DEPARTMENT OF HEALTH

PROPOSED CHANGES TO REGULATIONS.

Medicaid Inpatient Diagnosis Related Groups (DRG) Reimbursement.

- **7 AAC 100. Medicaid Eligibility.**
- **7 AAC 105. Medicaid Provider and Recipient Participation.**
- **7 AAC 140. Medicaid Coverage; Facility and Facility-Based Services.**
- **7 AAC 145. Medicaid Payment Rates.**
- **7 AAC 150. Prospective Payment System; Other Payment.**
- **7 AAC 160. Medicaid Program; General Provisions.**

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PUBLIC REVIEW DRAFT.
July 20, 2023.

COMMENT PERIOD ENDS: September 8, 2023.

Please see the public notice for details about how to comment on these proposed changes.

Notes to reader:

1. Except as discussed in note 2, new text that amends an existing regulation is **bolded and underlined**.

2. If the lead-in line above the text of each section of the regulations states that a new section, subsection, paragraph, or subparagraph is being added, or that an existing section, subsection, paragraph, or subparagraph is being repealed and readopted (replaced), *the new or replaced text is not bolded or underlined*.

3. [ALL-CAPS TEXT WITHIN BRACKETS] indicates text that is to be deleted.

4. When the word "including" is used, Alaska Statutes provide that it means "including, but not limited to."

5. Only the text that is being changed within a section of the current regulations is included in this draft. Refer to the text of that whole section, published in the current Alaska Administrative Code, to determine how a proposed change relates within the context of the whole section and the whole chapter.

7 AAC 100.510(d)(2) is amended to read:

(2) dividing the total in (1) of this subsection by the average monthly cost to a private patient of nursing home care in the individual's community on the date of application or, if the department cannot determine the community in which the individual would receive nursing facility services, the current swing-bed rate established under **7 AAC 150.160(k)** [7 AAC 150.160(i)];

7 AAC 100.510(e)(2) is amended to read:

(2) dividing the total in (1) of this subsection by the average monthly cost to a private patient of nursing home care in the individual's community on the date of application or, if the department cannot determine the community in which the individual would receive nursing facility services, the current swing-bed rate established under **7 AAC 150.160(k)** [7 AAC 150.160(i)]; and

(Eff. 7/20/2007, Register 183; am 2/1/2010, Register 193; am 7/1/2013, Register 206; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.020 AS 47.07.040

7 AAC 105.260(f)(4) is amended to read:

(4) recoupment actions identified in an independent certified audit under **7 AAC 150.180(*l*)** [7 AAC 150.180(n)] with respect to a hospital receiving payments as a disproportionate share hospital (DSH). (Eff. 2/1/2010, Register 193; am 10/1/2011, Register 199; am 5/11/2012, Register 202; am 9/1/2013, Register 207; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040
AS 47.05.200

7 AAC 140.310(c) is amended to read:

(c) The department will pay for the central hospital service, which includes [THE COST OF] supplies and [THE COST OF] preparing, handling, and storing supplies.

(Eff. 2/1/2010, Register 193; am 1/28/2021, Register 237; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 140.320 is amended by adding a new subsection to read:

(c) If the department reimburses a provider under the Diagnosis Related Groups (DRG) methodology, the department will use the method specified in 7 AAC 150.250(a)(4) to calculate

the amount that will be reimbursed for the length of stay. (Eff. 2/1/2010, Register 193; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 145.012(a)(6) is amended to read:

(6) inflation adjustments required under **7 AAC 150.160(j)** [7 AAC 150.160(h)] as that subsection relates to 7 AAC 150.150; and

(Eff. 7/1/2015, Register 215; am 7/1/2016, Register 219; am 10/1/2017, Register 223; am 3/1/2018, Register 225; am 7/1/2019, Register 231; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.036
AS 47.07.020

7 AAC 145.600(b) is amended to read:

(b) The department will pay an out-of-state general acute care hospital **for**

(1) outpatient care services at the Medicaid rate used by the jurisdiction where the hospital is located, or if no Medicaid rate has been established, the **hospital's** Medicare rate [FOR THE HOSPITAL]**;**

(2) inpatient care services at the All Patient Refined (APR) Diagnosis Related Groups (DRG) rates established in 7 AAC 150.250.

The introductory language of 7 AAC 145.600(d) is amended to read:

(d) The department may negotiate a hospital-specific payment agreement for unique expertise or specialized services not available in **the** [THIS] state. Factors that the department will consider in the decision to negotiate a facility-specific payment agreement under this subsection include

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7 AAC 145.600(d) is amended by adding a new paragraph to read:

(6) whether 7 AAC 150.250 is applicable to the provider.

7 AAC 145.600(i) is repealed and readopted to read:

(i) The department payment to a hospital

(1) under the Diagnosis Related Groups (DRG) program in 7 AAC 150.250 includes services rendered by the hospital from the day of admission through the day of discharge, transfer to another facility, or death; or

(2) under the cost-based prospective payment system includes the day of admission but not the day of discharge, transfer to another facility, or death. (Eff. 2/1/2010, Register 193; am 7/1/2019, Register 231; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

(((Publisher, please change the period at the end of 7 AAC 145.600(d)(5) to a semicolon and move the "and" connector from 7 AAC 145.600(d)(4) to (d)(5))))

7 AAC 145.610(a) is amended to read:

7 AAC 145.610. Inpatient psychiatric hospital payment rates. (a) Except as provided in (c) of this section, the department will pay for inpatient psychiatric services provided in accordance with 7 AAC 140.350 - 7 AAC 140.365 at the **rates** [DAILY RATE] determined under 7 AAC 150.

(Eff. 2/1/2010, Register 193; am 10/1/2011, Register 199; am 4/24/2020, Register 234; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 150.030(a) is amended to read:

7 AAC 150.030. Establishment of prospective rates. (a) The department will establish prospective **per-day** payment rates in accordance with 7 AAC 150.210 for facilities not less than annually for each facility **subject to the per-day reimbursement methodology**.

7 AAC 150.030(b) is amended to read:

(b) The department **will** [MAY] establish [TEMPORARY] prospective **per-stay Diagnosis Related Groups (DRG)** payment rates **in accordance with 7 AAC 150.250 for facilities not less than triennially for each facility subject to the DRG reimbursement methodology**. [THE FINAL RATE APPROVED BY THE DEPARTMENT SUPERSEDES THE TEMPORARY RATE, AND PAYMENTS WILL BE ADJUSTED IN ACCORDANCE

WITH THE FINAL RATE.]

7 AAC 150.030 is amended by adding a new subsection to read:

(c) The department may establish temporary prospective per-day or per-stay payment rates. The final rate approved by the department supersedes the temporary rate, and the department will adjust payments in accordance with the final rate. (Eff. 2/1/2010, Register 193; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.070

7 AAC 150.040 is repealed and readopted to read:

7 AAC 150.040. Prospective rates defined. (a) Prospective payment rates are units of payment the department will pay to enrolled facilities that render services to Medicaid recipients. A facility may not charge the department an amount that exceeds the charge to the general public for the same service.

(b) Prospective payment rates are per-day rates for

(1) inpatient services rendered in general acute care hospitals, except as provided in (c) of this section, specialty hospitals, and inpatient psychiatric hospitals; and

(2) long-term care facilities.

(c) Prospective payment rates are per-stay rates for inpatient services rendered in general acute care hospitals subject to 7 AAC 150.250.

(d) Prospective payment rates are a percentage of charges for outpatient hospital services,

except for outpatient clinical laboratory services.

(e) Prospective payment rates are per-procedure rates for

(1) outpatient clinical laboratory services; and

(2) ambulatory surgical centers.

(f) Prospective payment rates are per-visit rates for

(3) rural health clinics; and

(4) federally qualified health centers.

(g) The department will establish effective dates for all prospective payment rates. The department will pay for services provided at the rate in effect at the time the service was provided. For services provided that are to be paid under different prospective payment rates, the facility must provide separate bills to the department for each prospective payment rate period. However, the department will pay at the rate in effect on the date of discharge for inpatient services rendered at general acute care hospitals subject to the Diagnosis Related Groups (DRG) payment system set out under 7 AAC 150.250. (Eff. 2/1/2010, Register 193; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.070

7 AAC 150.100 is repealed:

7 AAC 150.100. Methodology and criteria for proportionate share payments to publicly owned or operated hospitals. Repealed. (Eff. 2/1/2010, Register 193; repealed ___/___/____, Register ____)

7 AAC 150.130(b) is amended to read:

(b) If a facility **reimbursed by the department under the prospective per-day payment rate methodology set out under 7 AAC 150.160** requests inclusion of certificate of need capital, the facility shall submit its budget information to the department not less than 60 days before the beginning of the facility's fiscal year. The budget information must contain that information specified in the department's manual and must be submitted in the form and manner specified in the manual. If more than one facility is operated by the reporting organization, the information required by this subsection must be reported for each facility separately. The chief executive officer and chairperson of the governing board of the facility shall attest that the information submitted under this subsection, including any subsequent modifications, has been examined by that person and to the best of that person's knowledge the information is correct. **This subsection does not apply to a facility reimbursed by the department under the prospective per-stay or Diagnosis Related Groups (DRG) payment rate methodology under 7 AAC 150.250.** (Eff. 2/1/2010, Register 193; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.070 AS 47.07.073
AS 47.07.040 AS 47.07.071 AS 47.07.074

7 AAC 150.140(c) is amended to read:

(c) Written notice will be provided by mail **or electronic mail** to the facility during the 20-day review period if the department determines that the annual year-end report does not

contain all required and completed forms. If the department does not provide written notice during the 20-day period, the department will treat the year-end report as complete. In the notice, the department will clearly identify the deficiencies and the time by which the corrected or modified annual year-end report must be received by the department. The department will give the facility at least seven days following receipt of the notice to return to the department the corrected or modified annual year-end report.

