NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

PREAMBLE

1. Articles, Parts, or Sections Affected **Rulemaking Action:**

R9-22-712.90 New Section

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

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

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

3. The effective date of the rule:

The agency selected an effective date of 60 days from the date of filing with the Secretary of State as specified in A.R.S. § 41-1032(A).

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: 22 A.A.R. 784, April 8, 2016

Notice of Proposed Rulemaking: 22 A.A.R. 770, April 8, 2016

Notice of Public Information: 22 A.A.R. 1067, May 6, 2016

Notice of Supplemental Proposed Rulemaking: 22 A.A.R. 1945, July 29, 2016

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

This rulemaking is proposed as part of the AHCCCS Administration's obligation under the federal Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), to establish methods for the reimbursement of health care providers that are consistent with efficiency, economy, quality care, and adequate access to care for persons enrolled in AHCCCS, Arizona's implementation of the Medicaid program. Hospitals that elect to participate in the AHCCCS program are required to execute a provider participation agreement. A.R.S. § 36-2904(D). As such, the relationship between the AHCCCS Administration and health care providers is contractual in nature. In general, the terms of State contracts are exempt from rulemaking. A.R.S. § 41-1005(A)(14). However, statutory provisions specific to the AHCCCS program require the agency to adopt rules regarding payment for hospital services. A.R.S. § 36-2903.01(G). This rulemaking distinguishes services provided by a hospital-based freestanding emergency department from other hospital services and establishes the payment methodology for services provided by hospital-based freestanding emergency departments.

The Arizona Department of Health Services has established a class of health care institutions known as outpatient treatment centers (OTCs). See generally, A.A.C. Title 9, Chapter 10, Article 10. A subclass of OTCs is authorized to provide emergency department services. A.A.C. R9-10-1019. In this rulemaking, OTCs licensed to provide emergency department services are referred to as "freestanding emergency departments" (FSEDs). FSEDs are relatively new to the Arizona health care delivery system with most of the facilities opening since 2015. A single license may be issued for a hospital which also operates satellite facilities, such as FSEDs, at the request of the hospital. A.R.S. § 36-422(F). Under the billing methodologies currently in place, a claim for services provided in the hospital is indistinguishable from a claim for services provided in a FSED operated by the same hospital when a single group license is issued because provider registration is based on that license.

For ease of reference, throughout this preamble, the terms "freestanding emergency

department" and "FSED" refer to hospital-based freestanding emergency departments except where the context explicitly states otherwise. Emergency departments that are located within a hospital are referred to as "on-site emergency departments" or "on-site EDs."

Outpatient hospital services are reimbursed using the outpatient prospective fee schedule described in A.A.C. R9-712.10 through R9-22-712.50. Because hospital-based FSED have been registered under the same license as the hospital operating the FSED, that reimbursement methodology has been used even though the hospital-based FSED does not have the same overhead costs and capabilities as an on-site emergency department according to secondary sources reviewed by the AHCCCS Administration (please see specific reference in the responses to public comments). They often do not have the same equipment and do not have the ability to immediately admit persons requiring inpatient care. By the very nature of being a FSED, transportation services are required when a patient requires inpatient care. Services provided by an OTC that is not hospital-based are reimbursed based on a capped fee schedule established by the AHCCCS Administration which also applies to services provided in any clinic or physician's office which, in general, is a lower total reimbursement than that provided for outpatient hospital services and associated professional (e.g., physician) services.

FSEDs are required to operate 24 hours a day, seven days a week: hours that exceed those of most urgent care clinics or physician's offices. Media coverage and promotional materials published by hospitals presenting these facilities emphasize the convenience, shorter wait times, and extended hours of FSEDS. Most offer patients the ability to schedule an appointment for a visit to the FSED (see, for example, the site maintained by Dignity Health at www.dignityhealth.org/arizonageneral/services/er-services and by Abrazo Community Health Network at www.abrazohealth.com/our-services/emergency-trauma). Clearly, scheduling an appointment is incongruous with the generally understood concept of an emergency. Dignity Health has sent direct mailings promoting its hospital-based freestanding emergency departments, offering one first aid kit per household per mailer when presented at the specific FSED location. Taken as whole, these promotional activities have the effect of misleading patients to conclude that a visit to the FSED is an appropriate and more convenient alternative to treatment by a primary care practitioner in an office setting.

