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:**
R9-22-712.60	Amend
R9-22-712.62	Amend
R9-22-712.63	Amend
R9-22-712.64	Amend
R9-22-712.65	Amend
R9-22-712.66	Amend
R9-22-712.68	Amend
R9-22-712.71	Amend
R9-22-712.72	Amend
R9-22-712.80	Amend
R9-22-712.81	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:

January 1, 2018

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. 1811, July 7, 2017

Notice of Proposed Rulemaking 23 A.A.R. 1791, July 7, 2017

Prior to the filing of this Notice of Final Rulemaking, GRRC approved amendments to R9-22-712.71 regarding incremental payments for hospitals that qualify for a value-based purchasing adjustment. The amendments will become effective October 1, 2017. Additional information regarding the value-based purchasing amendment can be found via the following related notices published in the Register:

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 Final Rulemaking: 23 A.A.R. To be filled in by the Secretary of State

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The Arizona Health Care Cost Containment System Administration is the single state agency responsible for administration of the Medicaid program in Arizona. The program is jointly funded by the State, counties, and the federal government. Federal law imposes a substantial number of conditions on the receipt of federal financial assistance reflected in federal statutes (42 U.S.C. § 1396 et seq.) and regulation (generally, 42 C.F.R. Parts 430 through 455). While States are provided substantial flexibility with respect to the payment methods for health care providers that agree to participate, federal law does require that States "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A). State law requires the agency to adopt a diagnosis-related group (DRG) based hospital reimbursement methodology consistent with Title XIX of the Social Security Act for inpatient dates of service on and after October 1, 2014. A.R.S. § 36-2903.01(G)(12).

A DRG based hospital reimbursement methodology pays a fixed amount on a "per discharge basis." Under this methodology each claim is assigned to a DRG based on the patient's diagnoses, surgical procedures performed, age, gender, birth weight, and discharge status. The goal of diagnosis related groups is to classify inpatient stays into categories based on similar clinical conditions and on similar levels of hospital resources required for

treatment. These categories are identified using DRG codes each of which is assigned a relative weight appropriate for the relative amount of hospital resources expected to be used to treat the patient. An essential element of a DRG based hospital payment methodology is the selection of one of the several DRG classification systems. The DRG system was first implemented via rule published in 20 A.A.R. 1956, published September 6, 2014. As originally published, the Agency elected to use the All Patient Refined DRG (APR-DRG) system of codes and relative weights established and maintained by 3M Health Information Systems. At the time, the most current version of that system was version 31. More than three years have elapsed since initial implementation of APR-DRG. The original DRG reimbursement methodology was developed using Fiscal Year 2011 data from the Agency's tiered per diem system. Since that time, 3M Health Information Systems has issued version 34 of the system which is in use in the health care industry as the basis for payments by other payers. In addition, there have been updates to the national code sets used for diagnoses and procedures.

To meet its federal obligation to establish payment methodologies that are consistent with efficiency, economy, quality and access, the Agency contracted with Navigant Consulting to assess the impacts of these changes on reimbursement for inpatient hospital reimbursement (often referred to as "rebasing" the payment methodology). The current rebase will utilize updated claims and encounter data and incorporates related changes to policy and service adjustors in an effort to maintain cost effectiveness.

Hospitals may wish to take particular note of the proposed amendment to R9-22-712.72(B). The proposed amendment strikes an overly restrictive direction regarding the coding of claims when a member's enrollment changes during an inpatient stay, which direction may result in certain claims failing to qualify for the outlier payment add-on under R9-22-712.68 when such payment is appropriate. Providers should consult AHCCCS policy manuals that are incorporated by reference into the provider participation agreement for specific guidance on correct coding practices effective for claims with dates of discharge on and after January 1, 2018.

In addition, hospitals should note that the wage indices referenced in R9-22-712.62(B) include the "rural floor" such that the wage index for a hospital in any urban area cannot be less than the wage index received by rural hospitals in the same State. Use of the rural floor is required for the Medicare program under 42 C.F.R. 412.64, and the AHCCCS Administration has elected to adopt the rural floor as part of this rulemaking.

Pursuant to A.R.S. § 36-2903.01(G), the Agency promulgates rules that describe the payment methodology; however, per A.R.S. § 41-1005(A)(9), the Agency is not required to have rules that set forth the actual amounts of fee-for-service payments. As a condition of federal financial participation, the Agency is required to provide notice through its website and/or publication through the State administrative register. In addition, the State must provide an opportunity for public comment on significant proposed changes to methods and standards for payment rates. 42 U.S.C. § 1396a(a)(13) and 42 C.F.R. § 447.205. To accommodate future editions of the APR-

DRG system, changes in the national code sets, and the corresponding changes to service and policy adjustors, the Agency is proposing to remove from the text of the rule references to specific dollar amounts and other numerical factors which, going forward, will be published to the Agency's website with advanced notice and public comment prior to implementation.

For ease of reference, the amounts intended for use as of January 1, 2018 (and historical values) appear below and will be published to the Agency's website:

Rule Section (R9-22)	**Description of Value Moved to Web**	**Current Values**	**Updated Values**
R9-22-712.60(C) R9-22-712.60(F)(1)	Reference to the version of the 3M APR-DRG classification system	Version 31	Version 34
R9-22-712.62(B)	The amount of the statewide standardized amount of the base payment.	$5,295.40	$5,168.06
R9-22-712.63	The amount of the alternative to the statewide standardized amount of the base payment for urban hospitals with high Medicare utilization and short-term hospitals.	$3,436.08	$3,359.24
R9-22-712.64(A)(2)	The amount of the DRG base payment for out of state hospitals.	$5,184.75	$5,157.58
R9-22-712.65(A)	The multiplier for high-utilization hospitals	1.055	1.110
R9-22-712.66	Multipliers for service policy adjustors.	Newborns: 1.55 Neonates: 1.10 Obstetrics: 1.55 Psychiatric: 1.65 Rehab: 1.65 Children -	Newborns: 1.55 Neonates: 1.10 Obstetrics: 1.55 Psychiatric: 1.65 Rehab: 1.65 Burns: 2.70