7 AAC 150.140(f) is amended to read:

(f) A copy of the department's findings and recommendations will be **provided by mail or electronic mail** [MAILED] to the facility not less than 30 days before the date set for the public hearing to consider the facility's proposed prospective payment rate.

(Eff. 2/1/2010, Register 193; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.071 AS 47.07.073
AS 47.07.070

7 AAC 150.150(a)(2) is amended to read:

(2) for general acute care, specialty, and inpatient psychiatric hospitals' allowable capital costs and allowable home office capital costs will be adjusted using **the most recent CMS base year PPS Hospital Capital Input Price Index (IPI) reported in the IHS Markit** [GLOBAL INSIGHT] Health Care Costs, Building Cost Index [, CMS NEW1997-BASED PPS

Register ____, _____ 2023 HEALTH

HOSPITAL CAPITAL IPI];

7 AAC 150.150(g) is repealed:

(g) Repealed ___/___/____.

7 AAC 150.150(h) is repealed:

(h) Repealed ___/___/____.

7 AAC 150.150 is amended by adding a new subsection to read:

(i) This section does not apply to a hospital reimbursed under the prospective Diagnosis Related Groups (DRG) payment rate methodology set out under 7 AAC 150.250. (Eff. 2/1/2010, Register 193; am 10/1/2017, Register 223; am 7/1/2019, Register 231; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.071 AS 47.07.073

AS 47.07.070

7 AAC 150.160 is repealed and readopted to read:

7 AAC 150.160. Methodology and criteria for approval or modification of a payment rate. (a) The department will use the following methodology and criteria in reviewing and establishing prospective payment per-day and percentage-of-charges rates for the Medicaid

program:

(1) the department will consider the following with the relative importance of each criterion being a matter of department discretion:

(A) whether the costs are related to patient care and are attributable to the Medicaid program;

(B) whether the payment rate is reasonably related to costs;

(2) the department will set annual rates established for the facility's fiscal year;

(3) base years may be changed to more current years and may be subject to audit; the department may determine the timing for a re-basing under this paragraph and whether and when to conduct an audit;

(4) for all facilities, except facilities with rate agreements established under 7 AAC 150.190, the department

(A) will perform a re-basing for the first fiscal year beginning after notification to the facilities that a re-basing will be done;

(B) will perform a re-basing no less than every four years;

(C) may perform a re-basing sooner than every four years; and

(D) will not consider the first cost-based rate a re-basing.

(b) The department will express the inpatient hospital payment rate for general acute care hospitals not subject to Diagnosis Related Groups (DRG) reimbursement under 7 AAC 150.250, specialty hospitals, and inpatient psychiatric hospitals as a per-day rate. The per-day inpatient hospital payment rate will be based on allowable costs calculated in (1) - (9) of this subsection

from the appropriate base year adjusted Medicare cost report, as follows:

(1) the noncapital routine portion of the prospective per-day rate is the base year's facility-specific Medicaid noncapital routine average cost, calculated as follows, and updated to the prospective year based on adjustment factors identified in 7 AAC 150.150:

(A) the Medicaid cost of each reimbursable routine cost center is determined by dividing the total noncapital costs in each reimbursable routine cost center by the total patient days in that cost center and multiplying that quotient by the allowable paid Medicaid patient days in that cost center;

(B) the sum of the Medicaid costs for each reimbursable routine cost center is divided by the sum of the allowable paid Medicaid patient days, resulting in the base year's facility-specific Medicaid noncapital routine average cost;

(2) the routine capital portion of the prospective per-day rate is the base year's facility-specific Medicaid inpatient routine average capital cost, calculated as follows, and updated to the prospective year based on adjustment factors identified in 7 AAC 150.150:

(A) the Medicaid cost of each reimbursable capital cost center is determined by dividing the total capital costs in each reimbursable routine cost center by the total patient days in that cost center and multiplying that quotient by the allowable paid Medicaid patient days in that cost center;

(B) the sum of the Medicaid costs for each reimbursable routine capital cost center is divided by the sum of the allowable paid Medicaid patient days, resulting in the base year's facility-specific Medicaid routine average capital cost;

(3) the ancillary capital portion of the prospective per-day payment rate is determined by calculating the percentage of capital cost for each ancillary cost center, multiplying the percentage by the related Medicaid patient ancillary costs from the base year adjusted Medicare cost report, by cost center, and totaling the calculated capital costs from all cost centers; the resulting total is divided by the sum of the Medicaid patient days from the base year and updated to the prospective year based on adjustment factors identified in 7 AAC 150.150;

(4) the noncapital ancillary portion of the prospective per-day rate is the sum of Medicaid inpatient noncapital ancillary costs from the base year divided by the facility's Medicaid patient days from the base year; the resulting per-day inpatient noncapital ancillary cost is updated to the prospective year based on adjustment factors identified in 7 AAC 150.150; total Medicaid inpatient ancillary costs less the capital portion of the Medicaid inpatient ancillary costs as determined in (3) of this subsection equals the total noncapital Medicaid inpatient ancillary costs to be used for this portion of the rate;

(5) for purposes of this subsection, nursery days constitute patient days and swing-bed days do not constitute patient days;

(6) for purposes of this subsection, the costs associated with swing-bed services, determined by multiplying the number of swing-bed days by the swing-bed rate in effect in the base year, are removed before calculating the acute care per-day rate;

(7) for purposes of this subsection, Medicaid patient days are

(A) the covered days from the MR-0-14 report for routine noncapital and

routine capital costs; and

(B) facility-reported Medicaid patient days for ancillary noncapital and ancillary capital costs; after re-basing, the department may use either facility-reported Medicaid patient days or covered days from the MR-0-14 report for ancillary noncapital and capital costs;

(8) for purposes of this subsection, and except for critical access hospitals designated under 7 AAC 12.190, costs are the lower of

(A) Medicaid inpatient costs; the department will calculate those costs as the sum of

(i) Medicaid inpatient routine costs, obtained by dividing the number of Medicaid inpatient days by the total number of hospital inpatient days, as those numbers are given in the Medicare cost report and adjusted in accordance with 7 AAC 150.170 and 7 AAC 150.200, and by multiplying the resulting quotient by the total hospital inpatient routine costs, as given in the adjusted Medicare cost report; and

(ii) Medicaid inpatient ancillary costs, obtained by multiplying for each cost center the total Medicaid charges, as given in the adjusted Medicare cost report, by the cost-to-charge ratio for that cost center, and by totaling the resulting products for the aggregate amount of inpatient ancillary costs;

(B) 100 percent of charges in the aggregate to the general public; the department will calculate those charges as the sum of the

(i) inpatient routine charges to Medicaid patients, as reported in the MR-0-14 report; and

(ii) inpatient charges for ancillary services to Medicaid patients, as those charges are determined from the adjusted Medicare cost report;

(9) for purposes of this subsection, if the department determines that a provision in this chapter became effective after the last adjustment under 7 AAC 150.150 and the provision may change the per-day rate by a material amount, the department will apply the provision when the per-day rate is updated to the prospective year by the adjustment factors in 7 AAC 150.150.

(c) The department will express outpatient general acute care hospital payment rates not subject to Diagnosis Related Groups (DRG) reimbursement under 7 AAC 150.250 as a percentage of charges calculated as follows:

(1) each outpatient cost-to-charge ratio by cost center from the adjusted Medicare cost report is multiplied by the corresponding Medicaid outpatient charges to calculate the Medicaid outpatient costs by cost center;

(2) the sum of Medicaid outpatient costs by cost center is divided by the sum of Medicaid outpatient charges by cost center to obtain the percentage rate;

(3) the applicable outpatient cost-to-charge percentage may not exceed 100 percent;

(4) under this subsection, the laboratory cost center is not included in the cost centers;

(5) for purposes of this subsection, if the department determines that a provision

in this chapter became effective after the last adjustment under 7 AAC 150.150 and the provision may change the outpatient rate by a material amount, the department will apply the provision when the per-day rate established under (b) of this section is updated to the prospective year by the adjustment factors in 7 AAC 150.150.

(d) The department will express outpatient general acute care hospital payment rates for hospitals providing inpatient and outpatient services only, and subject to Diagnosis Related Groups (DRG) reimbursement under 7 AAC 150.250, as a percentage of charges, where the outpatient cost-to-charge ratio is calculated in the same manner as set out in (c) of this section.

(e) The department will express outpatient general acute care hospital payment rates for hospitals providing inpatient, outpatient, and long-term care services, and subject to Diagnosis Related Groups (DRG) reimbursement under 7 AAC 150.250, as a percentage of charges, where the outpatient cost-to-charge ratio is calculated in the same manner as set out in (c) of this section.

(f) The department will determine a rate of payment for a hospital outpatient laboratory service based on reasonable costs as determined under 42 C.F.R. 405.515, adopted by reference in 7 AAC 160.900.

