NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

PREAMBLE

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

R9-22-712.35	Amend
R9-22-712.61	Amend
R9-22-712.71	Amend

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

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

Implementing statute: A.R.S. § 36-2903.01(G)(12)

3. The effective date of the rule:

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

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

Notice of Rulemaking Docket Opening: 23 A.A.R. 1046, May 5, 2017

Notice of Proposed Rulemaking: 23 A.A.R. 1015, May 5, 2017

Notice of Rulemaking Docket Opening: 22 A.A.R. 784, April 8, 2016

Notice of Proposed Rulemaking: 22 A.A.R. 761, April 8, 2016

Notice of Final Rulemaking: 22 A.A.R. 2187, August 19, 2016

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

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

AHCCCS Value Based Purchasing (VBP) initiatives are strategically designed to reward quality outcomes and reduce growth in the cost of health care. The objective of VBP Differential Adjusted Payments delineated in this rulemaking is to reward hospital providers that have taken designated actions to improve patients' care experience, improve members' health, and reduce the growth of the cost of care. Hospitals which satisfy the requirements delineated in rule will receive increased payments from the AHCCCS Administration and Contractors for inpatient and outpatient services. The VBP rulemaking represent the AHCCCS Administration's expanding efforts to enhance accountability of the health care delivery system beyond the 2016-2017 timeframe. The rulemaking will amend and clarify rules specifying requirements for receipt of VBP Differential Adjusted Payments for qualifying hospitals for both inpatient and outpatient services for the time period of October 1, 2017 through September 30, 2018. Although AHCCCS' initial undertaking was reflected in rulemaking which became effective in October 2016, those rules limit VBP payments to the October 1, 2016 through September 30, 2017 timeframe and will be expiring soon. Thus, the rulemaking will authorize AHCCCS to continue rewarding innovative activities and broaden the reach of the present model, emphasizing improved patient care and reduced growth in the cost of care. Also through this rulemaking, inpatient VBP payments will be extended to hospitals that are reimbursed for inpatient services on a per diem basis rather than exclusively under the diagnostic related group (DRG) methodology as limited under the existing rules.

7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where

the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

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

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

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

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

The Administration anticipates a moderate economic impact on the implementing agency, small businesses and consumers as a result of this rulemaking. Value Based Purchasing (VBP) as reflected in this rulemaking is anticipated to result in approximately $9.1 million of additional payments for the contract year October 1, 2017 through September 30, 2018 to about 70 qualifying hospitals that have taken designated actions to improve patients' care experience, improve members' health, and reduce the growth of the cost of care for inpatient and outpatient services.

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

No changes between the proposed rulemaking and the final rulemaking have been made.

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

No comments from the public were submitted in response to the proposed rulemaking.

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

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

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

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

b. Whether a federal law is applicable to the subject of the rule, whether the rule is

more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

The rule must comply with 42 CFR 438.6 and is not more stringent than federal law.

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

No such analysis was submitted.

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

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

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

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

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

A. For all claims with a begin date of service on or before September 30, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:

1. By 48 percent for public hospitals on July 1, 2005, and hospitals that were public anytime during the calendar year 2004;

2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;

3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;

4. By 115 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the criteria during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;

5. By 113 percent for a Freestanding Children's Hospital with at least 110 pediatric beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective; or

6. By 14 percent for a University Affiliated Hospital which is a hospital that has a majority of the members of its board of directors appointed by the Board of Regents during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective.

B. For all claims with a begin date of service on or after October 1, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of- state hospital services) for the following hospitals. A hospital shall receive an increase from only one of the following categories:

1. By 73 percent for public hospitals;

2. By 31 percent for hospitals in counties other than Maricopa and Pima with more than 100 licensed beds as of October 1 of that contract year;

3. By 37 percent for hospitals in counties other than Maricopa and Pima with 100 or fewer licensed beds as of October 1 of that contract year;

4. By 100 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the critical access criteria;

5. By 78 percent for a Freestanding Children's Hospital with at least 110 pediatric beds as of October 1 of that contract year; or

6. By 41 percent for a University Affiliated Hospital, this is a hospital that has a majority of the members of its board of directors appointed by the Arizona Board of Regents.

C. In addition to subsections (A) and (B), an Arizona Level 1 trauma center as defined by R9-22-2101 shall receive a 50 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services and out-of-state hospital services) for Level 2 and 3 emergency department procedures.

D. Hospitals with greater than 100 pediatric beds not receiving an increase under subsection (B) shall receive an 18 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services).

E. For outpatient services with dates of service from October 1, ~~2016~~ 2017 through September 30, ~~2017~~ 2018, the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, ~~2016~~ 2017. To qualify, ~~a hospital providing outpatient hospital services must meet the following criteria~~:

~~1. By June 1, 2016~~ by May 15, 2017, the hospital must have executed an agreement with and electronically submitted ~~admission, discharge, and transfer information, as well as data from the hospital emergency department~~ laboratory, radiology, transcription, and medication information, plus admission, discharge, and transfer information (including data from the hospital emergency department), to a qualifying health information exchange organization~~, and~~.