		• Severity level 1 & 2: 1.25 • Severity levels 3 & 4 (2016): 1.60	Children - • Severity level 1 & 2: 1.25 • Severity levels 3 & 4 (2016): 1.60 • Severity levels 3 & 4 (2017): 1.945 • Severity levels 3 & 4 (2018): 2.30 All other claims: 1.025
R9-22-712.68(D)	The fixed loss amount for CAHs and all other hospitals.	CAHs $5,000 All others $65,000	CAHs $5,000 All others $65,000
R9-22-712.68(E)	The DRG marginal cost percentages for burns and all other claims.	Burns 90% All others 80%	Burns 90% All others 80%

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:

The Agency engaged the services of Navigant Consulting who modeled the estimated impact of the proposed amendments on payments to hospitals for inpatient services under the DRG payment methodology. Information regarding that model will be posted to the Agency's website, and will be located on the webpage "AHCCCS APR-DRG REBASE". https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGRebase.html.

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:

Multiple factors may influence the actual economic impact of the amendments proposed by this rulemaking, including the nature and frequency of inpatient hospital services and where those services are received. Assuming no significant changes in utilization from prior years, the Agency anticipates that the aggregate increase in expenditures as a result of this rule will be $35.5 million in additional payments to hospitals annually. Through the Medicaid program, the federal government funds a substantial percentage of the Agency's expenditures for medical services which percentage varies by eligibility category. Based on estimates

of the level of federal financial participation, the Agency estimates the proposed amendments increase State expenditures (General Fund and hospital assessment) by $8.3 million annually. The Agency does not anticipate that the rulemaking will have an effect on State revenues or materially impact political subdivisions of the State. According to hospital uniform accounting reports information filed with the Arizona Department of Health Services for 2015 (the most current information publicly available), 2 of the 104 hospitals listed reported fewer than one hundred full-time employees which qualifies those hospitals as "small businesses" under A.R.S. § 41-1001(21). The two hospitals, Arizona Orthopedic Surgical and Specialty Hospital and Arizona Spine & Joint Hospital are hospitals that are small businesses impacted by the DRG payment system. Estimates regarding the impact to those hospitals and all other hospitals participating in the AHCCCS program are posted to the Agency's website.

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

There have been no changes between the proposed rulemaking and the final rulemaking.

The AHCCCS Administration may make minor grammatical and technical corrections, as needed.

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

The AHCCCS Administration appreciates the input of stakeholders to implement the modified DRG reimbursement methodology. AHCCCS held a stakeholder's meeting on May 4, 2017 and presented the preliminary model to the stakeholders. In addition, AHCCCS presented a power point with information at the Tribal Consultation Meeting on April 20, 2017. The proposed rules were also posted on the AHCCCS website on June 16, 2017. The proposed rules were published in the Arizona Administrative Register on July 7, 2017. As part of the Arizona Administrative Procedures Act, AHCCCS allowed for public comment at the public hearing and during the comment process. The AHCCCS Administration has listed the public comments and AHCCCS response in the table below:

	COMMENT FROM COMMENTOR	**AHCCCS RESPONSE:**
1.	**Comment from Julia Strange** **Vice President, Community Benefit** **Tucson Medical Center (TMC):** Under R9-22-712.62 DRG Base Payment, AHCCCS suggests using the wage index values published August 22, 2016. Although these values were the proposed values published by CMS, final values were subsequently published in the tables of the October 5, 2016 Federal Register. Tucson Medical Center believes that using the	**AHCCCS RESPONSE:** The values published on August 22, 2016 are part of a final rule applicable to reimbursement for inpatient services under the Medicare program. On October 5, 2016, the federal government published a correction to the earlier rule. Federal law does not require the application of these same indices to the Medicaid program. AHCCCS believes that the August 22, 2016 indices more accurately reflect wage values in Arizona.

	final values as opposed to the proposed values would be more appropriate, given that it matches the wage index value in place today.	
2.	**Comment from Julia Strange** **Vice President, Community Benefit** **Tucson Medical Center (TMC):** In regards to R9-22-712.66 DRG Service Policy Adjustor, while TMC is appreciative that AHCCCS has increased the policy adjustor for neonate cases when compared to the adjustors originally shared with the state hospitals, TMC remains concerned that it will have a detrimental impact on the newborn and obstetrics adjustors. While we understand the goal of infusing additional resources into pediatrics, we believe that that investment would be more appropriately spread across all of the service lines that are primary to AHCCCS' mission - and most notably, to support services for moms, babies, and children.	**AHCCCS RESPONSE:** Per 42 U.S.C. § 1396a(a)(30)(A), AHCCCS is required to establish rates that are consistent with efficiency, economy, quality of care, and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. In essence, the federal requirement is that AHCCCS pay neither too much nor too little to achieve the goal of access to appropriate care. Spreading an "investment" across all service lines is not necessarily consistent with the federal standard. In AHCCCS opinion, the Service Policy Adjustors reflect select adjustment to payments necessary to achieve adequate access to care.
3.	**Comment from Mary Lonon** **Senior Financial Analyst, Tucson Medical Center:** Was the proposed rule updated at any point? a. I originally had that the updated standardized payment rate for TMC would go from $5,295.40 to $5,142.36. Now when I pull up the proposed rule from the AHCCCS website, it shows that the new standard payment will be $5,168.06. b. If it has been revised and the $5,168.06 is correct, can you send me a copy of the original proposed rule? I want compare, so that I make and other necessary changes.	**AHCCCS RESPONSE:** The preamble to the proposed rule originally posted to the Agency website on July 16, 2017, included inaccurate values. On July 27, 2017, AHCCCS amended the information on the website. The values published on July 27, 2016 were the values that were included in the proposed rule published by the Arizona Secretary of State. In addition to this written response, AHCCCS provided technical assistance to the commenter.
4.	**Comment from Mary Lonon** **Senior Financial Analyst, Tucson Medical Center:** In the final model version that was posted this past week, the first section states that it is V31 ***without transition***. Is this referring to the transition from the base payments when AZ rebased payments based on going from a tiered per diem to a DRG payment formula? If not, what "transition" is it referring to?	**AHCCCS RESPONSE:** The contents of the final model posted to the AHCCCS website is not incorporated into the proposed rule and was provided as information to stakeholders about the anticipated impact of the rule. As originally implemented, the DRG methodology included a three year transition period. The statement "without transition" reflects that the transition period has concluded.
5.	**Comment from Mary Lonon**	**AHCCCS RESPONSE:**