(g) The department will express rates for long-term care facilities as a per-day rate calculated as follows:

(1) the long-term care noncapital routine portion of the prospective per-day rate is determined by adding together the long-term care noncapital routine costs from the base year adjusted Medicare cost report; the resulting total is divided by the sum of the facility's long-term

care patient days from the base year; the resulting per-day noncapital routine cost is updated to the prospective year based on adjustment factors identified in 7 AAC 150.150;

(2) the routine capital portion of the prospective per-day rate is the long-term care routine capital costs from the facility's base year adjusted Medicare cost report divided by the facility's total long-term care patient days from the base year; for purposes of this paragraph, the long-term care patient days are the greater of

(A) the total actual patient days; or

(B) 85 percent of licensed capacity days;

(3) the ancillary capital portion of the prospective per-day payment rate is determined by calculating the percentage of capital cost for each ancillary cost center and multiplying the percentage by the related Medicaid long-term care ancillary costs from the base year, by cost center, and totaling the calculated capital costs from all cost centers; the resulting total is divided by the sum of the Medicaid long-term care patient days from the base year;

(4) the noncapital ancillary portion of the prospective per-day rate is the Medicaid long-term care noncapital ancillary costs from the base year divided by the sum of the facility's Medicaid long-term care patient days from the base year; the resulting per-day noncapital long-term care ancillary cost is updated to the prospective year based on adjustment factors identified in 7 AAC 150.150; the total Medicaid long-term care ancillary costs less the capital portion of the Medicaid long-term care ancillary costs as determined in (3) of this subsection equals the total noncapital Medicaid long-term care ancillary costs to be used for this portion of the rate;

(5) for purposes of this subsection, Medicaid long-term care patient days are the

covered days from the MR-0-14 report;

(6) for purposes of this subsection, if the department determines that a provision in this chapter became effective after the last adjustment under 7 AAC 150.150 and the provision may change the per-day rate by a material amount, the department will apply the provision when the per-day rate is updated to the prospective year by the adjustment factors in 7 AAC 150.150;

(7) for purposes of this subsection, costs are the lower of

(A) Medicaid long-term care costs; the department will calculate those costs as the sum of

(i) Medicaid long-term routine costs, obtained by dividing the allowable routine costs by the number of total long-term care patient days, as those numbers given in the adjusted Medicare cost report, and multiplying the resulting quotient by the total Medicaid long-term care patients as adjusted in accordance with 7 AAC 150.170 and 7 AAC 150.200; and

(ii) Medicaid long-term care ancillary costs, obtained by multiplying for each allowable cost center the total Medicaid charges, as given in the adjusted Medicare cost report, by the cost-to-charge ratio for that cost center, and by totaling the resulting products for the aggregate amount of long-term care ancillary costs; or

(B) 100 percent of charges in the aggregate to the general public; the department will calculate those charges as the sum of the

(i) long-term care routine charges to Medicaid patients, as reported

on the MR-0-14 report; and

(ii) long-term care charges for ancillary services to Medicaid patients, as those charges are determined from the adjusted Medicare cost report.

(h) If the facility is granted a certificate of need under AS 18.07 to make an expenditure of at least $5,000,000, the department will allow a change in the per-day rates calculated under this section for certificate of need capital costs as follows:

(1) the department will change the per-day rate when the assets that have a certificate of need are placed in service by the facility after the base year;

(2) for facilities that provide both a long-term care component and a general acute care hospital component, budgeted capital will be allocated to each component based upon anticipated capital use for each component as determined by the department from the appropriate certificate of need documents and supporting documentation;

(3) if a facility is granted a certificate of need to make an expenditure of at least $5,000,000 to construct additional beds, additional capital payment add-on amounts to the per-day rate include the base year's patient days plus additional patient days associated with the additional beds; the additional days are calculated as the facility's base year occupancy percentage multiplied by 80 percent and multiplied by the additional beds approved in the certificate of need; the resulting figure is further multiplied by 365;

(4) the capital component of the rates will be adjusted to reflect appropriate capital costs for the prospective rate year based on certificate of need documentation, assets retired in conjunction with the certificate of need, and Medicare cost reporting requirements.

(i) If a new facility or a new psychiatric unit in a general acute care hospital, except a general acute care hospital subject to Diagnosis Related Groups (DRG) reimbursement under 7 AAC 150.250, is licensed or certified, or if a new provider begins to participate in the per-day prospective payment system, the rates for the facility will be calculated as follows:

(1) for general acute care and specialty hospitals, the inpatient per-day rate and the outpatient payment percentage will be established at the statewide weighted average of inpatient per-day rates and outpatient payment percentages of general acute care and specialty hospitals in accordance with this section for the most recent 12 months of permanent rates; patient rates are the statewide weighted average using the base year's patient days and the outpatient percentages are the statewide weighted average using the base year's outpatient charges;

(2) for an inpatient psychiatric hospital, or a separately licensed or certified psychiatric unit in a general acute care hospital, the inpatient per-day rate will be established at the statewide weighted average of inpatient per-day rates of psychiatric hospitals in accordance with this section for the most recent 12 months of permanent rates; rates are the statewide weighted average using the base year's patient days;

(3) for long-term care facilities, the rate is the sum of the

(A) swing-bed rate in effect at the start of the facility's rate year, less the average capital costs contained in the swing-bed rate; and

(B) capital costs identified by the new facility, subject to the limitations described in 7 AAC 150.170, using the greater of occupancy rates approved in the

certificate of need or 80 percent of licensed beds;

(4) rates for a new facility, a new separately licensed or certified psychiatric unit in a general acute care hospital, or a new provider subject to the per-day prospective payment system will be established under (b) - (h) of this section after two full fiscal years of cost data, timely filed with the department in accordance with 7 AAC 150.130(c), is reported.

(j) The department will determine a rate of payment for ambulatory surgical centers based on the federal Medicare ambulatory surgical center payment rates for federal fiscal year 2000, adopted by reference in 7 AAC 160.900, and as adjusted annually by the adjustment factors in 7 AAC 150.150.

(k) The department will determine a rate of payment for swing-bed services in accordance with 42 C.F.R. 447.280, adopted by reference in 7 AAC 160.900.

(*l*) Prospective payment rates for facilities that are calculated and paid on a per-day rate basis will be set at a level no greater than the per-day rates proposed in the certificate of need application and other information the applicant provided as a basis for approval of the certificate of need for the first year. The limitation set out in this subsection applies for the first year and for the two years immediately following the first year that at least one of the following events occurs:

(1) opening of the new or modified health care facility;

(2) alteration of the bed capacity;

(3) the implementation date of a change in offered categories of health service or bed capacity.

(m) The per-day rates calculated under this section may not exceed corresponding charges rendered to the general public. (Eff. 2/1/2010, Register 193; am 10/1/2017, Register 223; am 11/10/2018, Register 228; am 7/1/2019, Register 231; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.070

7 AAC 150.170(a) is amended to read:

(a) Allowable costs for prospective **per-day and percentage of charges** rates are the costs from the appropriate base year's Medicare cost report, in accordance with Medicare requirements and regulations, as audited or adjusted in accordance with this section. The department will consider only costs that are consistent with efficient, cost-effective management and operations. Only operating costs that are directly related to the delivery of health care services to Medicaid patients will be allowed for the purpose of rate setting.

7 AAC 150.170(b)(6) is amended by adding a new subparagraph to read:

(E) costs to inpatient hospital providers are limited to costs not reimbursed under the Diagnosis Related Groups (DRG) methodology set out under 7 AAC 150.250;

(Eff. 2/1/2010, Register 193; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.071 AS 47.07.073
AS 47.07.070

7 AAC 150.180 is repealed and readopted to read:

7 AAC 150.180. Methodology and criteria for additional payments as a disproportionate share hospital. (a) A qualifying hospital that provides services to a disproportionate share of low-income patients with special needs is eligible for Medicaid payments as a disproportionate share hospital (DSH). These payments are in addition to the Medicaid payment rate established under 7 AAC 150.160 or 7 AAC 150.190. The department will not award payments under this section to a qualifying hospital in a total amount that exceeds the facility-specific limit calculated under (e)(3) of this section.

(b) To qualify for additional payments under this section as a DSH, a hospital must meet the following criteria for each qualifying year:

(1) the hospital must be a general acute care hospital, a critical access hospital, a specialty hospital, or an inpatient psychiatric hospital;

(2) unless it qualifies for the exception set out in 42 U.S.C. 1396r-4(d)(2), the hospital must meet the obstetrical staffing requirements of 42 U.S.C. 1396r-4(d), and must provide the names and Medicaid provider numbers of at least two obstetricians who meet the requirements of that section;

(3) the hospital must have a minimum Medicaid utilization rate of not less than one percent for the qualifying year; for purposes of this paragraph, the Medicaid utilization rate is calculated by dividing the hospital's number of Medicaid-eligible inpatient days by the hospital's total number of inpatient days provided to all patients;

(4) not later than October 1 of the calendar year that precedes the payment period,

the hospital must submit to the department the following forms and documentation:

(A) the Medicare cost report filed for the qualifying year;

(B) Medicaid reporting forms for the qualifying year from the *Medicaid Hospital and Long-Term Care Facility Reporting Manual*, adopted by reference in 7 AAC 160.900, including the audited financial statements for the facility;

(C) an uninsured care log for the qualifying year for each patient having uninsured care; the log must be prepared and submitted in electronic spreadsheet format using the *Medicaid Log of Uninsured Care Reporting Form*, adopted by reference in 7 AAC 160.900; the hospital must certify the log as accurate in an electronic attachment with the submission of the uninsured care log; with respect to uninsured care, the log must specify, in sufficient detail for the department to verify the information,

(i) total charges;

(ii) each admission date;

(iii) the number of patient days;

(iv) any payments made by the patient, or on behalf of the patient by a third party, for services;

(v) each discharge date;

(vi) each service type;

(vii) each payment designation; and

(viii) each date service was provided for outpatient hospital services.

