NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ARIZONA LONG-TERM CARE SYSTEM

PREAMBLE

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

R9-28-702	New Section
R9-28-703	New Section

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

Authorizing statute: A.R.S. §§ 36-2903.01, 36-2903, 36-2932

Implementing statute: A.R.S. §§ 36-2999.52, 36-2999.54

3. The effective date of the rule:

The agency requests an immediate effective date of January 8, 2013. As required by A.R.S. § 41-1032 (A)(2) and (A)(3), the rulemaking will avoid a violation of federal law or regulation or state law and will comply with deadlines for the nursing facility assessment established in statute.

4. Citations to all related notices published in the Register to include the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 18 A.A.R. 2370, September 28, 2012

Notice of Proposed Rulemaking: 18 A.A.R. 2336, September 28, 2012

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

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

A.R.S. § 36-2999.52 authorizes the Administration to administer a provider assessment on health care items and services provided by nursing facilities and to make supplemental payments to nursing facilities for covered Medicaid expenditures. The Administration is proposing rule to delineate the method for imposing the assessment, the criteria for qualifying for supplemental payments, and the method for determining the amount of supplemental payments.

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 any analysis of each study and other supporting material:

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

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

The Administration anticipates a minimal to moderate economic impact to individual qualifying nursing facilities. Under the statute, the amount of the assessment cannot to exceed three and one-half percent of the net patient service revenue. The estimated amount of the aggregate assessment for the fiscal year ending September 30, 2013 is $18M. Ninety nine percent of the funds will be used as the non-federal share of supplemental payments to qualifying nursing facilities through the Medicaid program administered by AHCCCS. Because those funds will be matched with federal funds, the estimated amount of the aggregate supplemental payments for the fiscal year ending September 30, 2013 is $50M.

Minimal = less than $200,000

Moderate = $200,000 to $400,000

High = $400,000 or over

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The following technical changes were made between the proposed rulemaking and the final rulemaking:

R9-22-702(D)(3) – where the rule language stated "**fewer** annual Medicaid days than" it should have said "the number of annual Medicaid days **greater than or equal to**because those facilities with a high Medicaid volume should pay the $1. This rate was chosen by the Nursing Facility Association when sponsoring the bill to meet the payments intended to be generated. Slope calculations were used for a broad based and uniform tax as referred to under 42 CFR 433.68(e)(2).

R9-22-703(A)(1) – where the rule language stated "Estimating the nursing facility assessments **computed for** the upcoming assessment year" should state "Estimating the nursing facility assessments **to be collected in** the upcoming assessment year" because the assessment is not computed within the description of the payment rule.

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

The proposed rule language was available on the AHCCCS website www.azahcccs.gov as of September 10, 2012. The following oral or written comments were received by the close of the comment period, 5:00 p.m., October 29, 2012.

Item #	Rule Cite Line #	Comment From	Comment	Analysis/ Recommendation
1.	R9-22-702(D)(3)	Kathleen Pagels	Page 7 Rule Says: 3. For a nursing facility with fewer annual Medicaid days than the number required to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2), the provider assessment is calculated by multiplying the nursing facility's non-Medicare resident day data for each assessment year by $1.00. We Think it Should Say: should read "Greater than or equal to annual Medicaid days" than the number required (Essentially, as we see it, the posted rule is not correct- everybody but the high Medicaid would only pay $1 while the high MA volume would pay the $7.50-exactly opposite of the model developed- so it would have a great impact.)	The Administration agrees with the suggested change and has made the change in rule.
2.		Matt Luger	The reconciliation process as described,however,is problematic,as it "punishes" the compliant facilities who remit their Provider Assessment fees in a proper and timely manner,and does nothing to disincent the non-compliant facilities not making their required Assessment payments. If at the end of the program year,more funds have been distributed then collected,it appears that ALL the participant facilities would be subject to a fund recoupment by AHCCCS,based on their percentage of ALTCS patient days. This is not an equitable method. As AHCCCS will be receiving additional funding under this program for new overhead expense,it would seem reasonable for a part-time FTE to serve as liaison to the Az. Dept.of Revenue for the Assessment program. Only after AHCCCS and DOR agree that a particular facility has made the correct and timely remittal of their quarterly Provider Assessment should approval be given to release Assessment payments to that facility. In that manner,as no individual provider would receive Assessment funds until they have met their remittal obligation,there should be no need for an aggregate annual reconciliation process,or,at worst,there should be a dramatically diminished look-back review that was facility-specific,as opposed to blanket across the entire provider continuum. This change will better insure provider compliance with Assessment payment requirements and serve to prevent extensive gaming of the new system.	The issue of whether a facility pays taxes or not lies in the jurisdiction of the Department of Revenue; AHCCCS has no authority to be privy to this information. Due to the confidential nature of taxpayer information, AHCCCS is not privy to, nor can the Department of Revenue disclose, which facilities have or have not paid the assessment in a timely fashion. Furthermore, in general, if distributions to facilities are directly related to payment of the assessment, federal financial participation is not available for the distributions. The amendment to the rule proposed by the commenter has not been reviewed or approved by the federal government, and it is unlikely that approval for such an amendment could be obtained.