~~2. No sooner than January 4, 2016, and no later than February 29, 2016, CMS must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015; or, for a children's hospital that does not participate in the Medicare electronic health record~~

~~incentive program, no sooner than January 4, 2016, and no later than the date established by CMS, the administration must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015.~~

F. Fee adjustments made under subsection (A), (B), (C), (D), and (E) are on file with AHCCCS and current adjustments are posted on AHCCCS' web site.

R9-22-712.61. DRG Payments: Exceptions

A. Notwithstanding section R9-22-712.60, claims for inpatient services from the following hospitals shall be paid on a per diem basis, including provisions for outlier payments, where rates and outlier thresholds are included in the capped fee schedule published by the Administration on its website and available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The outlier CCR will be the sum of the urban or rural default operating CCR appropriate to the location of the hospital and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. The resulting amount will be the total reimbursement for the claim. There is no provision for outlier payments for hospitals described under subsection (A)(3).

1. Hospitals designated as type: hospital, subtype; rehabilitation in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website in March of each year;

2. Hospitals designated as type: hospital, subtype: long term in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;

3. Hospitals designated as type: hospital, subtype; psychiatric in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;

B. Notwithstanding section R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the principal diagnosis on the claim is a behavioral health diagnosis, shall be reimbursed as prescribed by a per diem rate described by a fee schedule established by the Administration; however, if the principal diagnosis is a physical health diagnosis, the claim shall be processed under the DRG methodology described in this section, even if behavioral health services are provided during the inpatient stay.

C. Notwithstanding section R9-22-712.60, claims for services associated with transplant services shall be paid in accordance with the contract between the AHCCCS administration and the transplant facility.

D. Notwithstanding section R9-22-712.60, claims from an IHS facility or 638 Tribal provider shall be paid the all-inclusive rate on a per visit basis in accordance with the rates published annually by IHS in the federal register.

E. For hospitals that have contracts with the Administration for the provision of transplant services, inpatient days associated with transplant services are paid in accordance with the terms of the contract.

F. For inpatient services with a date of admission from January 1, 2018 through September 30, 2018, provided by a hospital in subsection (A) that qualifies, the administration shall pay the hospital an Inpatient VBP Differential Adjusted Payment equal to the sum of the payment otherwise provided for in subsection (A) plus the product of the amount otherwise provided for in subsection (A) and a percentage published on the Administration's public website as part of its fee schedule, subsequent to a public notice published no later than December 1,

2017. To qualify for the Inpatient VBP Differential Adjusted Payment, the exempt hospital must have:

1. Executed an agreement with a qualifying health information exchange by May 15, 2017;

2. Been determined by a qualifying health information exchange organization, based on a readiness review conducted by the organization, capable of connecting with the exchange by October 1, 2017; and

3. Electronically submitted admission, discharge, and transfer information to a qualifying health information exchange organization by October 1, 2017, including information from the emergency department if the hospital operates an emergency department.

R9-22-712.71. Final DRG Payment

The final DRG payment is the sum of the final DRG base payment, the final DRG outlier add-on payment, and the Inpatient Value Based Purchasing (VBP) Differential Adjusted Payment.

1. The final DRG base payment is an amount equal to the product of the covered day adjusted DRG base payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

2. The final DRG outlier add-on payment is an amount equal to the product of the covered day adjusted DRG outlier add-on payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

3. The factor for each hospital and for each federal fiscal year is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS administration's website and is on file for public inspection at the AHCCCS administration located at 701 E. Jefferson Street, Phoenix, Arizona.

4. For inpatient services with a date of discharge from October 1, ~~2016~~ 2017 through September 30, ~~2017~~ 2018, the Inpatient VBP Differential Adjusted Payment is the sum of the final DRG base payment and the final DRG outlier add-on payment multiplied by a percentage published on the Administration's public website as part of its fee schedule, subsequent to the public notice published no later than September 1, ~~2016~~ 2017. To qualify for the Inpatient VBP Differential Adjusted Payment, a hospital providing inpatient hospital services must ~~meet the following criteria~~:

   a. ~~By June 1, 2016~~ by May 15, 2017, ~~the hospital must~~ have executed an agreement with a qualifying health information exchange organization and electronically submitted ~~admission, discharge, and transfer information, as well as data from the hospital emergency department~~ laboratory, radiology, transcription, and medication information, plus admission, discharge, and transfer information (including data from the hospital emergency department), to a qualifying health information exchange organization~~, and~~.

   b. ~~No sooner than January 4, 2016, and no later than February 29, 2016, CMS must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015; or, for a children's hospital that does not participate in the medicare electronic health record incentive program, no sooner than January 4, 2016, and no later than the date established by CMS, the administration must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015.~~