(c) When making a DSH classification under (d) of this section, the department will use the following data sources as applicable:

(1) for determination of Medicaid covered inpatient days, Medicaid charges, Medicaid payments, and Medicaid non-covered inpatient days, the MR-0-14 report for the qualifying year that is available at least six months after the end of the hospital's fiscal year at the time the calculation is performed;

(2) for determination and calculation of total hospital allowable costs, total inpatient hospital costs, Medicaid allowable costs, and physician costs, the Medicare cost report filed for the qualifying year and forms required by (b)(4)(A) of this section;

(3) for total hospital days, total hospital revenues, cash subsidies, and patient revenues, the forms required by (b)(4)(B) of this section;

(4) the log required by (b)(4)(C) of this section;

(5) if the department determines that a piece of data or a data source listed in (1) - (4) of this subsection is unavailable, an alternate data source that the department determines to include the same information as the sources in (1) - (4) of this subsection.

(d) A qualifying hospital may receive disproportionate share payments allocated to one or more of the following DSH classifications, if that hospital meets any additional criteria applicable to that classification, and subject to the limitations set out in (e) of this section:

(1) payments allocated to each Medicaid inpatient utilization DSH (MIU DSH), if the qualifying hospital has a state Medicaid inpatient utilization rate at least one standard deviation above the mean of state Medicaid inpatient utilization rates for all hospitals in this

state; for purposes of this paragraph,

(A) the state Medicaid inpatient utilization rate is a fraction, expressed as a percentage, of which the numerator is the hospital's number of Medicaid-eligible inpatient days in this state for the hospital's qualifying year and the denominator is the total number of the hospital's inpatient days for its qualifying year; and

(B) the mean of Medicaid inpatient utilization rates for all hospitals in the state is the fraction, expressed as a percentage, of which the numerator is the total number of Medicaid-eligible inpatient days for all hospitals in this state for their qualifying year and the denominator is the total number of inpatient days for all hospitals in this state for their qualifying year;

(2) payments allocated to each low-income DSH (LI DSH), if the qualifying hospital has a low-income utilization rate exceeding 25 percent; for purposes of this paragraph, the low-income utilization rate is calculated as the sum of

(A) the fraction, expressed as a percentage, of which the numerator is the sum of the total Medicaid hospital revenue paid to the qualifying hospital for patient services provided to Medicaid-eligible patients in this state in the hospital's qualifying year and the amount of cash subsidies received directly from the state or from local governments for patient services provided in this state in the hospital's qualifying year, and the denominator is the total amount of hospital revenue for services, including the amount of cash subsidies specified in this subparagraph for that hospital's qualifying year; and

(B) the fraction, expressed as a percentage, of which the numerator is the total amount of the qualifying hospital's charges for inpatient hospital services attributable to charity care for the hospital's qualifying year, less the portion of any cash subsidies received directly from the state or from local governments for inpatient hospital services, and the denominator is the total amount of the hospital's charges for inpatient services for the hospital's qualifying year; for a state-owned qualifying hospital that does not have a charge structure, the hospital's charges for charity care are equal to the cash subsidies received by the hospital from the state or from local governments;

(3) payments allocated to each designated evaluation and treatment DSH (DET DSH), if the qualifying hospital

(A) is designated as an evaluation and treatment facility as required by 7 AAC 72;

(B) enters into an agreement with the department to provide designated evaluation and treatment services and complies with the requirements of that agreement; and

(C) not later than 60 days after the end of each payment period, provides documentation to the department of the qualifying patients as defined in the agreement made under (B) of this paragraph; that documentation must include the number of encounters, the crisis category, the diagnosis at discharge, the provider and location of referral after discharge, and payment source information;

(4) payments allocated to each designated evaluation and stabilization DSH (DES

DSH) if the qualifying hospital

(A) is designated as an evaluation and stabilization facility as required by 7 AAC 72;

(B) enters into an agreement with the department to provide designated evaluation and stabilization treatment services and complies with the requirements of that agreement; and

(C) not later than 60 days after the end of each payment period, provides documentation to the department of the qualifying patients as defined in the agreement made under (B) of this paragraph; that documentation must include the number of encounters, the crisis category, the diagnosis at discharge, the provider and location of referral after discharge, and payment source information;

(5) payments allocated to each single-point-of-entry psychiatric DSH (SPEP DSH), if the qualifying hospital

(A) enters into an agreement with the department to provide single-point-of-entry psychiatric services and complies with the requirements of that agreement; and

(B) not later than 60 days after the end of each payment period, provides documentation to the department of the qualifying patients as defined in the agreement made under (A) of this paragraph; that documentation must include the number of encounters, the crisis category, the diagnosis at discharge, the provider and location of referral after discharge, and payment source information;

(6) payments allocated to each institution for mental disease DSH (IMD DSH), if

the IMD has been designated under 7 AAC 72 to receive involuntary commitments under AS 47.30.700 - 47.30.815;

(7) payments allocated to each children's medical care DSH (CMC DSH), if the qualifying hospital

(A) enters into an agreement with the department for medical and hospital care expenses for children in custody who are not Medicaid-eligible, and complies with the requirements of that agreement; and

(B) not later than 60 days after the end of each payment period, provides documentation to the department of the qualifying patients as defined in the agreement made under (A) of this paragraph; that documentation must include the number of encounters;

(8) payments allocated to each institutional community health care DSH (ICHC DSH), if the qualifying hospital

(A) enters into an agreement with the department for medical and hospital care expenses for individuals in institutions who are not Medicaid-eligible, and complies with the requirements of that agreement; and

(B) not later than 60 days after the end of each payment period, provides documentation to the department of the qualifying patients as defined in the agreement made under (A) of this paragraph; that documentation must include the number of encounters;

(9) payments allocated to each rural hospital clinic assistance DSH (RHCA DSH),

if the qualifying hospital

(A) enters into an agreement with the department to provide support services to a clinic; the support services that the hospital provides must include

(i) services by hospital professional employees at the clinic site; the hospital may include, as services, the services of a primary care provider, nurse midwife services, obstetrical services, and pediatrician's services; and

(ii) assistance in arranging safe transport for those who require emergency transport and services;

(B) complies with the requirements of the agreement made under (A) of this paragraph; and

(C) not later than 60 days after the end of each payment period, provides documentation to the department of the qualifying patients as defined in the agreement made under (A) of this paragraph; that documentation must include the number of encounters that the hospital provided at the clinic, and the support services as described in (A)(i) and (ii) of this paragraph;

(10) payments allocated to each mental health clinic assistance DSH (MHCA DSH), if the qualifying hospital

(A) enters into an agreement with the department to provide mental health services to a mental health clinic;

(B) complies with the requirements of the agreement made under (A) of this paragraph; and

(C) not later than 60 days after the end of each payment period, provides documentation to the department of the qualifying patients as defined in the agreement made under (A) of this paragraph; that documentation must include the number of mental health encounters that the hospital provided at the mental health clinic;

(11) payments allocated to each substance abuse treatment provider DSH (SATP DSH), if the qualifying hospital

(A) enters into an agreement with the department to provide substance abuse treatment services to a substance abuse treatment provider;

(B) complies with the requirements of the agreement made under (A) of this paragraph; and

(C) not later than 60 days after the end of each payment period, provides documentation to the department of the qualifying patients as defined in the agreement made under (A) of this paragraph; that documentation must include the number of substance abuse treatment encounters that the hospital provided through the substance abuse treatment provider.

