AHCCCS Differential Adjusted Payment (DAP) Activity

AHCCCS is providing the following Differential Adjusted Payment decisions:
For the contracting year October 1, 2018 through September 30, 2019 (CYE 2019), select AHCCCS-registered Arizona providers which meet agency established performance criteria will receive Differential Adjusted Payments (DAP). The AHCCCS Administration is implementing these DAP rates 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. AHCCCS will implement DAP rates for the following providers[1]:

- Hospitals Subject to APR-DRG Reimbursement
- Other Hospitals and Inpatient Facilities
- Nursing Facilities
- Integrated Clinics
- Physicians, Physician Assistants, and Registered Nurse Practitioners

DAP rates for the following providers are deferred for consideration to October 1, 2019 through September 30, 2020.

- Hospitals Subject to APR-DRG Reimbursement – relative to entering into a care coordination agreement
- Behavioral Health Outpatient Clinics

The DAP rates currently in place expire after September 30, 2018 dates of service. The DAP rates in this Notice for CYE 2019 will be effective with dates of service beginning October 1, 2018, through September 30, 2019, and all noted providers (based on distinct Provider Types) will have the opportunity to be considered for meeting the criteria described further below.

CYE 2019 Differential Adjusted Payment Rates:
The DAP Schedule represents a positive adjustment to the AHCCCS Fee-For-Service (FFS) rates. The purpose of the DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. These fee schedules will be limited to dates of service in CYE 2019.

AHCCCS managed care organizations (MCOs; including Regional Behavioral Health Authorities - RBHAs) will be required to pass-through DAP increases to their contracted providers, maintaining rates to match the corresponding AHCCCS Fee-For-Service rate increase percentages.

Hospitals Subject to APR-DRG Reimbursement (Provider Type 02) – Participation in the Network, the state's health information exchange (HIE), qualifies the hospital for a 3.0% DAP increase for both inpatient and outpatient services, effective for inpatient dates of discharge and outpatient dates of service October 1, 2018 through September 30, 2019.

- "Participation in the Network" means: By June 15, 2018, the hospital must have submitted a Letter of Intent (LOI) to AHCCCS and the HIE, in which it agrees to achieve the following

[1] IHS and 638 tribally owned and/or operated facilities are exempt from this initiative based on payments primarily at the federally-mandated all-inclusive rate.

milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:

- Milestone #1: No later than July 31, 2018 the hospital must execute an agreement with a qualifying HIE organization.
- Milestone #2: No later than October 31, 2018 the hospital must approve and authorize a formal scope of work (SOW) with a qualifying HIE organization to develop and implement the data exchange necessary to meet the requirements of Milestones #3 and #4.
- Milestone #3: No later than March 31, 2019 the hospital must electronically submit admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department, to a qualifying health information exchange organization.
- Milestone #4: No later than June 30, 2019 the hospital must electronically submit to a qualifying HIE organization laboratory and radiology information (if the provider has these services), transcription, medication information, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments/procedures conducted during the stay, active allergies, and discharge destination.

In order to receive the 3.0% DAP increase for participation in the Network a hospital **must** submit an LOI. If a hospital has already achieved one or more of the milestones as of June 15, 2018, the LOI must include a commitment by the hospital to maintain its participation in those milestone activities for the period June 1, 2018 through September 30, 2019.

If a hospital submits an LOI and receives the 3.0% DAP increase for CYE 2019, but fails to achieve one or more of the milestones by the specified date, or fails to maintain its participation in the milestone activities, that hospital will be ineligible to receive any DAP for dates of service from October 1, 2019 through September 30, 2020 (CYE 2020) if a DAP is available at that time.

A hospital may qualify for an additional 0.5% increase if the hospital holds a Pediatric-Prepared Emergency Care certification.

- "Holds a Pediatric-Prepared Emergency Care certification" means: By May 1, 2018, the hospital must have obtained Pediatric-Prepared Emergency Care certification from the Arizona Chapter of the American Academy of Pediatrics (AzAAP).

Hospitals will be eligible for an increase for meeting each of the two criteria, thus having the potential to earn a Differential Adjusted Payment increase of 3.5% if both criteria are met.