	Senior Financial Analyst, Tucson Medical Center: TMC had a shift in its wage index in recent years. Can you verify the wage index for TMC that is being used to calculate each of the V31 and V34 payments?	The wage indices applicable to TMC under the current rule and under the proposed rule are included in tables referenced in proposed R9-22-712.62. .
6.	**Comment from Dave Yoder, Senior Director - Client Services Toyon Associates, Inc.:** At MIHS, we found the latest two published exhibits to be very helpful. Our calculations based on FY2016 data were close to the published estimates for MIHS. We believe that the APR-DRG rebase does not penalize MIHS from a rate perspective. However, changes in patient volumes, in particular burn volumes, may affect the net benefit received year over year. Otherwise, we had no questions at this time, and we were interested in hearing the questions and comments from other Arizona healthcare systems.	**AHCCCS RESPONSE:** Thank you for your positive feedback.
7.	**Comment from Jim Champlin, Phoenix Children's Hospital:** In the 2014 project PCH was listed under High Medicaid Utilization Providers, why the change?	**AHCCCS RESPONSE:** One of the criteria for that designation is: "Covered inpatient days subject to DRG reimbursement, determined using adjudicated claim and encounter data during the fiscal year beginning October 1, 2015, equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals." PCH falls below that threshold.
8.	**Comment from Matt Goss, Reimbursement Manager, Dignity Health and Brandi Brashear, Reimbursement Director, Dignity Health:** We've reviewed the proposed rule and noticed that there is a new requirement to receive the high-utilization multiplier. Would the qualification requiring hospitals to receive less than $2M in outlier payments exclude St. Joseph's from getting this adjustment factor? Please let us know. What was the logic behind this additional qualifier?	**AHCCCS RESPONSE:** The new qualifier does not exclude St Joseph's Hospital which will continue to receive the high-utilization policy adjustor following the rebase. **AHCCCS RESPONSE:** This additional qualifier is further refinement to ensure the described policy adjustor receives its intended application.
9.	**Comment from John McMullin CPA, MBA, FHFMA, Chief Financial Officer at RMCHCS:** I don't see any information for RMCHCS is Gallup, NM. Are you able to help me understand	**AHCCCS RESPONSE:** Based on our FY 2016 data, Rehoboth McKinley no longer meets the threshold for a "High Utilization Out of State Hospital." For that reason, beginning 01/01/2018 under

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<td>how it will impact our AZ Medicaid population?</td>
<td>the proposed rule, Rehoboth McKinley would be reimbursed by AHCCCS under proposed A.A.C. R9-22-712.64(A)(2).
To gauge the practical effect of that, you can compare the current reimbursement values for Rehoboth McKinley (see the spreadsheet at this link, row 56: https://www.azahcccs.gov/PlansProviders/Downloads/FFSrates/APR/DRG_Provider_Table_FFY2017_20170101.xlsx) to the table below illustrating the rebased "All Other Out-of-State" reimbursement values under the proposed rule.

<table>
<tr><th>Parameter</th><th>Value</th></tr>
<tr><td>Hospital category</td><td>Out of State</td></tr>
<tr><td>Statewide Average DRG Base Rate</td><td>$5,157.58</td></tr>
<tr><td>High Medicaid Volume Hold-Harmless Adjustor</td><td>1.000</td></tr>
<tr><td>Out-of-state cost-to-charge ratio</td><td>0.240</td></tr>
<tr><td>Cost Outlier Fixed Loss Threshold</td><td>$65,000</td></tr>
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<td>10.</td>
<td>Comment from Mr. Robert Myers, Tenet Health:
Do you have a copy of the version 34 DRG table that you could send to us?</td>
<td>AHCCCS RESPONSE:
Provided table to Mr. Myers.</td>
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<td>11.</td>
<td>Comment from Greg Vigdor, President and Chief Executive Officer, AzHHA:
The Preamble to the NOPR states that state expenditures will increase by approximately $8.3 million, some of which will come from the general fund, and some from the hospital assessment. In order for stakeholders to evaluate the impact of this proposal, we recommend the Administration provide an estimate of how this proposal would impact the assessment paid by each hospital. This is especially important because some hospitals are not paid
within the APR-DRG system and would not receive any increased payments from this proposal. Moreover, the impact statement sent by the Administration to hospitals estimates that payments to thirteen hospitals and three health systems within the DRG system would be reduced under the rebase proposal. Payments to one hospital are estimated to be reduced by 4.1 %—not an inconsequential amount. While one</td>
<td>AHCCCS RESPONSE:
The impacts of the changes reflected in this proposed rule have been incorporated into the State Fiscal Year 2018 assessment amounts for individual hospitals that have been posted to the Agency’s website since May of this year.
Any future amendments to the hospital assessment will require separate rule making by the Agency. As part of any future rule making regarding the assessment, the Agency will publish the projected impact to individual hospitals. Any future amendments will include public notice and an opportunity for comments at that time.
Additionally, a hospital workgroup has been established to discuss any changes to the assessment for State Fiscal Year 2019. The first meeting of the workgroup has been scheduled for September 15, 2017.</td>
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	would expect a revenue-neutral rebasing initiative to result in estimated payment losses for some hospitals, the fact that the Administration's proposal includes additional funds, which are partially funded by the provider assessment, and the proposal includes a 1.025 policy adjustment "for all other claims" makes this proposal different. To be clear, we are not opposed to using the hospital assessment to fund a rate increase. In fact, AzHHA has previously supported the use of the assessment for this purpose. However, we feel very strongly that stakeholders should have the opportunity to understand the implications of this approach, particularly for providers who are reimbursed under different payment methodologies or who are estimated to experience reduced reimbursement under the proposal.	
12.	**Comment from Greg Vigdor, President and Chief Executive Officer, AzHHA:** However, the Administration has revised the methodology since its May meeting with stakeholders, and has not posted an updated model with the NOPR. While the Preamble states that information regarding the model would be posted to the agency's website with the publication of the NOPR, we have not been able to locate this information. We appreciate the Administration sending out hospital and health system impact information last week, but this does not provide enough information to fully evaluate the current model and its impact on access to care for Medicaid beneficiaries. We are particularly interested in understanding the rationale behind some of the policy adjusters and their corresponding weights. The APR-DRG system as a methodology takes into account high acuity cases that some providers may experience disproportionately, and the relative weights reflect the typical resources needed to care for a patient within a particular DRG category. AzHHA believes that any additional policy adjusters should be based on key Medicaid principles of enhancing access to care and/or improving quality and efficiency. Many of the policy adjusters that AHCCCS has put in place previously or that it proposes in the NOPR are typical of this approach. They target high cost service lines and/or those services on which Medicaid beneficiaries particularly rely, including pediatrics, obstetrics, and neonatology. Many other states use similar adjusters.	**AHCCCS RESPONSE:** The Arizona Administrative Procedure Act does not require the posting of models that estimate the impact of proposed rules on individual hospitals. Nevertheless, for the information of stakeholders, an updated model was posted to the Agency's website on August 7, 2017, and the comment period was extended to August 14, 2017. At the request of the AzHHA, additional information regarding the estimated payment to cost ratios was added to the model contributing to the delay in posting. All of the policy adjusters reflected in the proposed rules are based on the Agency's evaluation of adjustments that are necessary for, and consistent with, federal requirements for establishing payment methodologies consistent with efficiency, economy, quality of care, and access to care. We appreciate your support for the policy adjuster for burns and other service categories. The Agency's justifications regarding specific adjusters are addressed in responses to other comments.