(e) The department will determine, as of the qualification date, a hospital's eligibility for additional Medicaid payments under each classification in (d) of this section for the hospital's qualifying year, in the following manner:

(1) for the MIU or LI DSH classification, a disproportionate share payment to each qualifying hospital will be made annually; for any other DSH classification, a disproportionate share payment to each qualifying hospital will be made in accordance with the

agreement required for that classification;

(2) a disproportionate share payment is subject to the availability of appropriations from the legislature;

(3) the total annual disproportionate share payment for each qualifying hospital is subject to a facility-specific limit calculated under this paragraph and the federal requirements in 42 U.S.C. 1396r-4(g); for the hospital's qualifying year, the limit is the cost of services provided to Medicaid patients, less the amount paid to the hospital under provisions of this chapter other than this section, plus the cost of services provided to patients without health insurance or another source of third-party payments that applied to services rendered during the qualifying year, less any payments made by those patients without insurance or another source of third-party payment for those services; the hospital's cost of services for this calculation is the total hospital allowable costs, as determined in 7 AAC 150.160 and 7 AAC 150.170, divided by the hospital's total adjusted inpatient days; this result is multiplied by the total of the hospital's adjusted inpatient days not covered by insurance or third-party payment and Medicaid adjusted inpatient days; the cost of services includes the cost of excluded services under an insurance policy; the cost of services does not include amounts that were not paid to the hospital by the patient's health insurance or other source of third-party payments because of per diem maximums, coverage limitations, or unpaid patient co-payments or deductibles; for purposes of this paragraph, third-party payments do not include state payments to hospitals paid under 7 AAC 47 (general relief medical assistance) or 7 AAC 48.500 - 7 AAC 48.900 (chronic and acute medical assistance);

(4) a disproportionate share payment is not subject to the payment limitations in 7 AAC 150.160(b)(8), (c)(3), or (m);

(5) the disproportionate share payment is not used in calculating the hospital's future years' Medicaid payment rates or future disproportionate share payments;

(6) in addition to the general facility-specific limit set out in (3) of this subsection, the total disproportionate share payment amount to institutions for mental disease (IMDs) may not exceed the federal IMD disproportionate share cap in effect for the applicable fiscal year; by the qualification date each year, the department will prepare an estimate of the federal IMD disproportionate share allotment to the state and compare that estimate with the department's estimated total payment amounts to the qualifying hospitals under this section for the next federal fiscal year; if the department's estimated total payment amounts exceed the department's estimate of the federal IMD disproportionate share allotment, the disproportionate share payment amounts to each qualifying hospital for the next federal fiscal year will be adjusted downward on a prorated basis until the total amount of the disproportionate share payments for all qualifying hospitals combined is equal to the total federal IMD disproportionate share allotment to the state for the next federal fiscal year; the federal IMD disproportionate share allotment is subject to recalculation, reallocation, and recoupment, as set out in (j) of this section for the disproportionate share allotment;

(7) the department will allocate the federal disproportionate share hospital allotment as follows:

(A) for the IMD DSH classification, the department will distribute the

maximum allowed under the federal IMD disproportionate share cap and the federal IMD disproportionate share allotment;

(B) the department will allocate to the MIU DSH classification one percent of the remaining disproportionate share allotment after the allocation to the IMD DSH classification is determined;

(C) the department will allocate to the LI DSH classification one percent of the remaining disproportionate share allotment after the allocation to the IMD DSH classification is determined;

(D) the department will allocate to the DET DSH classification at least one percent but not more than 30 percent of the remaining disproportionate share allotment after deducting the allocation under (A) - (C) of this paragraph;

(E) the department will allocate to the DES DSH classification at least one percent but not more than 30 percent of the remaining disproportionate share allotment after deducting the allocation under (A) - (C) of this paragraph;

(F) the department will allocate to the SPEP DSH classification at least one percent but not more than 20 percent of the remaining disproportionate share allotment after deducting the allocations under (A) - (C) of this paragraph;

(G) the department may allocate to the CMC DSH classification from zero to 20 percent of the remaining disproportionate share allotment after deducting the allocation under (A) - (F) of this paragraph;

(H) the department may allocate to the ICHC DSH classification from

zero to 10 percent of the remaining disproportionate share allotment after deducting the allocation under (A) - (F) of this paragraph;

(I) the department may allocate to the RHCA DSH classification from zero to 35 percent of the remaining disproportionate share allotment after deducting the allocation under (A) - (F) of this paragraph;

(J) each disproportionate share payment for the MIU DSH classification will be calculated based on the qualifying hospital's SDM, divided by the sum of the SDMs of all qualifying MIU DSHs in the qualifying year; the resulting percentage will be multiplied by the allocation amount calculated in (B) of this paragraph;

(K) each disproportionate share payment for the LI DSH classification will be calculated based on the qualifying hospital's LUR, divided by the sum of the LURs of all qualifying LI DSHs in the qualifying year; the resulting percentage will be multiplied by the allocation amount calculated in (C) of this paragraph;

(L) each disproportionate share payment for the DET DSH, DES DSH, SPEP DSH, CMC DSH, ICHC DSH, RHCA DSH, MHCA DSH, and SATP DSH classifications will be based on the number of encounters to be performed by the qualifying hospital for that classification, as calculated in (D) - (I) and (M) and (N) of this paragraph;

(M) the department may allocate to the MHCA DSH classification from zero to 35 percent of the remaining disproportionate share allotment after deducting the allocation under (A) - (F) of this paragraph;

(N) the department may allocate to the SATP DSH classification from zero to 15 percent of the remaining disproportionate share allotment after deducting the allocation under (A) - (F) of this paragraph;

(O) the department may allocate a percentage greater than the maximum percentage in (D) - (I) and (M) and (N) of this paragraph only if the combined allocation under (D) - (I) and (M) and (N) of this paragraph does not exceed 100 percent of the remaining disproportionate share allotment after deducting the allocation under (A) - (D) of this paragraph and the department determines that the final allocation among all classifications will promote the availability of efficient and economic access to health care services; in making that determination, the department will consider these factors:

(i) the distribution of medical services and resources in the communities of the state;

(ii) the availability of health services to the general population in the same geographic area.

(f) The department will make to each qualifying hospital within the MIU DSH classification and to each qualifying hospital within the LI DSH classification a minimum payment of $10,000 per payment period and per classification, subject to the facility-specific limit calculated under (e)(3) of this section, the federal IMD disproportionate share cap in effect for the next federal fiscal year, and the amount of appropriations from the legislature. During a payment period, the department will not make total annual disproportionate share payments that exceed the total amount allowed under the state's federal disproportionate share allotment for the

applicable federal fiscal years. An eligible hospital choosing to participate must notify the department of the hospital's choice to participate in writing before the qualification date of the hospital's choice to participate and include one or more DSH classifications for which the hospital chooses to participate. The department's determination regarding participation by an eligible hospital is contingent upon the hospital's submission of a certified log of uninsured care for the qualifying year and a departmental determination that the hospital's facility-specific limit permits the receipt of DSH payments. The department's determination under this subsection is the department's final administrative action, unless a request for reconsideration is filed

(1) under (g) of this section, regarding whether a hospital is a qualifying hospital; or

(2) under (h) of this section, regarding the amount of a qualifying hospital's disproportionate share payment under this section.

(g) A hospital aggrieved by the department's decision under (f)(1) of this section may request reconsideration of the decision by filing a request for reconsideration with the department not later than 10 days after the date of the department's notification under (f)(1) of this section. The request for reconsideration must state the facts in the record that support a reversal of the initial decision. The department's decision on reconsideration is the department's final administrative action on a reconsideration request under this subsection. If the department does not issue a decision on reconsideration 30 days or less after the deadline for filing a request for reconsideration, and if the department does not waive the 30-day deadline, the request is considered denied by the department. The denial is the department's final administrative action

on a reconsideration request under this subsection.

(h) A qualifying hospital aggrieved by the department's determination under (f)(2) of this section may request reconsideration of the determination by filing a request for reconsideration not later than 10 days after the date of the department's list of amounts under (f) of this section. If the department has made the disproportionate share payment under this section to the qualifying hospital, the department will accept and consider a request for reconsideration under this subsection. A request for reconsideration under this subsection must state the facts in the record supporting a change in the payment amount. The department's decision on reconsideration is the department's final administrative action on a reconsideration request under this subsection. If the department does not issue a decision on reconsideration 30 days or less after the deadline for filing a request for reconsideration, and if the department does not waive the 30-day deadline, the request is considered denied by the department. The denial is the department's final administrative action on a reconsideration request under this subsection.

(i) The administrative appeal process provided under 7 AAC 150.220 and the exceptional relief process set out in 7 AAC 150.240 are not available to a hospital disputing an item on the department's list under (h) of this section of qualifying hospitals and amounts.

(j) The department will recalculate and reallocate the disproportionate share eligibility and payments for all hospitals and will recoup payments from all hospitals on a prorated basis if the

(1) disproportionate share eligibility and payment for any hospital will be recalculated as a result of a decision under (g) or (h) of this section or of a court decision; or

(2) outcome of a decision under (g) or (h) of this section or of a court decision would cause the total disproportionate share payments to exceed the federal allotment for the federal fiscal year in which the payment rate was in effect.

(k) A hospital that receives a Medicaid payment as a DSH

(1) is subject to an independent certified audit under 42 U.S.C. 1396r-4(j)(2) and 42 C.F.R. 455.300 - 455.304 three years after the payment year to determine if an overpayment occurred; and

(2) shall furnish, in addition to other information and documents required under this chapter, any additional information and documents necessary for completion of the audit.

(*l*) If an independent certified audit under 42 U.S.C. 1396r-4(j)(2) and 42 C.F.R. 455.300 - 455.304 identifies an overpayment for the payment year under review, the department will immediately issue a written determination based on the audit to recoup the amount of the overpayment from the hospital. A hospital aggrieved by a recoupment under this subsection may request reconsideration by filing a request for reconsideration with the department. The department staff that oversees Medicaid payment rates may reconsider recoupment of a DSH overpayment upon the department staff's own motion or at the hospital's request. A hospital seeking reconsideration must file a request for reconsideration not later than 30 days after the date of mailing the written determination to the hospital or providing the hospital the determination by electronic mail. The department staff shall deny a request for reconsideration as untimely if the request is filed later than 30 days after the date of mailing the written determination to the hospital or providing the hospital the determination by electronic mail. A

request for reconsideration under this subsection must be filed at the Anchorage location of the department office that oversees Medicaid payment rates. The department's decision on reconsideration is the department's final administrative action on a reconsideration request under this subsection. If the department does not issue a decision on reconsideration 30 days after receiving the request, the request is considered denied. The denial is the department's final administrative action on a reconsideration request under this subsection. However, the department may notify the hospital that the 30-day period for issuing a decision on reconsideration is tolled if the department needs to request additional information from the hospital or consult with other state or federal agencies.

