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State/Territory Name: Arizona

State Plan Amendment (SPA) #: 14-009

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

OCT 21 2014

Tom Betlach, Director
Arizona Health Care Cost Containment System
801 E. Jefferson
Phoenix, AZ 85034

RE: Arizona SPA 14-009

Dear Mr. Betlach:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-009. This amendment implements All Patient Refined Diagnosis Related Group payment methodology for inpatient hospital services effective October 1, 2014.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment TN 14-009 is approved effective October 1, 2014. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Mark Wong at (415) 744-3561 or Blake Holt at (415) 744-3754.

Sincerely,

[redacted]

Timothy Hill
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: Centers for Medicare and Medicaid Services

1. TRANSMITTAL NUMBER: 14-009

2. STATE: Arizona

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 U.S.C. 1396a(a)(30)(A)
42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
FFY 2015: ($9,854,914)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pages 18-26

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:

Describes the All Patient Refined Diagnosis Relation Group hospital reimbursement methodology in the State Plan for Inpatient dates of service on and after October 1, 2014.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Monica Coury

14. TITLE:
Assistant Director

15. DATE SUBMITTED:
August 27, 2014

16. RETURN TO:
Monica Coury
801 E. Jefferson, MD#4200
Phoenix, Arizona 85034

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
OCT 21 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristie FAN

22. TITLE: Deputy Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

STATE OF ARIZONA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL CARE

VIII. INPATIENT HOSPITAL PAYMENTS EFFECTIVE OCTOBER 1, 2014

A. Applicability

Except as specified in this paragraph, the inpatient payment method applies to all inpatient stays in all acute care hospitals. It does not apply to the following:

1. Stays in Indian Health Services (IHS) hospitals, or hospitals operated as 638 facilities, which are paid the all-inclusive rate published annually by IHS.
2. Stays in rehabilitation hospitals and long term acute care hospitals which are paid on a per diem basis using the per diem rates that were in effect for each hospital on September 30, 2014.
3. Stays in psychiatric hospitals, which are paid on a per diem basis in accordance with the methodology described in Att. 4.19-A, page 11, paragraph V.
4. Stays associated with organ transplant services that are paid under contract, which are paid in accordance with the contract between AHCCCS and the transplant hospital.
5. Stays where the principle diagnosis upon admission is a behavioral health diagnosis, which are covered by the Arizona Department of Health Services in accordance with state law and which are paid on a per diem basis in accordance with the methodology described in Att. 4.19-A, page 11, paragraph V.

B. APR-DRG Reimbursement

For dates of discharge on and after October 1, 2014, inpatient hospital services will be reimbursed using the diagnosis related group (DRG) payment methodology. Each claim for an inpatient hospital stay will be assigned a DRG code and a corresponding DRG relative weight based on the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. DRG payments made using this methodology shall be the sole reimbursement to the hospital for all inpatient hospital services and related supplies provided by the hospital. A hospital will not be reimbursed separately for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis, if the patient is admitted as an inpatient to the same hospital directly from the emergency room, observation or other outpatient department.

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C. DRG Relative Weights

The APR-DRG methodology classifies inpatient stays into categories based on similar clinical conditions and similar levels of hospital resources required for treatment. The categories are identified using diagnosis-related group codes, each of which is assigned a relative weight appropriate to the relative amount of hospital resources expected to be used to treat the patient. Each claim is assigned to a DRG based on the patient's diagnoses, surgical procedures performed, age, gender, birth weight, and discharge status. An APR-DRG payment is determined by multiplying the DRG base rate by the DRG relative weight and any applicable policy adjustors. The DRG relative weights are posted on the AHCCCS website as of October 1, 2014 at http://www.azahcccs.gov/commercial/ProviderBilling/rates/APRDRG.aspx.

D. DRG Base Rate for Arizona Hospitals

The DRG base rate for each hospital other than those described in paragraphs 1 and 2 below is a statewide standardized amount adjusted by applying the hospital's wage index to the hospital's labor-related share. The hospital wage index and labor-related share are those used in the Medicare inpatient prospective payment system for the fiscal year October 1, 2013 through September 30, 2014, and will not be subject to annual updates. For the following described hospitals, the DRG base rate will be calculated in the same manner except that an alternative standardized amount will be used in place of the statewide standardized amount:

1. Hospitals that are licensed by the state of Arizona Department of Health Services as short-term hospitals, indicated by a license number beginning with the letters "SH." These hospitals typically practice in a limited, specialized field.
2. Hospitals that are located in a city with a population greater than one million, which on average have at least 15% of inpatient days for patients who reside outside of Arizona and at least 50% of discharges reimbursed by Medicare as reported on the hospital's Medicare Cost Report for the hospital's cost reporting period ending between January 1, 2011 and December 31, 2011.