	The proposal to include a policy adjuster for burn services fits this approach as well. It is a very high cost, specialized service that is critical to maintain for Medicaid Beneficiaries. If the State were to lose burn services at the one burn center in Arizona, Medicaid beneficiaries would need to be transported out of state for appropriate care. For this reason, we support including an adjuster for burn services. While we support the inclusion of a policy adjuster for burn services, we seek clarity on how the Administration developed the specific weight for this service line adjustment, as well as the weights associated with the other policy adjusters. Specifically, what is the rationale for the *specific weights* proposed by the Administration for each policy adjuster?	
13.	**Comment from Greg Vigdor, President and Chief Executive Officer, AzHHA:** There is one adjuster for which we have not been able to ascertain a specific policy rationale—regardless of the weight proposed. The Administration proposes to retain a provider adjuster for "high Medicaid utilization hospitals," and in fact proposes to double the weight for this adjuster in the rebase proposal. According to information released last week, three hospitals would qualify as "high Medicaid utilization hospitals" under the revised definition. The definition does not necessarily target hospitals with the highest Medicaid payer mix in the State, although having a Medicaid inpatient utilization rate greater than 30% for FY 2016 is one of the criteria. Rather, in order to qualify for the adjustment, a hospital for all practical purposes must be one of the largest in the State—because the adjustment is also based on the hospital having at least 400% of the statewide average number of AHCCCS-covered inpatient days during FFY 2016. All three hospitals that qualify for this provider adjustment are located in the Phoenix metropolitan area. They are surrounded by many other hospitals that offer similar services to Medicaid beneficiaries. As such, we ask the Administration to describe the policy rationale for providing additional payments to these specific hospitals. For example, how does this adjustment enhance access to care for Medicaid beneficiaries? What inpatient services do these facilities provide that beneficiaries cannot receive elsewhere nearby? What hardships would	**AHCCCS RESPONSE:** While the published model identifies three "high utilizing hospitals," under section R9-22-712.65 and 712.68 of the proposed rule, AHCCCS estimates that only one high utilizing hospital would meet all criteria including the proposed outlier threshold. Without the adjustment, this one hospital is projected to have losses under the DRG reimbursement methodology. Establishing a methodology that permits the hospital to incur a projected loss would be inconsistent with AHCCCS' obligation under the federal requirements for the Medicaid program to ensure adequate access to care. The preliminary model was precisely that – a preliminary model. While AHCCCS values the input of stakeholders, to implement the modified DRG reimbursement methodology reflected in the proposed rule by January 1, 2018, AHCCCS solicited comments on the final model through the notice and comment process established as part of the Arizona Administrative Procedures Act.