(m) In this section,

(1) "adjusted inpatient days" means patient days calculated as the product of patient days multiplied by total hospital inpatient and outpatient charges, divided by hospital inpatient charges;

(2) "admission" means admission to a hospital for inpatient care;

(3) "encounter" means a unit of service, visit, or face-to-face contact that is a covered service under an agreement with the department as required under (d)(3), (4), (5), (7), (8), (9), (10), or (11) of this section;

(4) "inpatient days" means patient days at licensed hospitals that are calculated

(A) to include patient days related to a hospitalization for acute treatment of the following:

(i) injured, disabled, or sick patients;

(ii) substance abuse patients who are hospitalized for substance abuse detoxification;

(iii) swing-bed patients whose hospital level of care is reduced to nursing facility level without a physical move of the patient;

(iv) patients hospitalized for rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(v) patients in a hospital receiving psychiatric services for the diagnosis and treatment of mental illness;

(vi) newborn infants in hospital nurseries; and

(B) not to include patient days related to the treatment of patients

(i) at licensed nursing facilities;

(ii) in a residential treatment bed;

(iii) on a leave of absence from a hospital beginning with the day the patient begins a leave of absence;

(iv) who are in a hospital for observation to determine the need for inpatient admission; or

(v) who receive services at a hospital during the day but are not housed there at midnight;

(5) "Medicaid-eligible inpatient days" means patient days at licensed hospitals that are calculated

(A) to include Medicaid-covered and Medicaid-noncovered days related to

a hospitalization for acute treatment of the following:

(i) injured, disabled, or sick patients;

(ii) substance abuse patients who are hospitalized for substance abuse detoxification;

(iii) swing-bed patients whose hospital level of care is reduced to nursing facility level without a physical move of the patient;

(iv) patients hospitalized for rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(v) patients in a hospital receiving psychiatric services for the diagnosis and treatment of mental illness;

(vi) newborn infants in hospital nurseries; and

(B) not to include Medicaid covered and Medicaid non-covered patient days related to the treatment of patients

(i) at licensed nursing facilities;

(ii) in a residential treatment bed;

(iii) on a leave of absence from a hospital beginning with the day the patient begins a leave of absence;

(iv) who are in a hospital for observation to determine the need for inpatient admission; or

(v) who receive services at a hospital during the day but are not housed there at midnight;

(6) "payment designation" means a designation related to the source of reported payments;

(7) "payment period" means the state fiscal year plus 90 days;

(8) "qualification date" means July 1 of each year;

(9) "qualifying hospital" means a hospital that qualifies as a DSH under this section;

(10) "qualifying year" means the hospital's fiscal year ending

(A) at least 11 but not later than 23 months before the beginning of the state fiscal year in which the disproportionate share payment is made; and

(B) during the most recent 12-month reporting cycle in which all facilities have filed a complete year-end report with the department;

(11) "service type" means a descriptor for the type of service provided during an inpatient stay or an outpatient visit;

(12) "uninsured care" means an inpatient or outpatient hospital service furnished by a hospital to an individual who has no health insurance or other source of third-party coverage in effect at the time the service was rendered. (Eff. 2/1/2010, Register 193; am 9/1/2013, Register 207; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.070 AS 47.07.073

7 AAC 150.190(a) is amended to read:

(a) The provisions of this section apply to a small facility that

(1) had 4,000 or fewer acute care patient days at an general acute care, specialty, or inpatient psychiatric hospital or at a combined general acute care hospital-nursing facility or had 15,000 or fewer Medicaid nursing facility days at a nursing facility that is not combined with a general acute care hospital during the small facility's fiscal year that ended 12 months before the beginning of the prospective year; [AND]

(2) elects to participate in rate setting under (c) of this section**; and**

(3) is not a general acute care hospital reimbursed under the Diagnosis Related Groups (DRG) payment methodology under 7 AAC 150.250.

7 AAC 150.190(g)(3) is amended to read:

(3) a first year payment rate for long-term care will be expressed as a per-day rate as calculated in **7 AAC 150.160(g)** [7 AAC 150.160(e)]; for each complete fiscal year of the small facility that begins during the period after the first payment year of the rate agreement made under (d) of this section and that ends at the expiration of the rate agreement, the first year payment rate will be increased by updating the noncapital portion of the payment rate annually at the rate of three percent per year and by updating the capital portion of the payment rate annually at the rate of 1.1 percent per year; [FOR STATE FISCAL YEAR 2020, THE INFLATION REFERENCED IN THIS PARAGRAPH WILL NOT BE APPLIED;]

7 AAC 150.190(c)(2) is amended to read:

(2) notify the department staff that oversees Medicaid payment rates of the

facility's election on the written notification form provided by the department under this section and return the form to the department staff that oversees Medicaid payment rates **not** [NO] later than 30 days after the date of the department's **providing** [MAILING OF] the notification **by mail or electronic mail**.

The introductory language of 7 AAC 150.190(g)(4) is amended to read:

(4) the department will allow an increase in the capital component under (1) or (3) of this subsection of the prospective payment rate for new assets that the small facility places in service after its base year as set out in **7 AAC 150.160(h)** [7 AAC 150.160(f)], if

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(Eff. 2/1/2010, Register 193; am 10/1/2017, Register 223; am 7/1/2019, Register 231; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.071 AS 47.07.073
AS 47.07.070

7 AAC 150.200(d) is amended to read:

(d) The department may limit its review of a facility to a desk review. The department is not required to conduct a desk review in accordance with the auditing standards applicable to field audits. As part of a desk review, the department may submit requests for documents or production of other items, as well as requests for information or responses to specific questions. A facility will be allowed at least 15 days, but not more than 45 days, including extensions, to

provide the department with its response to the requests, as measured from the date that the department mailed**, sent by electronic mail,** or otherwise forwarded the requests to the facility. A facility's failure to timely respond to the department's requests as provided for in this subsection may result in permanent disallowance of the items in question. This section does not limit the right of a facility to appeal adjustments under 7 AAC 150.220.

(Eff. 2/1/2010, Register 193; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.071 AS 47.07.074

AS 47.07.070

7 AAC 150.210 is amended to read:

7 AAC 150.210. Procedure for establishment of rates. (a) Based on consideration of the documents submitted by the facility, audit or review of the facility**,** [AND] the facility's responses to audit or review testimony at the public hearing, and the requirements of AS 47.07 and 7 AAC 105 - 7 AAC 160, the department staff that oversees Medicaid payment rates shall establish the prospective payment rate in a written determination**. The department** [AND] shall send a copy of the written determination **and a certificate showing the date the determination was mailed or electronically delivered** to the facility. [THE WRITTEN DETERMINATION MUST BE ACCOMPANIED BY A CERTIFICATE SHOWING THE DATE OF MAILING TO THE FACILITY.]

(b) The department staff that oversees Medicaid payment rates may reconsider a prospective payment rate upon the department staff's own motion or at the facility's request. A

facility seeking reconsideration **shall** [MUST] file a request for reconsideration **not later** [NO MORE] than 30 days after the date [OF MAILING] the written determination **was mailed or electronically delivered** to the facility. The department staff shall deny a request for reconsideration as untimely if the request was [NOT] filed **later than** 30 days [OR LESS] after the date [OF MAILING] the written determination **was mailed or electronically delivered** to the facility. The notice of denial of reconsideration or the decision on reconsideration must be accompanied by a certificate showing the date **the written determination was mailed or electronically delivered** [OF MAILING TO THE FACILITY].

(c) A request for reconsideration under (b) of this section must be filed at the Anchorage office of the department with the staff that oversees Medicaid payment rates. (Eff. 2/1/2010, Register 193; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.070

The introductory language of 7 AAC 150.220(a) is amended to read:

7 AAC 150.220. Administrative appeal. (a) **Not later** [NO MORE] than 30 days after [THE DATE] a written determination under 7 AAC 150.210(a) is mailed **or electronically delivered to a facility**, a facility aggrieved by that determination may request reconsideration under 7 AAC 150.210(b) or may file a written notice of appeal with the commissioner. In the notice of appeal, the facility must

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7 AAC 150.220(a)(5) is amended to read:

(5) include a certificate **showing the date the appeal was mailed or electronically delivered** [OF MAILING].

The introductory language of 7 AAC 150.220(b) is amended to read:

(b) If a request for reconsideration under 7 AAC 150.210(b) is denied, or if a facility is aggrieved by a decision on reconsideration under 7 AAC 150.210(b), the facility may file a written notice of appeal with the commissioner **not later** [NO MORE] than 30 days after the date the denial or decision is mailed **or electronically delivered**. In the notice of appeal, the facility must

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7 AAC 150.220(b)(5) is amended to read:

(5) include a certificate **showing the date the appeal was mailed or electronically delivered** [OF MAILING].

(Eff. 2/1/2010, Register 193; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.070 AS 47.07.075

7 AAC 150.240(a) is amended to read:

7 AAC 150.240. Exceptional relief to prospective payment rate setting. (a) If application of the methodology in 7 AAC 145.700 or **in** 7 AAC 150.040 - 7 AAC 150.190 **and**

7 AAC 150.250 results in a permanent prospective payment rate that does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the facility may apply to the deputy commissioner for exceptional relief from the rate-setting methodology.