For CYE 2020, AHCCCS will consider implementing a DAP under which a hospital may qualify for an increase if the hospital collaborates with the AHCCCS Administration to improve care to American Indian/Alaska Native members by entering into a care coordination agreement with an IHS or Tribal 638 facility.

- "Entering into a Care Coordination Agreement" means: By May 1, 2019, the hospital must have executed a written agreement with an IHS or Tribal 638 facility providing for:

    1. Receipt of a referral from the IHS/Tribal 638 facility for clinical services for a referred member

2. Member records and release of information protocol, providing clinical documentation back to the IHS/638 facility

- AHCCCS will monitor hospital activity specified under the Care Coordination Agreement(s) to ensure compliance.

Other Hospitals and Inpatient Facilities (Psychiatric Hospitals, Provider Type 71; Subacute Facilities (1-16 Beds), Provider Type B5; Rehabilitation Hospitals, Provider Type C4; Long Term Acute Care Hospitals, Provider Type C4) – Participation in the Network, the state's HIE, qualifies the hospital for a 3.0% DAP increase for both inpatient and outpatient services, effective for dates of service October 1, 2018 through September 30, 2019.

- "Participation in the Network" means: By June 15, 2018, the hospital must have submitted an LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones , or maintain its participation in the milestone activities if they have already been achieved:
  - Milestone #1: No later than July 31, 2018 the hospital must execute an agreement with a qualifying HIE organization.
  - Milestone #2: No later than October 31, 2018 the hospital must approve and authorize a formal SOW with a qualifying HIE organization to develop and implement the data exchange necessary to meet the requirements of Milestones #3 and #4.
  - Milestone #3: No later than March 31, 2019 the hospital must electronically submit admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department, to a qualifying health information exchange organization.
  - Milestone #4: No later than June 30, 2019 the hospital must electronically submit to a qualifying HIE organization laboratory and radiology information (if the provider has these services), transcription, medication information, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments/procedures conducted during the stay, active allergies, and discharge destination.

In order to receive the 3.0% DAP increase for participation in the Network a hospital **must** submit an LOI. If a hospital has already achieved one or more of the milestones as of June 15, 2018, the LOI must include a commitment by the hospital to maintain its participation in those milestone activities for the period June 1, 2018 through September 30, 2019.

If a hospital submits an LOI and receives the 3.0% DAP increase for CYE 2019, but fails to achieve one or more of the milestones by the specified date, or fails to maintain its participation in the milestone activities, that hospital will be ineligible to receive any DAP in CYE 2020 if a DAP is available at that time.

Nursing Facilities (Provider Type 22) – Pressure Ulcer performance based on resident assessment information reported in the Minimum Data Set (MDS) 3.0 qualifies the Nursing Facility for a 2% DAP increase:

- AHCCCS will assess the percent of High-Risk Residents with Pressure Ulcers (Long Stay) based on the facility's performance results for long-stay, high-risk residents with Stage II-IV pressure ulcers reported in MDS 3.0 for this CMS Nursing Home Quality Measure metric. Facility results will be compared to the accompanying Arizona Average results for the measure, for the most

recently published rate as of April 30, 2018. Nursing Facilities that meet or fall below the average percentage reported in the MDS 3.0 for the measure qualify for a 2% DAP increase.

Integrated Clinics (Provider Type IC) – AHCCCS registration as an Integrated Clinic, with claims for behavioral health services accounting for at least 40% of total AHCCCS claims, together with participation in the Network, the state's health information exchange (HIE), qualifies the IC for a 10% DAP increase for select codes:

- An Integrated Clinic is a provider licensed by the Arizona Department of Health Services as an Outpatient Treatment Center which provides both behavioral health services and physical health services.