	beneficiaries encounter if they had to travel elsewhere to receive these services? If these hospitals provide specialty services that Medicaid beneficiaries cannot access elsewhere, why not provide an adjustment for those specific service lines rather than an across-the-board provider adjustment? It is vital for the integrity of the APR-DRG payment system and to promote fairness and transparency that stakeholders fully understand the policy rationale for each adjustment. This is especially true for this particular adjustment because (1) the adjustment was modified after the preliminary model was released, and there has been no public discussion on it since then; (2) other hospitals may be paying for this adjustment through an increase to their provider assessment; and (3) the qualifying providers will continue to receive the adjustment regardless of whether their Medicaid utilization or other factors shift from year to year—at least until the rule is next modified.	
14.	**Comment from Greg Vigdor, President and Chief Executive Officer, AzHHA:** In the NOPR, the Administration is also proposing to no longer set the APR-DRG base amounts and weights through the rulemaking process. We are opposed to this proposal. The rulemaking process requires a certain level of accountability for agencies–regardless of who is leading the agency at a particular time. While rulemakings can be cumbersome for state agencies, the public benefits from this accountability and transparency. If the Administration chooses to move ahead with eliminating the base payment amounts and weights from the Administration's rules and instead adjusting them periodically on the Administration's website, we strongly recommend that the proposed rules be modified to include a requirement that the Administration publish modeling information and hospital impact analyses, and hold meetings with stakeholders when changes are proposed to the payment methodology, including changes to base amounts, weights and policy adjusters.	**AHCCCS RESPONSE:** As stated in the preamble to the proposed rule, pursuant to A.R.S. § 36-2903.01(G), the Agency promulgates rules that describe the payment methodology; however, per A.R.S. § 41-1005(A)(9), the Agency is not required to have rules that set forth the actual amounts of fee-for-service payments. As a condition of federal financial participation, the Agency is required to provide notice through its website and/or publication through the State administrative register when proposing a change to the payment methodology. In addition, the State must provide an opportunity for public comment on significant proposed changes to methods and standards for payment rates. 42 U.S.C. § 1396a(a)(13) and 42 C.F.R. § 447.205. Going forward, references to specific dollar amounts and other numerical factors will be published to the Agency's website with advanced notice and public comment prior to implementation. This approach is necessary to accommodate future editions of the APR-DRG system, changes in the national code sets, and the corresponding changes to service and policy adjustors.
15.	**Comment from Greg Vigdor, President and Chief Executive Officer, AzHHA:** Finally, we would like to thank the Administration for the change it made to the original model regarding the wage index. We	**AHCCCS RESPONSE:** The Agency appreciates your support with respect to the changes to the wage index.

	support the inclusion of the "rural floor," which is also used by the Medicare program. AzHHA appreciates the opportunity to provide comments on this rulemaking.	
16.	**Comment from Craig McKnight, Executive VP, Chief Financial Officer, Phoenix Children's Hospital:** The first relates to the qualifying calculation for High Medicaid Utilization Providers. One of the factors of the criteria for that designation is, "covered inpatient days subject to DRG reimbursement, determined using adjudicated claim and encounter data during the fiscal year beginning October 1, 2015, equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals." This calculation compares total AHCCCS days at each facility to the Statewide average. We would suggest that a more relevant measurement for High Medicaid Utilization providers would be a calculation that better represents the extent to which each hospital has dedicated its resources to Medicaid patient services. This calculation should include a factor for or be based on the comparison of AHCCCS days as compared to the total inpatient days of each facility. Utilizing AHCCCS payor mix would show that Phoenix Children's percentage of AHCCCS patient days is over 62%, among the very highest in Arizona. It is worth noting that the State data shows that the average AHCCCS inpatient payor mix is 27%. This shows that PCH is impacted to a much greater degree by AHCCCS APR-DRG reimbursement than most AZ Hospitals while being one of largest hospitals by AHCCCS days and should be considered a High Medicaid Usage facility.	**AHCCCS RESPONSE:** We agree that there are many different methods that could be used to identify high utilizing hospitals. We disagree that the method proposed by the commenter would materially improve the analysis compared to the methodology set forth in the rule. The current rule continues the methodology for identifying high utilizing hospitals that has been in place for the past several years. With the addition of the outlier criteria, the proposed methodology is consistent with the federal standard for establishing a reimbursement methodology that is consistent with efficiency, economy, quality of care, and access to care, and with the objective of not incurring expenditures for inpatient services above the level necessary to meet that standard.
17.	**Comment from Craig McKnight, Executive VP, Chief Financial Officer, Phoenix Children's Hospital:** The second area of concern for PCH is the data utilized in the study. PCH would have welcomed being involved in validating the data gathered for the study. As it is, the reported patient days for PCH are 19% below the level that PCH reports as AHCCCS patient days for that same time period and is below the level that we report annually on our Cost Report as Title XIX Days (excluding observation). Using corrected data would materially impact the representation of PCH. The costs as reported of $127,403,159 do not	**AHCCCS RESPONSE:** We disagree that the data from the AHCCCS claims and encounter system is invalid. That data is a representative and easily available source that AHCCCS employed for its analysis for the entire system. This is the same data source that is attested to by certified actuaries and accepted by the federal government as the basis for capitation payments to managed care organizations. To the extent the commenter is suggesting that every hospital should have the opportunity to validate data or that the analysis should rely on hospital-reported

	represent PCH's cost to provide care for AHCCCS patients. Total costs for that time period related to AHCCCS inpatients were $177,058,162. Subtracting this from the calculated reimbursement as reported of $190,302,017, produces a payment-to-cost ratio of 1.07, not the 1.49 reported.	data, the suggestion is administratively impractical. In addition, given that identification of high utilizing hospital is determined relative to the utilization of all hospitals, it is uncertain at best that a different data source would result in any improvement to the analysis or the outcome of the analysis.
18.	**Comment from Craig McKnight, Executive VP, Chief Financial Officer, Phoenix Children's Hospital:** Lastly, Supplemental payments are a factor in the calculations included in the study report, the inclusion and degree of which can preclude facilities from receiving various policy adjusters. Phoenix Children's is in the process of transitioning away from the Safety Net Care Pool that has recently provided the majority of supplemental payments, including those in this survey. To the extent to which supplemental payments is a factor in these calculations, we would ask that decisions made regarding future reimbursement levels take into consideration that PCH will no longer be receiving SNCP once the current approved SNCP has been distributed.	**AHCCCS RESPONSE:** The commenter incorrectly assumes that supplemental payments affect the application of the adjusters included in the rule. Supplemental payments were not a factor considered in those determinations. At the request of stakeholders based upon input on the preliminary model, the final model includes data on supplemental payments for informational purposes.
19.	**Comment from Linda Hunt, Sr. Vice President of Operations & President/CEO, Arizona, Dignity Health** **Shirley Gunther, VP of External Affairs, Arizona** **Dignity Health, Arizona Service Area Office:** **R9-22-712.65 DRG Provider Policy Adjustor** The Proposed Rule takes into account the unique populations and the high level of acuity served in high-utilization acute care facilities. Hospitals that meet the criteria of a high-utilization provider should be adequately compensated to meet high acuity and frequency of such patients. SJHMC is one of Arizona's first intercity urban acute care hospitals that delivers world-class and as such is one of the State's largest high-utilizers for a subset of patients. **Therefore, we strongly support and urge the adoption of the provider adjustment as it addresses the inequities high-utilization hospitals incur.**	**AHCCCS RESPONSE:** AHCCCS appreciates the commenter's support.
20.	**Comment from Linda Hunt, Sr. Vice President of Operations & President/CEO, Arizona, Dignity Health** **Shirley Gunther, VP of External Affairs, Arizona** **Dignity Health, Arizona Service Area Office:** **R9-22-712.66. DRG Service Policy Adjustor** Dignity Health requests "neurology" services to	**AHCCCS RESPONSE:** While the Agency appreciates and values the skilled services provided by the Barrow Neurological Institute, the Agency has determined that the proposed reimbursement structure, including policy adjustors, is adequate to ensure access to quality care and comply with federal requirements to