7 AAC 150.240(c) is amended to read:

(c) The facility shall provide other information requested by the deputy commissioner [IN ORDER] to evaluate the request **for exceptional relief**. If a facility fails to supply the requested information within a reasonable period, the deputy commissioner may deny the request **for exceptional relief**.

7 AAC 150.240(h) is amended to read:

(h) Exceptional relief granted under this section is effective prospectively from the date of the exceptional relief decision, and for a period [OF TIME] not to extend beyond the end of the facility's rate-setting year. A facility may apply for exceptional relief in the following year by submitting a new application under (a) of this section.

7 AAC 150.240(i) is amended to read:

(i) Notwithstanding 7 AAC 150.220, a party aggrieved by a decision of the deputy commissioner concerning exceptional relief may, **not later** [NO MORE] than 30 days after the date of mailing of the decision to that party **or the date of providing that party the decision by electronic mail**, request an administrative hearing to the commissioner of the department. The

commissioner will consider the request for appeal as untimely filed if the commissioner has not received the request 30 days or less after the deputy commissioner's mailing of the notice of the decision to the party **or providing the notice of decision to the party by electronic mail**. The exceptional relief granted by the deputy commissioner will be effective subject to adjustment based on the decision reached by the commissioner on the appeal. A copy of the commissioner's decision on appeal will be provided to the facility, to the deputy commissioner, and to the department staff that oversees Medicaid payment rates.

7 AAC 150.240(j) is amended to read:

(j) The deputy commissioner shall send copies of the decision of the deputy commissioner concerning exceptional relief to the facility, to the director of the division of the department responsible for paying Medicaid program claims, and to the department staff that oversees Medicaid payment rates. The exceptional relief decision shall be accompanied by a certificate showing the date **the decision was mailed or electronically delivered** [OF MAILING] to the persons listed in this subsection. (Eff. 2/1/2010, Register 193; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.073 AS 47.07.075
AS 47.07.070

7 AAC 150 is amended by adding a new section to read:

7 AAC 150.250. Inpatient prospective payment based on Diagnosis Related Groups

(DRG). (a) For discharges on or after January 1, 2024, the department will reimburse inpatient hospital services provided by general acute care hospitals on a per-stay basis using a Diagnosis Related Groups (DRG) payment methodology. The department will apply the DRG payment methodology to in-state general acute care hospitals, except hospitals listed in (b) of this section, and to all out-of-state hospitals. The department will designate certain out-of-state hospitals with a high volume of Medicaid claims for this state as border hospitals for reimbursement purposes. Components of the DRG payment methodology are as follows:

(1) the department will determine and assign hospital-specific DRG base rates to in-state general acute care hospitals subject to the DRG payment methodology and to designated border hospitals; the department will determine and assign a single DRG base rate to all other out-of-state hospitals;

(2) the DRG grouper used to assign inpatient stays to a DRG is an All Patient Refined Diagnosis Related Groups (APR DRG) grouper; the APR DRG system classifies each inpatient stay based on information contained in the Medicaid inpatient claim, including diagnosis codes, procedure codes, discharge status codes, and patient characteristics;

(3) DRG relative weights are derived from an APR DRG national hospital-specific relative value (HSRV) weight set for the version of the grouper that is in place; the department may scale the DRG relative weight values to represent Medicaid claims experience for this state to achieve a case mix index of 1.0;

(4) average lengths of stay are derived from an APR DRG national weight set for the version of the grouper that is in place;

(5) a Healthcare Acquired Conditions (HAC) utility is used to remove HACs from consideration in an APR DRG assignment;

(6) the department may multiply DRG relative weights by policy adjustors based on patient age or the patient's APR DRG assignment to increase or decrease reimbursement; each APR DRG is assigned to a service category determined by the department;

(7) the DRG base payment before the application of other payment adjustments is calculated as follows:

DRG base rate * APR DRG relative weight * policy adjustor = DRG base payment;

(8) transfer adjustments that are based on uniform billing discharge status codes, as set out in the American Hospital Association's *Official UB-04 Data Specification Manual*, 2024 edition, adopted by reference in 7 AAC 160.900(a), and that are based on length of stay, prorate payments as follows:

(A) transfer adjustments apply in cases where a patient is transferred to another hospital before completing the expected full course of treatment as determined by the national length of stay for the APR DRG assigned to a case;

(B) the transfer payment policy applies to the hospital making the transfer; the hospital receiving the patient is not subject to the transfer payment policy;

(C) APR DRGs that are specifically described to apply to transferred patients are exempt from transfer payment adjustments;

(D) in the transfer adjustment calculation, one day is added to the actual length of stay to reflect the higher costs of care that typically occur on the first day of an

inpatient stay;

(E) the discharge status codes triggering a transfer payment are discharge status codes 02, 05, 62, 63, 65, 66, 82, 85, 90, 91, 93, and 94;

(F) if the actual length of stay plus one is less than the national average length of stay and the discharge status code on the claim is one specified by the department to trigger the transfer adjustment, the transfer adjustment calculation is as follows:

(DRG base payment / national average length of stay) * (actual length of stay + 1) = transfer-adjusted allowed amount;

(9) the department will make outlier payments for high-cost cases; in order to receive an outlier payment, the estimated financial loss to a hospital must exceed a threshold, calculated by the department, that aims to result in outlier payments between five percent and 15 percent of total payments; the department will multiply amounts in excess of that threshold by a marginal cost percentage, as follows, to calculate outlier payments:

(A) estimated cost is calculated as: charges * cost-to-charge ratio = estimated cost;

(B) estimated gain or loss is calculated as: DRG base payment (or transfer-adjusted allowed amount if applicable) - estimated cost = estimated gain or loss;

(C) if estimated loss is greater than the cost outlier threshold, the claim qualifies for an outlier payment; the department will publish the cost outlier threshold value on the department's website;

(D) the outlier payment is calculated as: (estimated loss - cost outlier threshold) * outlier payment percentage = cost outlier payment;

(E) outlier payments are added to the DRG base payment, or transfer-adjusted allowed amount if applicable;

(10) the department will utilize a cost-to-charge ratio in the calculation of outlier payments; the department will assign a hospital-specific cost-to-charge ratio to in-state general acute care hospitals and designated border hospitals; the department will assign the in-state average cost-to-charge ratio to all other out-of-state hospitals;

(11) the department will adjust the DRG base rate for an in-state teaching hospital for direct medical education costs reported on the Medicare hospital cost report; the specific criteria and methodology for teaching hospital base rate adjustments are described in the *Alaska Provider Billing Manual*, adopted by reference in 7 AAC 160.900;

(12) the APR DRG base payment is calculated by multiplying the hospital's base rate by the relative weight and each policy adjustor; transfer adjustments and outlier payment calculations follow this initial calculation;

(13) the department will reimburse all services, supplies, and devices provided during an inpatient stay through the DRG payment; however, the department may make a payment in addition to the DRG payment for

(A) a quality incentive program; or

(B) another initiative adopted by regulation under the Administrative Procedure Act (AS 44.62).

(b) The DRG payment methodology does not apply to critical access hospitals, psychiatric hospitals, rehabilitation hospitals, and long-term acute care hospitals. Tribally owned and operated general acute care hospitals not being paid under the state payment methodology are exempted from the DRG payment methodology. Tribally owned and operated general acute care hospitals may opt in to the DRG payment methodology upon notification to the department.

(c) The department will assign a new in-state general acute care hospital or designated border hospital the in-state average base rate and cost-to-charge ratio until a hospital-specific base rate and cost-to-charge ratio can be determined during the next biennial or triennial DRG rate update.

(d) The department will periodically update base rates and other DRG system parameters. The department will make updates on a biennial or triennial basis as determined by the department. If base rates are updated triennially, the department will adjust base rates between years two and three using the most recent quarterly publication of the IHS Markit *Healthcare Cost Review*, Hospital Market Basket inflationary index, available 60 days before the beginning of a facility's fiscal year. The department will determine classification as a border hospital during the DRG update process. (Eff. ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.070 AS 47.07.073

7 AAC 150.990 is repealed and readopted to read:

(1) "adjusted Medicare cost report" means a base year's Medicare cost report that has been adjusted in accordance with 7 AAC 150.170 or 7 AAC 150.200;

(2) "All Patient Refined Diagnosis Related Groups" or "APR DRG" means a type of classification system used to assign inpatient stays to a Diagnosis Related Group (DRG), under which a grouping algorithm utilizes the diagnoses code, procedure code, patient birthdate, patient age, patient gender, admission date, discharge date, and discharge status to assign a DRG code to each claim;

(3) "assets" means all economic resources of a health facility, recognized and measured in conformity with generally accepted accounting principles; in this paragraph, "assets" include certain deferred charges that are not resources but that are recognized and measured in accordance with generally accepted accounting principles;

(4) "audit" means the systematic inspection of accounting records involving analyses, tests, or confirmations;

(5) "base year" means the facility's fiscal year ending 12 months before the fiscal year for which prospective payment rates are to be re-based;

(6) "budget" and "budgeting" mean the financial data for, and the process of, developing a capital budget for annual submission to the department, by a facility that has received a certificate of need for the facility's prospective fiscal year or for a facility that has a rate established under 7 AAC 150.160(i)(3)(B);

