means physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level.
"Responsible offeror" means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.
"Responsive offeror" means an individual or entity that submits a proposal that conforms in all material respects to an RFP.
"Review" means a review of all factors affecting a member's eligibility.
"Review month" means the month in which the individual's or family's circumstances and case record are reviewed.
"RFP" means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.
"Service location" means a location at which a member obtains a covered service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.
"Service site" means a location designated by a contractor as the location at which a member is to receive covered services.
"S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).
"Specialist" means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.
"Spouse" means a person who has entered into a contract of marriage recognized as valid by this state.
"SSN" means Social Security number.
"Standard of care" means a medical procedure or process that is accepted as treatment for a specific illness, injury, or medical condition through custom, peer review, or consensus by the professional medical community.
"Subcontract" means an agreement entered into by a contractor with any of the following:
A provider of health care services who agrees to furnish covered services to a member,
A marketing organization, or
Any other organization or person that agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

"Taxi" is as defined in A.R.S. § 28-2515.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-711. Copayments

A. No Change
B. No Change
C. The following individuals are exempt from AHCCCS co-payments
1. An individual under age 19, including individuals eligible for the KidsCare Program in A.R.S. § 36-2982;
2. An individual determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services;
3. An individual eligible for the Arizona Long-term Care Program in A.R.S. § 36-2931;
4. An individual eligible for Medicare Cost Sharing in 9 A.A.C. 29;
5. An individual eligible for the Children's Rehabilitative Services program under A.R.S. § 36-2906(E);
6. An institutionalized person under R9-22-216; and
7. An individual receiving hospice care as defined in 42 U.S.C. 1396d(o).
8. An American Indian individual enrolled in a health plan and who has received services through an IHS facility; tribal 638 facility or urban Indian health program.

D. No Change
E. No Change
F. Copayments for individuals covered under Section 1115 Waiver. Unless otherwise listed in subsection (C), (D), or (E) the ~~following~~ individuals whose income is equal to or under 100% of the Federal Poverty Level in A.R.S. § 36-2901.01 are required to pay the co-payments listed in this subsection. The provider may deny a service if the member does not pay the required copayment. However, a provider may choose to reduce or waive co-payments under this subsection on a case-by-case basis.
~~1. An individual whose income is equal to or under 100% of the Federal Poverty Level in A.R.S. § 36-2901.01, or~~
~~2. An individual eligible for the Medical Expense Deduction program in A.R.S. § 36-2901.04.~~

Covered Services	Copayment
Generic prescriptions or brand name prescriptions if generic is not available	$4.00 per prescription drug
Brand name prescriptions when generic is available	$10.00 per prescription drug
Nonemergency use of the emergency room.	$30.00 per visit
Physician office visit	$5.00 per office visit
Taxi transportation (Maricopa and Pima county residents only)	$2.00 per one-way trip

G. No Change
H. No Change
I. No Change

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 <u>through September 30, 2011</u>.
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 <u>through September 30, 2011</u>.
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 through September 30, 2011, as described under A.R.S. § 36-2903.01. For ~~the rate year effective~~ inpatient hospital admissions with begin dates of service on and after 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 described in subsection (6)(b). ~~as of August 31, 2011~~.

   iii. ~~In addition, for~~ 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.

   iv. Subject to approval by CMS, for qualification and payment of outlier claims with begin dates of service on or after October 1, 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 June 1, 2012, 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 new hospitals. 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.
12. Reductions to tiered per diem payment for inpatient hospital services. Inpatient hospital admissions with begin dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the tiered per diem rates in effect on September 30, 2011.

R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule

A. No Change

B. For all claims with a begin date of service on or after October 1, 2011, the AHCCCS Outpatient Capped Fee-for-Service Schedule shall be derived from the CMS Medicare Outpatient Prospective Payment System (OPPS) fee schedule modified by an Arizona conversion factor determined annually ~~in accordance with R9-22-712.40(C)~~.

1. When clinic services are billed using 51X revenue codes, the reimbursement to the hospital is the difference between the facility and non-facility rates payable to the practitioner for the procedures listed in the Administration's Capped Fee-for-Service Schedule under R9-22-710.
2. Observation services, when not billed in conjunction with a service for which a single payment is made under R9-22-712.25, are reimbursed at an hourly rate published in the Outpatient Capped Fee-for-Service Schedule. This hourly rate includes reimbursement for associated services.

C. No Change

R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule

A. No Change

B. No Change

C. No Change

D. No Change

E. Reductions to payments for outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule. Outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rate published by CMS pursuant to subsection (C) of this section.

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

A. Procedure codes. When procedure codes are issued by CMS and added to the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add to the Outpatient Capped Fee-for-Service Schedule the new procedure codes for covered outpatient services and shall either assign the default CCR under ~~R9-22-712.40(E)(2)~~ R9-22-712.40(F)(2), the Medicare rate, or calculate an appropriate fee.

B. No Change

C. Annual update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, through September 30, 2011, AHCCCS shall adjust outpatient fee schedule rates:

1. Annually by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or
2. In a particular year the director may substitute the increases in subsection (C)(1) by calculating the dollar value associated with the inflation index in subsection (C)(1), and applying the dollar value to adjust rates at varying levels.

D. Reductions to the Outpatient Capped Fee-For-Service Schedule. Claims paid using the Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rates in effect on September 30, 2011, subject to the annual adjustments to procedure codes and APC's under this section.

~~**D.**~~**E.** Rebase. AHCCCS shall rebase the outpatient fees every five years.

~~**E.**~~**F.** Statewide CCR.:

1. For begin dates of service on or before September 30, 2011, the statewide CCR calculated in R9-22-712.30 shall be

recalculated at the time of rebasing. When rebasing, AHCCCS may recalculate the statewide CCR based on the costs and charges for services excluded from the outpatient hospital fee schedule.

2. For begin dates of service on or after October 1, 2011, the statewide CCR shall be set under R9-22-712.30 (C).