	be added to the policy adjustors under the Proposed Rule. Like the other services listed in R9-22-712.66, neurology patients are acutely ill patients with diseases of the brain, spinal cord and nervous system issues that often have associated medical problems complicating their care. The Barrow Neurological Institute at SJHMC is known throughout the U.S. and world as a leader in brain and spine patient care often taking the most complex cases other facilities can't or won't consider. The Barrow preforms more brain surgeries than any other hospital in the United States. It is our experience that claims/encounters data are disproportionately high for this service and the hospital resources required to treat the acuity and complex conditions of these patients justifies the need for neurology to be included the Service Policy Adjustor. **For those reasons, Dignity Health requests that the AHCCCS Administration consider including "neurology" to Service Policy Adjustors in this Proposed Rule.**	establish methodologies consistent with efficiency and economy.
21.	**Comment from Jason Bezozo** **Vice President, Government Relations, Banner Health:** Under the proposed rule, eligible hospitals for the high-utilization policy adjuster would also need to have less than $2 million in outlier payments in FFY 16. Banner would strongly urge AHCCCS to maintain the historical eligibility criteria and eliminate the proposed outlier test. The purpose of outlier payments is to reimburse providers for extraordinary costs that are not represented in the base APR-DRG reimbursement methodology. The inclusion of an outlier test for this adjuster unfairly penalizes high-Medicaid volume hospitals solely based on the provider's presentation of unusually high-cost Medicaid patients. Based on the DRG projections provided by AHCCCS, this proposed addition would preclude both Banner Desert Medical Center and Banner-University Medical Center Phoenix from being eligible for the high-utilization policy adjuster. Both of these facilities have very high Medicaid inpatient utilization compared to other hospitals across the state and should be included in this peer group—not excluded. As AHCCCS prepares to finalize the proposed	**AHCCCS RESPONSE:** We disagree that the outlier test unfairly penalizes high utilizing hospitals. Receipt of projected outlier payments in excess of $2 million results in the hospital receiving adequate reimbursement for extraordinary costs above the DRG. Thus, an additional adjuster for these hospitals is not necessary. Under sections R9-22-712.65 and 712.68 of the proposed rule, AHCCCS estimates that only one high utilizing hospital would meet all criteria including the proposed outlier threshold. Without the adjustment, this one hospital is projected to have losses under the DRG reimbursement methodology. In contrast, other high utilizing hospitals that do not meet the outlier threshold are not projected to have losses. Adoption of the commenter's suggestion would increase AHCCCS expenditures for inpatient hospital services without an anticipated commensurate increase in quality or access to care. This would be inconsistent with the federal standard for establishing a reimbursement methodology that is consistent with efficiency, economy, quality of care, and access to care.

	rule changes to the APR-DRG payment system, we would strongly urge the AHCCCS Administration to establish a payment system that reimburses all high-Medicaid utilization hospitals equally. With AHCCCS covering over 1.9 million Arizonans, nearly 28% of the state population, AHCCCS has the ability to create distortions in the marketplace. That should not be the role of government which is why it is important to treat all providers and peer groups fairly and equally. Thank you	

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 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:

R9-22-712.62(B) references the labor share for the Medicare inpatient prospective payment system published in Volume 81 of the Federal Register at page 57312 and the wage index tables referenced in Volume 81 of the Federal Register at page 57311 for the fiscal year beginning October 1, 2016.

R9-22-712.71(4)(b) references 42 C.F.R. § 495.22.

R9-22-712.81 references 42 C.F.R. § 447.205.

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

Section

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-712.60. Diagnosis Related Group Payments

A. Inpatient hospital services with discharge dates on or after October 1, 2014, shall be reimbursed using the diagnosis related group (DRG) payment methodology described in this section and sections R9-22-712.61 through R9-22-712.81.

B. Payments made using the DRG methodology shall be the sole reimbursement to the hospital for all inpatient hospital services and related supplies provided by the hospital. Services provided in the emergency room, observation area, or other outpatient departments that are directly followed by an inpatient admission to the same hospital are not reimbursed separately. Are reimbursed through the DRG methodology and not reimbursed separately.

C. Each claim for an inpatient hospital stay shall be assigned a DRG code and a DRG relative weight based on ~~version 31 of~~ the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. ~~If version 31 of the APR-DRG classification system will no longer support assigning DRG codes and relative weights to claims, and 3M Health Information Systems issues a newer version of the APR-DRG classification system using updated DRG codes and/or updated relative weights, then~~

~~an updated version established by 3M Health Information Systems will be used; however,~~ The applicable version of the APR-DRG classification system shall be available on the agency's website. ~~if the posted version employs updated relative weights, those weights will be adjusted using a single adjustment factor applied to all relative weights if necessary to ensure that the statewide weighted average of the updated relative weights does not increase or decrease from the statewide weighted average of the relative weights used under version 31~~.

D. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to quick pay discounts and slow pay penalties under A.R.S. 36-2904.

E. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to the Urban Hospital Reimbursement Program under R9-22-718.

F. For purposes of this section and sections R9-22-712.61 through R9-22-712.81:

1. "DRG National Average length of stay" means the national arithmetic mean length of stay published in ~~version 31 of~~ the All Patient Refined Diagnosis Related Group (APR-DRG) classification established by 3M Health Information Systems.
2. "Length of stay" means the total number of calendar days of an inpatient stay beginning with the date of admission through discharge, but not including the date of discharge (including the date of a discharge to another hospital, i.e., a transfer) unless the member expires.
3. "Medicare" means Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq*.
4. "Medicare labor share" means a hospital's labor costs as a percentage of its total costs as determined by CMS for purposes of the Medicare Inpatient Prospective Payment System.

R9-22-712.62. DRG Base Payment

A. The initial DRG base payment is the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code assigned to the claim, and any applicable provider and service policy adjustors.

B. The DRG base rate for each hospital is the statewide standardized amount of which the hospital's labor-related share of that amount is adjusted by the hospital's wage index~~,~~. ~~where the standardized amount is $5,295.40, and the~~ The hospital's labor share is determined based on the labor share for the Medicare inpatient prospective payment system published in Volume 81 of the Federal Register at page 57312 published August 22, 2016. ~~and the~~ The hospital's wage index ~~are those used in the Medicare inpatient prospective payment system for the fiscal year beginning October 1, 2013~~ is determined based on the wage index tables reference in Volume 81 of the Federal Register at page 57311 published August 22, 2016. The statewide standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.

C. Claims shall be assigned both a DRG code derived from all diagnosis and surgical procedure codes included on the claim (the "pre-HCAC" DRG code) and a DRG code derived excluding diagnosis and surgical procedure codes associated with the health care acquired conditions that were not present on admission or any other provider-preventable conditions (the "post-HCAC" DRG code). The DRG code with the lower relative weight shall be used to process claims using the DRG methodology.

R9-22-712.63. DRG Base Payments Not Based on the Statewide Standardized Amount

A. Notwithstanding section R9-22-712.62, ~~the amount of $3,436.08~~ a select specialty hospital standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) to calculate the DRG base rate for the following hospitals:

1. Hospitals located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2011 Medicare Cost Report are reimbursed by Medicare.
2. Hospitals designated as type: hospital, subtype: short-term that has a license number beginning "SH" in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year.

B. The select specialty hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.

R9-22-712.64. DRG Base Payments and Outlier CCR for Out-of-State Hospitals

A. DRG Base payment:

1. For high volume out-of-state hospitals defined in subsection (C), the wage adjusted DRG base payment is determined as described in R9-22-712.62.
2. Notwithstanding subsection R9-22-712.62 the wage adjusted DRG base rate for out-of-state hospitals that are not high volume hospitals shall be ~~$5,184.75~~ included in the AHCCCS capped fee schedule available on the agency's website.

B. Outlier CCR:

1. Notwithstanding subsection R9-22-712.68, the CCR used for the outlier calculation for out-of-state hospitals that are not high volume hospitals shall be the sum of the statewide urban default operating cost-to-charge ratio and the statewide capital CCR in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
2. The CCR used for the outlier calculation for high volume out-of-state hospitals is the same as in-state hospitals as described in R9-22-712.68.

C. A high volume out-of-state hospital is a hospital not otherwise excluded under R9-22-712.61, that is located in a county that borders the State of Arizona and had 500 or more AHCCCS covered inpatient days for the fiscal year beginning October 1, ~~2010~~ 2015.

D. Other than as required by this section, DRG reimbursement for out-of-state hospitals is determined under R9-22-712.60 through R9-22-712.81.

R9-22-712.65. DRG Provider Policy Adjustor

A. After calculating the DRG base payment as required in sections R9-22-712.62, R9-22-712.63, or R9-22-712.64,

for claims from a high-utilization hospital, the product of the DRG base rate and the DRG relative weight for the post-HCAC DRG code shall be multiplied by a provider policy adjustor ~~of 1.055~~ that is included in the AHCCCS capped fee schedule available on the agency's website.

B. A hospital is a high-utilization hospital if the hospital had:

1. ~~At least 46,112 AHCCCS covered~~ Covered inpatient days subject to DRG reimbursement, determined using adjudicated claim and encounter data during the fiscal year beginning October 1, ~~2010~~ 2015, ~~which is~~ equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals ~~of 11,528 days~~; ~~and,~~
2. A Medicaid inpatient utilization rate greater than 30% calculated as the ratio of AHCCCS-covered inpatient days to total inpatient days as reported in the hospital's Medicare Cost Report for the fiscal year ending ~~2011~~ 2016; and,
3. Received less than $2 million in add-on payment for outliers under R9-22-712.68, based on adjudicated claims and encounters for fiscal year beginning October 1, 2015.

R9-22-712.66. DRG Service Policy Adjustor

In addition to subsection R9-22-712.65, for claims with DRG codes in the following categories, the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code, and the DRG provider policy adjustor shall be multiplied by the service policy adjustor listed in the AHCCCS capped fee schedule, available on the agency's website, corresponding to the following DRG codes ~~following service policy adjustors~~:

1. Normal newborn DRG codes~~: 1.55.~~
2. Neonates DRG codes~~: 1.10.~~
3. Obstetrics DRG codes~~: 1.55.~~
4. Psychiatric DRG codes~~: 1.65.~~
5. Rehabilitation DRG codes~~: 1.65.~~
6. Burn DRG codes.
7. ~~6~~. Claims for members under age 19 assigned DRG codes other than listed above:
   a. ~~1.25 for~~ For dates of discharge occurring on or after October 1, 2014 and ending no later than December 31, 2015 regardless of severity of illness level,
   b. ~~1.25 for~~ For dates of discharge on or after January 1, 2016, for severity of illness levels 1 and 2,
   c. ~~1.60 for~~ For dates of discharge on or after January 1, 2016 and before January 1, 2017, for severity of illness levels 3 and 4.
   d. For dates of discharge on or after January 1, 2017, and before January 1, 2018 for severity of illness levels 3 and 4.
   e. For dates of discharge on or after January 1, 2018, for severity of illness levels 3 and 4.
8. Claims for members assigned DRG codes other than listed above.