(7) "capital" means capital-related costs as determined in accordance with 42 C.F.R. 413.130 - 413.153, governing the Medicare cost report;

(8) "certificate" or "certificate of need" means a certificate of need required by and approved under AS 18.07 and 7 AAC 07;

(9) "charges" means amounts that patients are billed for health care services provided by a facility;

(10) "charity care" means health care services that

(A) a facility does not expect to result in cash payments; and

(B) result from a facility's policy to provide health care services free of charge to an individual who meets certain financial criteria;

(11) "clinical laboratory service" means a biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body, for the purpose of diagnosis, prevention, or treatment of a disease, or assessment of a medical condition of a human being;

(12) "CMC DSH" means a children’s medical care DSH;

(13) "commissioner" means the commissioner of health or the commissioner's designee;

(14) "cost center" means a breakout of costs on the Medicare cost report related to a particular type of service or administrative function at the facility;

(15) "department" means the Department of Health;

(16) "depreciation" means the systematic distribution of the cost or other base of a tangible asset over the estimated useful life of the asset;

(17) "deputy commissioner" means a deputy commissioner of the department or the deputy commissioner's designee;

(18) "DET DSH" means a designated evaluation and treatment DSH;

(19) "Diagnosis Related Groups" or "DRG" means a patient classification system that standardizes prospective payments to hospitals by grouping services that consume similar hospital resources;

(20) "DSH" means disproportionate share hospital;

(21) "effective date" means the date on which a new or modified prospective payment rate is determined by the department to be effective;

(22) "findings and recommendations" means the analysis of a facility prospective payment rate or amendment to the prospective payment rate, the resulting findings, and the department's recommendations relating to the acceptance or modification of a facility's proposed prospective payment rates or effective dates;

(23) "fiscal year" means a facility's operating or business year; in this paragraph, "fiscal year" includes 12 consecutive calendar months;

(24) "generally accepted accounting principles" means accounting principles approved by the Financial Accounting Standards Board (FASB);

(25) “government entity” means an entity that qualifies as a unit of government for the purposes of 42 U.S.C. 1396b(w)(6)(A);

(26) "grouper" or "DRG grouper" means a software application used to assign an inpatient hospital claim to a DRG;

(27) "IMD DSH" means an institution for mental disease DSH;

(28) "institution for mental disease" or "IMD" means a facility of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with

mental diseases, including medical attention, nursing care, and related services; whether an institution is an institution for mental disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not the facility is licensed as such;

(29) "intergovernmental transfer" means a transfer of money between state or local governments and public facilities;

(30) "licensed capacity days" means the number of beds for which the facility is licensed under 7 AAC 12.900 in the base year, multiplied by 365;

(31) "LI DSH" means a low-income DSH;

(32) "LUR" means the amount over a low-income utilization rate exceeding 25 percent as calculated in 7 AAC 150.180(d)(2);

(33) "Medicaid nursing facility day" means a nursing facility day that is a Medicaid covered day of service;

(34) "Medicaid patient day" means a patient day that is a Medicaid covered day of service;

(35) "Medicaid utilization rates" means, in acute care, the percentage of Medicaid acute care patient days within a hospital's total acute care patient days for a fiscal year;

(36) "MHCA DSH" means a mental health clinic assistance DSH;

(37) "MIU DSH" means a Medicaid inpatient utilization DSH;

(38) "MR-0-14 report" means the cost settlement detail report, generated by the department, of the claims processed and paid for by Medicaid for each facility;

(39) "new facility" means a facility that has not, during the previous 36 months, provided the same or similar level of Medicaid certified patient services within 25 miles of the facility either through present or previous ownership;

(40) "notify" means

(A) to place written notice of an action in the United States mail or other independent national post carrier, addressed to the last known address of a person;

(B) to deliver written notice by hand to a person; or

(C) to contact a person by means of electronic mail, at the electronic mail address that the person has most recently provided;

(41) "nursery day" means a calendar day related to inpatient nursing care of a newborn infant in a hospital nursery;

(42) "nursing facility day" means a calendar day of care in a nursing facility, including the day of admission and not the day of discharge;

(43) "patient day" means a calendar day of inpatient care, including the day of admission and not the day of discharge;

(44) "prospective payment rate" means the rate described in 7 AAC 150.040 and authorized by the department to be paid to a facility for services provided to Medicaid recipient;

(45) "psychiatric hospital"

(A) means a facility that primarily provides inpatient psychiatric services for the diagnosis and treatment of mental illness;

(B) does not include a residential psychiatric treatment center;

(46) "public facility" means a hospital that is, or is owned by, a government entity;

(47) "re-basing" means a change in the base year as described in 7 AAC 150.160(a)(3);

(48) "RHCA DSH" means a rural hospital clinic assistance DSH;

(49) "SATP DSH" means a substance abuse treatment provider DSH;

(50) "SDM" means the amount over a Medicaid inpatient utilization rate at least one standard deviation above the mean of state Medicaid inpatient utilization rates for all hospitals in this state as calculated under 7 AAC 150.180(d)(1);

(51) "specialty hospital" means a rehabilitation hospital that is operated primarily for the purpose of inpatient care assisting in the restoration of persons with physical disabilities;

(52) "SPEP DSH" means a single point of entry psychiatric DSH;

(53) "state" means the State of Alaska;

(54) "swing-bed day" means a calendar day related to a hospitalization for treatment of a patient whose hospital level of care is reduced to nursing facility level without a physical move of the patient;

(55) "swing-bed rate" means a rate set under 7 AAC 150.160(k);

(56) "terms of issuance" means the terms specified by a certificate of need describing the nature and extent of the activities authorized by the certificate;

(57) "uninsured care" means services provided to patients without health insurance or another source of third-party payments that applied to services rendered during the

qualifying year;

(58) "year-end report" means the report submitted to the department that contains the following:

(A) the uniform Medicare cost report as submitted to the Medicare intermediary;

(B) the Medicare home office cost statements and any audit performed by Medicare of those statements, if applicable;

(C) the Medicare provider cost report payment questionnaire;

(D) any supporting schedules sent to the Medicare intermediary with the Medicare cost report;

(E) audited financial statements specific to the reporting facility and matching the time period of the Medicare cost report that identify the facility's financial information;

(F) audit adjustments made by the financial statement auditors;

(G) reconciliation of the audited financial statements to the Medicare cost report worksheet A;

(H) the post-audit working trial balance;

(I) reconciliation of the post-audit working trial balance to the Medicare cost report worksheets A, A-8, C, and G series;

(J) appropriate Medicaid reporting forms from the *Medicaid Hospital and Long-Term Facility Reporting Manual*, adopted by reference in 7 AAC 160.900. (Eff.

2/1/2010, Register 193; am 11/10/2018, Register 228; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.070 AS 47.07.073

7 AAC 160.900(d)(20) is amended to read:

(20) *Medicaid Hospital and Long-Term Care Facility Reporting Manual*, dated **August 22, 2022** [SEPTEMBER 2005];

(Eff. 2/1/2010, Register 193; am 8/25/2010, Register 195; am 12/1/2010, Register 196; am 1/1/2011, Register 196; am 1/15/2011, Register 197; am 2/9/2011, Register 197; am 3/1/2011, Register 197; am 10/1/2011, Register 199; am 12/1/2011, Register 200; am 1/26/2012, Register 201; am 3/8/2012, Register 201; am 4/1/2012, Register 201; add'l am 4/1/2012, Register 201; am 5/11/2012, Register 202; am 10/16/2012, Register 204; am 11/3/2012, Register 204; am 12/1/2012, Register 204; am 12/2/2012, Register 204; am 1/1/2013, Register 204; am 1/16/2013, Register 205; am 7/1/2013, Register 206; add'l am 7/1/2013, Register 206; am 11/3/2013, Register 208; am 1/1/2014, Register 208; am 2/2/2014, Register 209; am 3/19/2014, Register 209; am 3/22/2014, Register 209; am 5/18/2014, Register 210; am 2/26/2015, Register 213; am 3/15/2015, Register 213; am 7/1/2015, Register 214; am 5/1/2016, Register 218; am 6/16/2016, Register 218; am 7/22/2017, Register 223; am 11/5/2017, Register 224; am 3/1/2018, Register 225; am 10/1/2018, Register 227; am 1/1/2019, Register 228; am 3/24/2019, Register 229; am 6/2/2019, Register 230; am 6/13/2019, Register 230; am 7/1/2019, Register 231; am 10/25/2019, Register 232; am 11/10/2019, Register 232; am 4/24/2020, Register 234; am 5/21/2020, Register 234; am 6/25/2020, Register 234; am 10/1/2020, Register 235; am 10/4/2020, Register 236; am

1/1/2021, Register 236; am 3/31/2021, Register 238; am 6/30/2021, Register 238; am 8/27/2021, Register 239; am 9/9/2021, Register 239; am 10/9/2021, Register 240; am 11/1/2021, Register 240; am 5/25/2022, Register 242; am 9/4/2022, Register 243; am 9/18/2022, Register 243; am 10/16/2022, Register 244; am 12/1/2022, Register 244; am 12/23/2022, Register 244; am 3/3/2023, Register 245; am 3/26/2023, Register 245; am 5/1/2023, Register 246; am 5/19/2023, Register 246; am ___/___/____, Register ____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.085

AS 47.05.012 AS 47.07.040