- Utilizing claims and encounter data for dates of service from October 1, 2016 through September 30, 2017, AHCCCS will compute claims and encounters for behavioral health services as a percentage of total claims and encounters as of May 1, 2018 to determine which providers meet the 40% minimum threshold
    - Only approved and adjudicated AHCCCS claims and encounters will be utilized in the computations
    - AHCCCS will not consider any other data when determining which providers qualify for the Differential Adjusted Payment increase

- "Participation in the Network" means: By May 1, 2018, the clinic must have executed an agreement with a qualifying health information exchange organization and electronically transfer information, including both a registration event as well as an encounter summary, to a qualifying health information exchange organization.

- The Differential Adjusted Rates will be paid for select physical health services and will provide an increase of 10% over the AHCCCS Fee-For-Service rates for those dates of service in CYE 2019 that coincide with the provider's registration as an IC.

  Physical health services which qualify for the increase include Evaluation and Management (E&M) codes, vaccine administration codes, and a global obstetric code. See the attachment for the specific list of codes which are proposed to increase for purposes of DAP.

Physicians, Physician Assistants, and Registered Nurse Practitioners (Provider Types 08, 31, 18, 19) – Physicians, physician assistants, and registered nurse practitioners who have written at least 80 prescriptions for AHCCCS members, and who have written at least 60% of their total AHCCCS prescriptions as Electronic Prescriptions (E-Prescriptions) will qualify for a 1% DAP increase for all services billed on the CMS Form 1500.

E-Prescription statistics will be identified by the AHCCCS provider ID for the prescribing provider, and computed by AHCCCS based on the following factors:

- Only approved and adjudicated AHCCCS claims and encounters for July 1, 2017 through December 31, 2017 dispense dates will be utilized in the computations
- AHCCCS will compute claims and encounters for this purpose as of May 1, 2018 to determine which providers meet the minimum threshold
- AHCCCS will not consider any other data when determining which providers qualify for the DAP increase

- E-Prescriptions include those prescriptions generated through a computer-to-computer electronic data interchange protocol, following a national industry standard and identified by Origin Code 3
- Refills of original prescriptions whereby the original prescriptions meet the definition of E-Prescriptions shall not be counted as E-Prescriptions

The DAP will apply to claims for covered AHCCCS services where the rendering provider ID on the claim is the same as the prescribing provider ID that was identified and found to meet the criteria described above.

- Due to operational issues related to contracting arrangements with entities rather than individual practitioners, AHCCCS' MCOs may pay the DAP in a manner other than on an individual claim basis, on at least a quarterly basis. In the event an expected quarterly payment to an entity is less than twenty five dollars, the MCOs will be permitted to delay payment to the entity until the earlier occurs: payments due of at least twenty five dollars or final quarterly payment for CYE 2019.

Behavioral Health Providers (Provider Type 77; Provider Type IC) – <u>For CYE 2020</u>, effective with dates of service on October 1, 2019, AHCCCS will consider implementing a DAP under which claims for behavioral health providers will be increased if the following criteria are met:

1. Effective for dates of service on and after October 1, 2018, the behavioral health provider accepts and provides services for Fee-For-Service American Indian Health Program (AIHP) enrolled members.
    - Effective October 1, 2018, AHCCCS Fee-For-Service will be responsible for reimbursement of behavioral health services for its integrated AIHP enrolled members
    - Unlike MCOs, AIHP does not enter into individual contracts with providers (the contractual relationship between AIHP and the provider is established through the AHCCCS Provider Participation Agreement)
    - AHCCCS will monitor AIHP utilization of qualifying behavioral health providers to ensure compliance
    - The DAP increase applied to FFS rates for members enrolled in AIHP will not begin until dates of service effective October 1, 2019

2. Contracts are in place with AHCCCS Complete Care (ACC) Contractors as of May 1, 2019, as follows:
    - In the North geographic service area (GSA), with 100% of ACC Contractors
    - In the South GSA (excluding Pima County), with 100% of ACC Contractors
    - In Pima County, with at least 2 of 3 ACC Contractors
    - In the Central GSA, with at least 5 of 7 ACC Contractors
    - For the purpose of DAP, the GSAs are reflective of the ACC GSAs and not the RBHA GSAs

The following is the anticipated timeline regarding Differential Adjusted Payments:

Activity	Date
Post Public Notice (this document)	May 22, 2018
Post Notice of Proposed Rulemaking (NPRM)	Early June 2018
NPRM Public Comments Due	Mid-July 2018
Tribal Consultation	July 26, 2018
Submit State Plan Amendment to CMS	Late-July/Early-August 2018
Implement Differential Adjusted Payments	October 1, 2018 – September 30, 2019 Dates of Service

Note: Dates are subject to change

AHCCCS anticipates that the criteria for DAP could change for CYE 2020 and may differ for inpatient and outpatient services. AHCCCS also expects to expand DAP to other provider types for CYE 2020. DAP increases noted above may change based on budgetary considerations.