For example, the website maintained by Honor Health for the Sonoran health and Emergency Center states that the FSED offers treatment for multiple conditions including "headache" and "fever." (see https://www.honorhealth.com/locations/emergency/sonoran-health-and-emergency-center). Treatment of non-emergency conditions by healthcare providers other than the patient's primary care practitioner restricts the ability of the primary care practitioner to coordinate care for the patient, potentially leading to sub-optimal health outcomes. Federal law significantly restricts the ability of the AHCCCS program to use copayments to discourage the low-income population it serves from inappropriate use of emergency departments including FSEDs. However, as justification for its final rule authorizing imposition of higher Medicaid copayments for nonemergency use of the emergency room, the Centers for Medicare and Medicaid Services stated that "The goal underlying the policy is to ensure that the *right* care is provided at the *right* time in an *appropriate* setting." (emphasis added) 78 FR 42160 at 42277. The federal government also noted that "…it is important for states to have options to incentivize care in the most appropriate settings and to encourage individuals to develop a regular source of care, to the extent that beneficiaries are assured timely access to needed care" 78 FR 42160 at 42276. The AHCCCS Administration is reasonably concerned about use of FSEDs as a substitute for services that are more appropriately and cost-effectively rendered in a clinic or physician's office, and the proposed rule furthers the goal of delivery and payment of the most appropriate care in the most appropriate setting.

This rulemaking requires hospital-based FSEDs to register separately from the hospital with which it shares common ownership regardless of whether both are listed as part of a single group license so that the AHCCCS Administration can clearly distinguish claims for services from hospital-based FSEDs from claims for services provided by the hospital itself. The rule provides that reimbursement for services in a hospital-based FSED is a percentage (that varies depending on the level of services provided) of the amount that would otherwise be paid for similar services provided as outpatient hospital services but does not include the adjustment in A.A.C. R9-22-712.35 that accounts for the unique costs of services provided in a hospital outpatient setting but which are not applicable to FSEDs. The percentage reductions are applied to level 1, 2, and 3 emergency department visits, many of which can

be addressed by a primary care physician in an office setting which offers better continuity of care at a lower cost.

The rulemaking also includes an exception that permits the application of the adjustment applicable to the hospital in instances where a FSED is established to replace the services of a hospital that has closed in a rural area where appropriate local care might not otherwise be available.

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

A study was not referenced or relied upon when revising these regulations other than secondary sources referenced in the responses to comments and the cost estimations included in the economic, small business and consumer statement submitted to the Governor's Regulatory Review Council. Due to federal and state requirements, the raw data used for the estimates (claims and encounter data) cannot be made publicly available. However, information regarding fee schedule payments to hospitals, urgent care centers, and physicians are available on the agency's public website (www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/). In addition, data regarding historical AHCCCS payments to hospital is also available through the public website at https://azahcccs.gov/PlansProviders/RatesAndBilling/hosptialReimbursement.html) through the link on that page to the "summary of all hospital payments." As hospital-based freestanding emergency departments are currently indistinguishable in the AHCCCS claims data from on-site hospital emergency departments, utilization data specific to these facilities is not available.

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:

This rulemaking does not diminish a previous grant of authority of a political subdivision.

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

As noted earlier in this preamble, the purpose of this rule is to establish the payment

methodology for hospital-based FSEDs. As such, it is not a rule that is designed or intended to directly change any particular conduct. The rule does reflect the AHCCCS Administration's efforts to contain costs and establish payment methodologies that do not intentionally or unintentionally encourage health care providers to deliver services in ways that are not cost effective. Absent this rule, the AHCCCS Administration expects - as a result of the increasing availability of FSEDs - an increase in the amount of taxpayer dollars spent on payments to FSEDs for services that could be addressed more cost effectively at an urgent care center or physician's office.

Hospital-based FSEDs, a subclass of outpatient treatment centers, are relatively new to Arizona. About 12 such facilities have been identified as currently existing, although the administration has information that additional hospital-based FSEDs are planned for the future. Because the administration cannot currently distinguish services provided by hospital-based FSEDs from other outpatient hospital services, the AHCCCS Administration presumes that services provided at these facilities have been reimbursed as specified in A.A.C. R9-22-712.10 through R9-22-712.50. While this proposed rulemaking reduces the payments for level 1, 2 and 3 – services that could usually be provided more efficiently and cost effectively by a primary care physician – information provided to the administration by an operator of several of the hospital-based FSEDs suggests low utilization of services at those levels of care.