12. 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:

Not applicable

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:

No permit is required by this rulemaking.

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:

The rule must conform to the requirements of 42 U.S.C. § 1396b(w) and the implementing federal regulations found at 42 C.F.R. Part 433, Subpart B. An assessment or supplemental payments that do not meet federal requirements would result in a reduction in federal financial participation in the Medicaid program administered in Arizona. As indicated in the statute, federal approval for the assessment and the supplemental payments is required. As such, the rule will not exceed the parameters of federal law.

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.

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

Not applicable

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable

15. The full text of the rules follows:

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ARTICLE 7. STANDARDS FOR PAYMENTS

Section

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-28-702. ~~Repealed~~ **Nursing Facility Assessment**

A. For purposes of this Section, in addition to the definitions under A.R.S. 36-2999.51, the following terms have the following meaning unless the context specifically requires another meaning:

"Assessment year" means the 12 month period beginning October 1st each year.

"Nursing Facility Assessment" means a tax paid by a qualifying nursing facility to the Department of Revenue on a quarterly basis established under A.R.S. § 36-2999.52.

"Medicaid days" means days of nursing facility services paid for by the Administration or its contractors as the primary payor and as reported in AHCCCS' claim and encounter data.

"Medicare days" means resident days where the Medicare program, a Medicare advantage or special needs plan, or the Medicare hospice program is the primary payor.

B. Subject to Centers for Medicare and Medicaid Services (CMS) approval, effective October 1, 2012, nursing facilities shall be subject to a provider assessment payable on a quarterly basis.

C. All nursing facilities licensed in the state of Arizona shall be subject to the provider assessment except for:

1. A continuing care retirement community,
2. A facility with 58 or fewer beds,
3. A facility designated by the Arizona Department of Health Services as an Intermediate Care Facility for the Mentally Retarded, or
4. A tribally owned or operated facility located on a reservation.

D. The Administration shall calculate the prospective nursing facility provider assessment for qualifying nursing facilities as follows:

1. AHCCCS shall utilize each nursing facility's Universal Accounting Report (UAR) submitted to the Arizona Department of Health Services as of August 1st immediately preceding the assessment year. In addition, by August 1st each year, each nursing facility shall provide AHCCCS with any additional information necessary to determine the assessment. For any nursing facility that does not provide by August 1st the additional information requested by AHCCCS, AHCCCS shall determine the assessment based on the information available.

2. For each nursing facility, other than a nursing facility noted in subsection (D)(3), the provider assessment is calculated by multiplying the nursing facility's non-Medicare resident day data for each assessment year by $7.50.

3. For a nursing facility with the number of annual Medicaid days greater than or equal to the number required to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2), the provider assessment is calculated by multiplying the nursing facility's non-Medicare resident day data for each assessment year by $1.00.

4. The number of annual Medicaid days used in subsection (D)(3) shall be recalculated each August 1, to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2).

5. The assessment calculated under subsections (D)(2), (D)(3) and (D)(4), shall not exceed 3.5 percent of aggregate net patient service revenue of all assessed providers.

6. AHCCCS will forward the provider assessment by facility to the Department of Revenue by September 1st preceding the assessment year.

R9-28-703. ~~Repealed~~ **Nursing Facility Supplemental Payments**

A. On an annual basis, AHCCCS shall determine the total funds available in the nursing facility assessment fund available for supplemental payments by:

1. Estimating the nursing facility assessments to be collected in the upcoming assessment year,
2. Subtracting one percent of the total estimated assessments , and
3. Multiplying the appropriate federal matching assistance percentage (FMAP) by the difference of subsections (A)(1) and (A)(2).

B. AHCCCS shall calculate each year's quarterly supplemental payments to each nursing facility with Medicaid utilization, excluding ICFMRs, by:

1. Determining each facility's proportion of Medicaid resident bed days to total nursing facility Medicaid resident bed days by utilizing adjudicated claims and encounter data for the most recent 12 month period, including appropriate claims lag.
2. Multiplying subsections (B)(1) and (A)(3).
3. Dividing the payments determined under subsection (B)(2) by four.

C. AHCCCS and its contractors shall make quarterly supplemental payments to nursing facility providers.

D. Following the end of each assessment year, AHCCCS shall reconcile the supplemental nursing facility payments made during the assessment year to the annual deposits to the nursing facility assessment fund for the same year less one percent of the actual assessments deposited in the fund plus federal matching funds. The proportion of each nursing facility's Medicaid resident bed days shall be used to calculate the reconciliation amounts. AHCCCS and its contractors shall make additional payments to or recoupments from nursing facilities based on the reconciliation.

E. Aggregate supplemental payments to nursing facilities shall not exceed upper payment limits established under 42 CFR 447.272.

F. A facility must be open on the date the supplemental payment is made in order to receive a payment.