Advancing Value Based Provider Contracts

AHCCCS MCOs will have target requirements according to the following table regarding the percentage of payments that must be governed by Alternative Payment Model (APM) contracts under the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model Framework.

	LAN-APM TARGET REQUIREMENTS					
	AHCCCS COMPLETE CARE	**ALTCS/EPD**	**RBHA**		**DDD**	
		(EPD/ MA-DSNP)	**SMI-INTEGRATED**	**NON-INTEGRATED**	**SUB-CONTRACTORS**	**LTSS**
CYE 19 Anticipated	50%	50%/50%	35%	20%	35%	10%
CYE 20 Anticipated	60%	60%/60%	50%	25%	50%	20%
CYE 21 Anticipated	70%	70%/70%	60%	25%	60%	35%

The table below provides the sub-requirements of the overall target requirements in the table above for Categories 3 and 4 only, with increasing expectations for Categories 3 and 4 over time.

	SUB-REQUIREMENT FOR LAN-APM CATEGORIES 3 AND 4					
	AHCCCS COMPLETE CARE LAN 3&4	**ALTCS/EPD**	**RBHA**		**DDD**	
		(EPD/ MA-DSNP) LAN 3&4	**SMI-INTEGRATED LAN 3&4**	**NON-INTEGRATED LAN 3&4**	**SUB-CONTRACTORS LAN 3&4**	**LTSS LAN 3&4**
CYE 19 Anticipated	40%	25%	10%	10%	40%	5%
CYE 20 Anticipated	50%	35%	20%	20%	50%	10%
CYE 21 Anticipated	60%	45%	30%	30%	60%	15%

Integrated Clinic (IC) Physical Health Services Codes for AHCCCS VBP Differential Adjusted Rates

CPT	DESCRIPTION
59400	ROUTINE OBSTETRIC CARE INCLUDING ANTEPARTUM CARE, VAGINAL DELIVERY (WITH OR WITH
90471	IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS,
90472	IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS,
90473	IMMUNIZATION ADMINISTRATION BY INTRANASAL OR ORAL ROUTE; ONE VACCINE (SINGLE OR
90474	IMMUNIZATION ADMINISTRATION BY INTRANASAL OR ORAL ROUTE; EACH ADDITIONAL
99201	New patient office or other outpatient visit, typically 10 minutes
99202	New patient office or other outpatient visit, typically 20 minutes
99203	New patient office or other outpatient visit, typically 30 minutes
99204	New patient office or other outpatient visit, typically 45 minutes
99205	New patient office or other outpatient visit, typically 60 minutes
99211	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLI
99212	Established patient office or other outpatient visit, typically 10 minutes
99213	Established patient office or other outpatient visit, typically 15 minutes
99214	Established patient office or other outpatient, visit typically 25 minutes
99215	Established patient office or other outpatient, visit typically 40 minutes
99243	Patient office consultation, typically 40 minutes
99244	Patient office consultation, typically 60 minutes
99245	Patient office consultation, typically 80 minutes
99381	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVI
99382	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVI
99383	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVI
99384	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVI
99385	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVI
99391	Established patient periodic preventive medicine examination infant younger than
99392	Established patient periodic preventive medicine examination, age 1 through 4 ye
99393	Established patient periodic preventive medicine examination, age 5 through 11 y
99394	Established patient periodic preventive medicine examination, age 12 through 17
99395	Established patient periodic preventive medicine examination age 18-39 years
99403	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S)

*Descriptions are truncated due to field length limitations in the AHCCCS mainframe