As such, the administration assumes that the economic impact of this supplemental proposed rulemaking on hospital revenues will be minimal based on the following. Approximately eighty general acute care hospitals have participation agreements with AHCCCS, and these are the entities most likely to expand existing emergency departments through the creation of FSEDs. However, none of those hospitals are small business as defined by A.R.S. § 41-1001(21). As stated in greater detail in the economic, small business, and consumer impact statement submitted to the Governor's Regulatory Review Council, the AHCCCS Administration anticipates that the reimbursement impact on hospital providers will be minimal. AHCCCS is aware of approximately 12 hospital-based freestanding emergency departments in Arizona. Assuming those 12 facilities realize a volume of Medicaid-eligible ED visits proportional to their number, it is estimated that reimbursements

for levels 1-3 visits to these facilities under the current fee schedule would equal at most 1.1% ($22,730,608) of total acute hospital reimbursements (more than $2 billion in FY 2015), and that the incremental percentage reductions resulting from this rulemaking would reduce total reimbursements for those 12 facilities by approximately $3 million annually.

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

The Notice of Proposed Rulemaking, published at 22 A.A.R. 770 on April 8, 2016, proposed that services provided by outpatient treatment centers, including hospital-based FSEDs, are not outpatient hospital services which are reimbursed as specified in A.A.C. R9-22-712.10 through R9-22-712.50. Instead, the administration proposed that those services be reimbursed under the capped fee schedule established by the AHCCCS Administration which schedule is exempt from the requirements of rule-making under A.R.S. § 41-1005(A)(9). Public comments received in response to the Notice of Proposed Rulemaking requested that the Proposed Rulemaking describe the reimbursement methodology in the proposed rule. In response, the Administration filed a Notice of Supplemental Proposed Rulemaking, published at 22 A.A.R. 1945 on July 29, 2016, treats hospital-based FSEDs as a special type of outpatient hospital services which are reimbursed based on a modified version of the methodology for other outpatient hospital services.

Based on comments received on the Notice of Supplemental Proposed Rulemaking, the AHCCCS Administration has also made some clarifying changes to the Final Rule:

- The phrase “hospital-based” has been added to the title of the rule to clarify that the rule only applies to FSED that have common ownership with a hospital.
- Subsection (E) of the rule has been amended to remove an incorrect cross-reference to subsection (B); instead and in addition, subsection (E) has been amended to clarify that the payment rates and methods for hospital-based outpatient departments other than FSED are not affected by this rulemaking.
- Subsection (C) has been amended to clarify the impact of this rulemaking on claims for services other than for the evaluation and management procedure codes for the emergency department visit that may appear on the claims from a hospital-based FSED.

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

Dignity Health, September 6, 2016	
1.	*Comment:* FSEDs are not urgent care centers. Laws and regulation mandate FSEDs and On-Site emergency departments be alike.
	Response: AHCCCS agrees that FSEDs are not urgent care centers and that FSEDs must meet minimum standards applicable to all emergency departments; however, this does not mean that on-site emergency departments and FSEDs are the same. Obviously, FSEDs lack on-site inpatient admission capabilities, do not have intensive care capabilities, and are unprepared to handle volume influxes from natural and man-made disasters. See Ayers, Alan A. "Understanding the Freestanding Emergency Department Phenomenon." The Journal of Urgent Care Medicine. February 2014. http://www.jucm.com/understanding-the-freestanding-emergency-department-phenomenon/2/. On-site EDs have immediate access to inpatient cardiac catheterization services – a service often required to promptly treat patients who present with complaints of chest pain – while FSEDs do not. Another commenter, AzHHA, noted that some of the FSEDs do not have MRI services available or have them easily accessible.
2.	*Comment:* Dignity Health acknowledges that more can be done to educate patients regarding accessing the appropriate level of care, but Dignity has found no promotional materials that promote primary care through Dignity FSEDs.
	Response: The AHCCCS Administration agrees that many factors, including lack of patient education, lead to inappropriate utilization of emergency department visits, and the AHCCCS Administration appreciates Dignity Health's commitment to improving patient knowledge regarding accessing the appropriate level of care. Nevertheless, it is not prudent for the AHCCCS Administration to maintain a reimbursement methodology that facilitates the growth of FSEDs. Dignity Health acknowledges in its own comments that Level 1 and Level 2 services "are similar to encounters that could be treated in a physician's office or