R9-22-712.68. DRG Reimbursement: Unadjusted Outlier Add-on Payment

A. Claims for inpatient hospital services qualify for an outlier add-on payment if the claim cost exceeds the outlier cost threshold.

B. The claim cost is determined by multiplying covered charges by an outlier CCR as described by the following subsections:

1. For hospitals designated as type: hospital, subtype: children's in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year. The outlier CCR will be calculated by dividing the hospital total costs by the total charges using the most recent Medicare Cost Report available as of September 1 of that year.
2. For Critical Access Hospitals the outlier CCR will be the sum of the statewide rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
3. For all other hospitals the outlier CCR will be the sum of the operating cost-to-charge ratio and the capital cost-to-charge ratio established for each hospital in the impact file established as part of the Medicare Inpatient Prospective Payment System by CMS.

C. AHCCCS shall update the CCRs described in subsection (B) to conform to the most recent CCRs established by CMS as of September 1 of each year, and the CCRs so updated shall be used ~~For~~ for claims with dates of discharge on or after October 1 of that year.

D. The outlier threshold is equal to the sum of the unadjusted DRG base payment plus the fixed loss amount. The fixed loss amount ~~is $5,000~~ for critical access hospitals and ~~$65,000~~ for all other hospitals are included in the AHCCCS capped fee schedule available on the agency's website.

E. For those inpatient hospital claims that qualify for an outlier add-on payment, the payment is calculated by subtracting the outlier threshold from the claim cost and multiplying the result by the DRG marginal cost percentage. The DRG marginal cost percentage ~~is 90%~~ for claims assigned DRG codes associated with the treatment of burns and ~~80%~~ for all other claims are included in the AHCCCS capped fee schedule available on the agency's website.

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. For claims with dates of discharge prior to January 1, 2018, ~~The~~ 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. For claims with dates of discharge on and after January 1, 2018, no adjustment will be made to limit the financial impact to individual hospitals of the transition from the tiered per diem

payment methodology or to account for improvements in documentation and coding.

2. For claims with dates of discharge prior to January 1, 2018, ~~The~~ 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. For claims with dates of discharge on and after January 1, 2018, no adjustment will be made to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology or to account for improvements in documentation and coding.
3. The factor for each hospital and for ~~each federal fiscal year~~ claims with dates of discharge prior to January 1, 2018 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, 2017 through September 30, 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, 2017. To qualify for the Inpatient VBP Differential Adjusted Payment, a hospital providing inpatient hospital services must by May 15, 2017, have executed an agreement with a qualifying health information exchange organization and electronically submitted 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.

R9-22-712.72. DRG Reimbursement: Enrollment Changes During an Inpatient Stay

A. If a member's enrollment changes during an inpatient stay, including changing enrollment from fee-for-service to a contractor, or vice versa, or changing from one contractor to another contractor, the contractor with whom the member is enrolled on the date of discharge shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in sections R9-22-712.60 through R9-22-712.81. If the member is eligible but not enrolled with a contractor on the date of discharge, then the AHCCCS administration shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in sections R9-22-712.60 through R9-22-712.81.

B. When a member's enrollment changes during an inpatient stay, the hospital shall use the date of enrollment with the payer responsible on the date of discharge as the "from" date of service on the claim regardless of the date of admission. ~~The claim may include all surgical procedures performed during the entire inpatient stay, but the hospital shall only include revenue codes, service units, and charges for services performed on or after the date of enrollment~~.

C. Interim claims submitted to a payer other than the payer responsible on the day of discharge shall be processed in the same manner as other interim claims as described in R9-22-712.76.

R9-22-712.80. DRG Reimbursement: New Hospitals

A. DRG base payment for new hospitals. For any hospital that does not have a labor share or wage index published by CMS as described in section R9-22-712.62(B) because the hospital was not in operation, the DRG base rate described in section R9-22-712.62(B) shall be calculated as the statewide standardized amount ~~of $5,295.40~~ after adjusting that amount for the labor-related share and the wage index published by CMS as described in section R9-22-712.62(B) that is appropriate to the location of the hospital published by CMS as described in section R9-22-712.62(B).

B. Outlier calculations for new hospitals. For any hospital that does not have an operating cost-to-charge ratio listed in the impact file described in section R9-22-712.68(B) because the hospital was not in operation prior to the publication of the impact file, the statewide urban or rural default operating cost-to-charge ratio appropriate to the location of the hospital and the statewide capital cost-to-charge ratio shall be used to determine the unadjusted outlier add-on payment. The statewide urban or rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio shall be based on the ratios published by CMS and updated by the Administration as described in section R9-22-712.68(C).

C. In addition to the requirement of this section, DRG reimbursement for new hospitals is determined under R9-22-712.60 through R9-22-712.79.

R9-22-712.81. DRG Reimbursement: Updates

In addition to the other updates provided for in sections R9-22-712.60 through R9-22-712.80, the Administration may update the version of the APR-DRG classification system established by 3M Health Information Systems, adjust the statewide standardized amount in section R9-22-712.62, the base payments in sections R9-22-712.63 and R9-22-712.64, the provider policy adjustor in section R9-22-712.65, service policy adjustors section R9-22-712.66, and the fixed loss amounts and marginal cost percentages used to calculate the outlier threshold in section R9-22-712.68 to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. The Administration shall publish any proposed classification system on the agency's website at least 30 days prior to the effective date, to ensure a sufficient period for public comment, as required by 42 C.F.R. § 447.205. In addition, the public notice shall be available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. The requirements of 42 C.F.R. § 447.205 as of November 2, 2015 are incorporated by reference and do not include any later amendments.