	primary health center." AHCCCS believes that most Level 1 services, many Level 2 services, and even some Level 3 services should not be provided in an ED, nor should taxpayers bear the increased costs of treating such services in more costly ED settings. Conditions such as insect bites (level 1), sunburns (level 2), and fevers that respond to ibuprofen (level 3) should not typically be provided in an ED. See the *ED Facility Level Coding Guidelines* published by the American College of Emergency Physicians https://www.acep.org/physician-resources/practice-resources/administration/financial-issues-/-reimbursement/ed-facility-level-coding-guidelines/ . While the expansion of FSEDs expands access to emergency care, there is no evidence of an inability to access emergency care through on-site emergency departments, and the expansion of FSEDs increases opportunities for inappropriate utilization of emergency services without a commensurate benefit.
3.	*Comment:* The proposed rule implies, without supporting data, that AHCCCS members will use FSEDs inappropriately rather than seeking care from their primary care provider. We believe the reasons why AHCCCS members seek care at any emergency room for non-emergent needs are numerous and complex and should not be solely attributed to the availability of FSEDs. The elimination of FSEDS will not change behavior.
	Response: The AHCCCS Administration agrees that many factors lead to inappropriate utilization of emergency department visits. All commenters agree that there is some level of inappropriate use of the ED. The proliferation of FSEDs will exacerbate the problem. The AHCCCS Administration lacks data specific to FSEDs and Medicaid recipients because, under current AHCCCS requirements, a claim from hospital-based FSEDs is not distinguishable from a claim from the hospitals' on-site ED. However, other sources support the AHCCCS Administration's concern. For example: • According to Freeman White (a healthcare consulting and design firm), FSEDS do not appear to lower ED visits at main hospital EDs but rather tend to tap into pent up demand. They are "a last ditch attempt to bolster inpatient volumes." See, *Do Freestanding Emergency Departments Make Financial Sense?*

	http://www.freemanwhite.com/do-freestanding-emergency-departments-make-financial-sense/ • An analysis by the Colorado-based Center for Improving Value in Health Care found that the cost of treating someone in in an ED exceeds that in an urgent care center by $400-$800. Of the top ten reasons for seeking care at a FSED, seven were non-life threatening conditions such as sore throats and bronchitis. See, Warren, David. "As the Number of Freestanding ERs Grows, so does Scrutiny." *Associated Press.* August 21, 2016. http://bigstory.ap.org/article/39dffacdeddc4eee888eeca1924f50bf/number-freestanding-ers-grows-so-does-scrutiny • Dignity Health's comments state that the admission rate from FSEDs tends to be lower than at on-site EDs, suggesting that there may be a greater percentage of non-emergency use of FSEDs than on-site emergency departments. • FSEDs often differentiate themselves from on-site EDs by patient experience and shorter wait times. See Ayers, Alan A. "Understanding the Freestanding Emergency Department Phenomenon." The Journal of Urgent Care Medicine. February 2014. http://www.jucm.com/understanding-the-freestanding-emergency-department-phenomenon/2/. While this is certainly not a negative thing, this can encourage non-emergency usage among Medicaid recipients since many do not have deterrent to using FSED services such as a higher co-pay.
4.	*Comment:* The proposed rate methodology is arbitrary. AHCCCS did not evaluate negative impacts on delivery systems or member utilization patterns. Neither did AHCCCS analyze the cost of FSED operations.
	Response: The proposed payment methodology provides for the identical base payment for Levels 4 and 5, which the Administration acknowledges to be primarily true emergencies. For each of Levels 1 -3, the proposed based payment to an FSED is more than the payment for like services when provided in a physician's office or Urgent Care clinic. There are numerous resources suggesting that it is less expensive to run a FSED than an on-site ED.

For example:

- In a webinar, Greg Davis, Chief Strategy Officer for the Arizona Market for Dignity Health stated "I look at these [FSED] facilities as a lower cost setting than our hospital based emergency departments."

- The New England Journal of Medicine recently stated "FSEDs can charge the same fees with a fraction of the overhead costs required to run a full-service hospital" See, Harish, Nir. "How the Freestanding Emergency Department Boom Can Help Patients," New England Journal of Medicine. http://catalyst.nejm.org/how-the-freestanding-emergency-department-boom-can-help-patients/. February 18, 2016.

- A 2015 congressional briefing by the Medicare Advisory Commission found that it takes some independent ERs just 20 patients a day to turn a profit. See, Goodman, Matt. "Are Freestanding Emergency Rooms Driving Up Costs?" http://www.dmagazine.com/publications/d-ceo/2016/may/freestanding-emergency-rooms/. May 2016.

- The CEO of Baylor Emergency Medical Centers, Dr. John Wood, has been quoted as saying, "for the cost of an 80-bed hospital, we can build 10 ER centers," See, Shlachter, Barry. "As Free-Standing ERs' Business Grows, so Does Backlash." http://www.star-telegram.com/news/business/article3868661.html.

In addition, consistent with federal requirements, AHCCCS is required to submit to CMS an analysis of the impact of restructuring provider payments on enrollees' access to care. Historical analyses of access to care have not identified any problems with access to hospital services or emergency department services. See reports posted at https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/. As such, there is no evidence suggesting that expansion of ED services are necessary to ensure AHCCCS enrollees have adequate access to care.

5.	*Comment:* Dignity Health acknowledges that patients at FSEDs must be transferred when inpatient care is required; however, it also noted that on-site EDs also transfer patients to other hospitals depending on acuity and specialty.
	Response: The Administration acknowledges that transfers sometimes occur at both FSEDs and on-site locations. However, many, if not most, admissions from an FSED will require two AHCCCS covered transports – one to the FSED and another from the FSED to the hospital when inpatient care is required. This, obviously, is not true of on-site emergency departments. The commenter acknowledges that their own data shows that patients presenting at FSEDs have lower acuity than at on-site EDs. Research shows that only 3-5% of patients at FSEDs are transferred to hospitals compared to at least 15% being admitted at on-site locations (See, Ayers and Harish, *Id.*). These statistics support the AHCCCS administration's concern that higher non-emergency use occurs at FSEDs.
6.	*Comment:* The proposed rulemaking does not comply with the Arizona Administrative Procedures Act, specifically requirements in A.R.S. § 41-1055.
	Response: The commenter incorrectly states the requirements of the Arizona Administrative Procedures Act. First, none of the requirements of A.R.S. § 41-1055(B) are applicable to a Notice of Supplemental Proposed Rulemaking. That subsection sets forth the requirements for the economic, small business and consumer impact statement that must accompany the Notice of Final Rulemaking. See A.R.S. § 41-1052(A); A.A.C. R1-1-602(C)(5). A *proposed* rulemaking need only include a "preliminary *summary* of the economic, small business, and consumer impact" (emphasis added). See A.A.C. R1-1-502(B)(12). The required contents of such a summary are listed in A.R.S. § 41-1055(A). The Notice of Supplemental Proposed Rulemaking meets those requirements. Under subsection (A), the summary should identify the conduct and the frequency of occurrence that the rule is designed to change, the harm resulting from the conduct, the likelihood it will continue, the estimated change in frequency, and a summary of the impact statement. However, not every rule has its purpose changing conduct. Consistent with A.R.S. § 36-2903.01(G), the AHCCCS Administration is required to adopt rules regarding payments to

	hospitals that contract with the AHCCCS Administration. This is what this rulemaking does. State law requires that the AHCCCS Administration, like every State agency, must operate its program within its appropriation. A.R.S. § 36-2903(P). Likewise, federal law requires that the AHCCCS Administration establish payment rates and methodologies that 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." 42 U.S.C. 1396a(a)(30)(A). It is a fundamental objective of the AHCCCS program to contain costs and minimize the burden on Arizona taxpayers. The preamble to the Notice of Supplemental Proposed Rulemaking clearly identifies reimbursement of hospital-based FSED as its topic, clearly identifies the AHCCCS Administration's concern that the growth of FSED will exacerbate the problem of inappropriate and costly use of emergency departments, identifies that taxpayers are currently funding services at FSED that could be provided more economically in other settings, and states that the taxpayers will be harmed if the current billing practice continues.
7.	*Comment:* Arizona law requires that all rulemaking must be evidence-based.
	Response: Dignity Health in its own comments acknowledges that this is an inaccurate statement of the law. While a description of the data relied on as part of rulemaking should generally be included in the economic, small business and consumer impact statement included with the Notice of Final Rulemaking, the statute also acknowledges that this is not always possible. See A.R.S. 41-1055(C) ("If for any reason adequate data are not reasonably available to comply with the requirements of subsection B of this section, the agency shall explain the limitations of the data and the methods that were employed in the attempt to obtain the data and shall characterize the probable impacts in qualitative terms. The absence of adequate data, if explained in accordance with this subsection, shall not be grounds for a legal challenge to the sufficiency of the economic, small business and consumer impact statement.")

8.	*Comment:* Subsection (F) of proposed R9-22-712.90 creates an incentive for a hospital to transfer to a non-affiliated hospital which could negatively impact coordination of care with the patients PCP because a transfer from an FSED to an affiliated hospital results in no payment for the services rendered at the FSED.
	Response: The AHCCCS Administration believes it is unlikely that a hospital system would transfer an FSED patient to an unaffiliated hospital when doing so would be contrary to the best interest of the patient, just so the hospital system could bill separately for the ED visit rather than having the cost of the ED reimbursed as part of the inpatient stay at the affiliated hospital. With respect to on-site EDs, it has been the long-standing policy of AHCCCS (as reflected in both the administrative rules applicable to payments under tier and DRG), that the costs for ED services are reflected in the tier/DRG payment when there is an inpatient admission directly from the ED to the "same" hospital. Similarly, when the admission is from a hospital based FSED to a hospital with a common ownership interest, the cost of the FSED visit is recovered through the DRG payment. Based on this comment, AHCCCS will be reviewing its policy of separate reimbursement of on-site ED visits when there is an admission to a physically separate hospital that shares common ownership. Any changes will be reflected in separate rule making.
9.	*Comment:* Dignity Health concludes that AHCCCS has proposed this regulation solely to penalize Dignity Health alone, for participating in the development of FSEDs.
	Response: This proposed rulemaking applies to all current and future hospital-based FSEDs. At least four other hospital systems in Arizona also operate FSEDs. The rulemaking is not targeted at Dignity Health.
10.	*Comment:* Subsection E of the proposed rule removes all hospital-based outpatient treatment centers from the outpatient capped fee schedule otherwise applicable under R9-22-712.10 through 712.50. Not all hospital-based OTC's are FSEDs
	Response: The AHCCCS Administration agrees. The preamble to the Notice of Supplemental Proposed Rulemaking reflects the intention of the AHCCCS Administration

	to establish payment rules for services provided at FSEDs. Subsection (E) was intended to apply only to non-hospital-based FSEDs and not to other hospital-based OTCs. The final rule has been modified to reflect this.
11.	*Comment:* Subsection (D) of the proposed rule appears to establish an exception applicable to only one rural FSED. The rule should not dissuade other hospitals from establishing FSEDs in underserved communities.
	Response: The rule exempts prospectively any hospital-based FSED that opens in any rural setting where the only hospital-based ED has closed after January 1, 2015. This addresses the AHCCCS Administration's concern for ensuring appropriate ED access in light of the national trend of rural hospital closures.
12.	*Comment:* Level 3 FSED visits should be fully compensated because level 3 visits require specialized immediate diagnostic tools that are generally only available in an ED setting.
	Response: The AHCCCS Administration agrees that many – but not all – level 3 visits require the resources found in an ED setting. This is reflected in the lowest percentage reduction (10%). However, not all level 3 visits require those resources. According to the ED Facility Level Coding Guidelines published by the American College of Emergency Physicians, level 3 visits include visits for fevers that respond to antipyretics (e.g., aspirin).
Arizona Hospital & Healthcare Association, September 10, 2016	
13.	*Comment:* We have serious concern that—while well-intentioned—the proposed rule will harm access to emergency care in medically underserved areas of the state while doing little to address the underlying causes of inappropriate use of emergency department (ED) services by AHCCCS members.
	Response: This rulemaking does not prohibit or restrict the opening of FSEDs in either rural or urban locations. The rule simply establishes the rate of payment for FSED services. Providers are free to make independent business judgments regarding the establishment of new FSEDs. The proposed payment methodology provides for the

	identical base payment for Levels 4 and 5, which the Administration acknowledges to be emergencies. And for each of Levels 1 -3, the proposed base payment to a FSED is more than the payment for like services when provided in a physician's office or Urgent Care clinic. The Administration does not believe, nor is there any evidence to support, that this payment methodology will negatively impact access to care to emergency department services. Subsection (D) addresses the concern in rural areas where the only hospital-based ED has closed. This is consistent with other AHCCCS payment methodologies that treat urban and rural settings differently. The rule does not encourage hospitals to establish FSEDs where ED services already exist thereby limiting opportunities for inappropriate use of FSEDs.
14.	*Comment:* We also dispute a number of assumptions the Administration makes about hospital-based FSEDs in the Preamble, including statements about the capabilities of these facilities, their role within the larger delivery system, and how they hold themselves out to their respective communities. While some of these statements may be true for certain FSEDs in the metro Phoenix area—where the garnering of market share and/or marketing objectives may be a motivating factor—they should not be generalized to all hospital-based FSEDs, particularly those located in rural and medically underserved areas.
	Response: Please see the responses to comment number 1 regarding FSED capabilities, number 5 regarding transportation for inpatient care, and number 4 regarding access to care.
15.	*Comment:* We have not seen promotional materials that present FSED as an alternative to primary care. We have queried our members as to whether they have held out their FSED services as an appropriate alternative to primary care and they have responded with a resounding "no."
	Response: Please see the response to comment number 2.
16.	*Comment:* The proposed payment reductions do not adequately address the fixed costs of all services provided at the FSED, especially those located in rural areas.

	Response: Federal law, 42 CFR 1396a(a)(30)(A) directs the State Medicaid agency to establish rates that are consistent with efficiency, economy, quality care, and access to care. In essence, federal law requires that the State pay no more or no less than necessary to assure adequate access to care. The law does not require the State to establish rates that individually meet the fixed costs of each cost center of a hospital. As the commenter noted, for level 4 and level 5 ED visits the payment to a FSED is the same as the payment to an on-site ED. The Administration does not believe, nor is there any evidence to support, that this payment methodology will materially impact aggregate hospital revenues or, more importantly, negatively impact access to care to emergency department services.
17.	*Comment:* The Preamble does not identify any data or studies used by the Administration to justify the proposed payment changes, including development of the proposed methodology, which makes it impossible to evaluate the reasonableness of this proposal.
	Response: Please see the response to comment number 7.
18.	*Comment:* The Administration should explain how it determined the appropriateness of this particular fee schedule, which will allow the public and other stakeholders, including policymakers, to more effectively evaluate the proposal.
	Response: Please see the responses to comments number 4 and 13.
19.	*Comment:* In subsection (E) it appears the cross-reference to subsection (B) should refer to subsection (A).
	Response: The AHCCCS Administration agrees and has changed the cross-reference in the final rule.
20.	*Comment:* Subsection (E) states that all hospital-based outpatient treatment centers will be reimbursed based on the non-hospital fee schedule. We recommend limiting the application of subsection (E) to FSED not associated with hospitals.
	Response: Please see the response to comment number 10. Subsection (E) was intended to

	apply only to non-hospital-based FSEDs and not to other hospital-based OTCs. The final rule has been modified to reflect this.
21.	*Comment:* Subsection C should clarify whether the proposed schedule for hospital-based FSEDs applies to all CPT codes, including ancillary service codes. We recommend excluding the latter codes and retaining their current reimbursement rate.
	Response: AHCCCS agrees that the entire claim is not subject to the percentage reduction. The reductions are applied only to the evaluation & management procedure codes for Levels 1-3. Subsection C has been modified to reflect this more clearly.
Susan Watchman of Gammage & Burnham, September 6, 2016 (Public Hearing)	
22.	*Comment:* Subsection (E), as written, sweeps in other kinds of provider-based outpatient clinics and suggests that their billing would change from being UV billers reimbursed under hospital outpatient fee schedule RF133 into 1500 billers
	Response: Please see the response to comments 10 and 20. Subsection (E) was intended to apply only to non-hospital-based FSEDs and not to other hospital-based OTCs. The final rule has been modified to reflect this.
23.	*Comment:* Subsection (D) carves out a very narrow rule exception that appears to address just one situation. FSEDs can serve a purpose in some of our underserved areas and perhaps even in urban areas, but are so disperse. By narrowing the exception so much you may actually be acting counter to desires to increase access to care in those areas
	Response: Please see the response to comment number 11.
Health System Alliance of Arizona, September 6, 2016.	
	Comment: The proposed rule was promulgated without the historical cost study on impacted systems.
	Response: Please see the response to comments number 3, 4, and 7.

Abrazo Community Health Network, September 6, 2016	
	Comment: Abrazo FSEDs are not designed or marketed as alternatives to primary care or urgent care.
	Response: Please see the response to comment number 2.
	Comment: Abrazo FSEDs are equipped with the same diagnostic equipment as the hospital attached EDs
	Response: Please see the response to comment number 1.
	Comment: Abrazo is concerned that the proposed reductions to FSED reimbursement will place financial stress on the hospital.
	Response: Please see the response to comment number 16. In addition, please see the economic, small business and consumer statement submitted to the Governor's Regulatory Review Council along with the Notice of Final Rulemaking. The AHCCCS Administration estimates that the adjustment to payments to hospital-based FSEDs represents approximately three million dollars annually to all hospitals operating such facilities.
Honor Health Network, September 1, 2016	
	Comment: Savings to AHCCCS as a result of this change in payment methodology should be used to increase reimbursement rates for hospitals in order to enhance quality of care and efficient delivery of services.
	Response: The AHCCCS Administration appreciates the suggestion; however, the use of program savings is beyond the scope of this rulemaking.

12. Other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules.

There are no other matters prescribed by statute applicable to rulemaking specific to this agency, to this specific rule, or to this class of rules.

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:

The rule does not require the provider to obtain a permit or a general permit.

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 comply with 42 U.S.C. 1396a(a)(30)(A). The AHCCCS Administration believes this rule is consistent with state and federal requirements to conserve taxpayer funds while assuring access to quality health care services.

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 such 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 rules:

The rule incorporates by reference the does not include any incorporation by reference of materials as specified in statute.

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:

The rule was not previously made, amended or repealed as an emergency rule.

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

R9-22-712.90. Reimbursement of Hospital-based Freestanding Emergency Departments

A. "Hospital-based freestanding emergency department" (FSEDs) means an outpatient treatment center as defined in R9-10-101 that: (1) provides emergency department services under R9-10-1019, (2) is subject to the requirements of 42 CFR 489.24, and (3) shares an ownership interest with a hospital, regardless of whether the outpatient treatment center operates under a hospital's single group license as described in A.R.S. § 36-422.

B. Hospital-based FSEDs shall be required to register with the Administration separately from the hospital and obtain a separate provider identification number. The Administration shall not charge a separate provider enrollment fee for registration of the hospital-based FSEDs. The Administration shall accept the hospital's compliance with the provider screening and enrollment requirements of 42 CFR Part 455 as compliance by the hospital-based FSEDs.

C. For dates of service on and after March 1, 2017, and except as provided in subsection (D), services provided by hospital-based FSEDs for evaluation and management CPT codes 99281 through 99285 shall be reimbursed at the following percentages of the amounts otherwise reimbursable under sections R9-22-712.20 through R9-22-712.30 CPT and revenue codes. All other covered codes shall be reimbursed in accordance with sections R9-22-712.20 through R9-22-712.30 without a percentage reduction.

1. 60% for a level 1 emergency department visit as indicated by CPT 99281.
2. 80% for a level 2 emergency department visit as indicated by CPT 99282.
3. 90% for a level 3 emergency department visit as indicated by CPT 99283.
4. 100% for a level 4 or 5 emergency department visit as indicated by CPT codes 99284 and 99285.

D. Hospital-based FSEDs located in a city or town in a county with less than 500,000 residents where the only hospital in the city or town operating an emergency department closed on or

after January 1, 2015, shall be reimbursed under sections R9-22-712.20 through R9-22-712.35 using the adjustment in R9-712.35 associated with the nearest hospital with which the freestanding emergency department shares an ownership interest.

E. Services provided by an outpatient treatment center that provides emergency services under R9-10-1019 but does not otherwise meet the criteria in subsection A shall be reimbursed based on the non-hospital AHCCCS capped fee-for-service schedule under R9-22-710.

F. AHCCCS will not reimburse a hospital for services provided at a hospital-based FSED if the member is admitted directly from the hospital-based FSED to a hospital with an ownership interest in the hospital-based FSED. As provided in R9-22-712.60(B), payments made for the inpatient stay using the DRG methodology shall be the sole reimbursement.