The statewide standardized amount, the alternative standardized amount, and the DRG base rates for all hospitals are posted on the AHCCCS website as of October 1, 2014 at http://www.azahcccs.gov/commercial/ProviderBilling/rates/APRDRG.aspx.

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E. DRG Base Rate for Out-of-State Hospitals

The DRG base rate for high volume out-of-state hospitals will be calculated in the same manner as for Arizona hospitals, using the Arizona statewide standardized amount. A high volume out-of-state hospital is a hospital 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. The DRG base rate for all other out-of-state hospitals is posted on the AHCCCS website that is referenced in paragraph D.

F. Policy Adjustors

Where AHCCCS has determined that an adjustment to the base payment is appropriate to ensure access to quality care, a policy adjustor will be applied to the base payment. Firstly, AHCCCS will apply a provider policy adjustor of 1.055 times the base rate to all claims from hospitals that are high volume Medicaid providers. A high volume Medicaid provider is a hospital that had at least 46,112 AHCCCS-covered inpatient days during the fiscal year beginning October 1, 2010 and had a Medicaid utilization rate greater than 30% as reported in the hospital's Medicare Cost Report for the hospital's cost reporting period ending between January 1, 2011 and December 31, 2011. These calculations include both Fee-For-Service and Managed Care Organization data. Secondly, and in addition to the provider policy adjustor if it applies, AHCCCS will apply one of six service policy adjustors where the claim meets certain conditions. The six service policy adjustors, the conditions to which they apply, and the adjustment values are described below:

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. Claims for patients under age 19 assigned DRG codes other than listed above: 1.25

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G. DRG Initial Base Payment

A claim for an inpatient hospital stay will be assigned both a DRG code derived from all diagnosis and surgical procedure codes included on the claim and a DRG code derived by excluding diagnosis and surgical procedure codes associated with health care acquired conditions or other provider-preventable conditions listed in Att. 4.19-A, page 13. The DRG code with the lower relative weight will be used to process the claim. For each hospital stay, the DRG initial base payment equals the DRG base rate multiplied by the DRG relative weight and any applicable policy adjustors.

The DRG initial base payment may be subject to additional adjustments as described in the following paragraphs to produce a DRG final base payment.

H. Outlier Add-on Payments

Cases which are extraordinarily costly in relation to other cases within the same DRG due to the severity of illness or complicating conditions may qualify for an outlier add-on payment. A claim will qualify for an outlier add-on payment if the claim cost exceeds the outlier cost threshold. The claim cost is determined by multiplying the covered charges by the hospital's outlier cost-to-charge ratio. The outlier threshold is equal to the DRG base payment plus the fixed loss amount, where the DRG base payment for this purpose is the lesser of the DRG initial base payment determined under paragraph G and the DRG transfer payment determined under paragraph I. The fixed loss amounts for critical access hospitals and for all other hospitals are posted on the AHCCCS website as of October 1, 2014 at http://www.azahcccs.gov/commercial/ProviderBilling/rates/APRDRG.aspx. The outlier cost-to-charge ratios for all hospitals will be determined as follows:

1. For children's hospitals in Arizona, the outlier cost-to-charge ratio will be calculated by dividing the hospital's total costs by its total charges using the most recent Medicare Cost Report available as of September 1st each year.
2. For Critical Access Hospitals in Arizona, the outlier cost-to-charge ratio will be the sum of the statewide rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio contained in the Medicare inpatient prospective payment system data file available as of September 1st each year.

3. For all other Arizona hospitals and for high volume out-of-state hospitals, the outlier cost-to-charge ratio will be the sum of the operating cost-to-charge ratio and the capital cost-to-charge ratio established for the specific hospital and contained in the Medicare inpatient prospective payment system impact file available as of September 1st each year.
4. For all other out-of-state hospitals, the outlier cost-to-charge ratio will be the sum of the Arizona statewide urban default operating cost-to-charge ratio and the Arizona statewide capital cost-to-charge ratio contained in the Medicare inpatient prospective payment system data file available as of September 1st each year.

AHCCCS will update the cost-to-charge ratios annually on October 1st each year. AHCCCS will not adopt any Medicare updates that CMS publishes subsequently for that payment year. Where a claim qualifies 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.

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I. Transfer Payments

A transfer payment adjustment applies when a patient is transferred from a hospital that is subject to DRG reimbursement to another hospital that is subject to DRG reimbursement for inpatient care. The transferring hospital will be reimbursed the lesser of the DRG initial base payment and the DRG transfer payment. The DRG transfer payment is equal to the DRG initial base payment divided by the DRG national average length of stay for the assigned DRG code, multiplied by the actual length of stay plus one day. The receiving hospital will not be impacted by the transfer payment adjustment unless it transfers the patient to another hospital.

J. Prorated Payments

When a patient has Medicaid coverage for fewer days than the actual length of stay, the DRG payment will be prorated. The proration factor is determined as follows:

1. Where the patient is ineligible for Medicaid on the first day of the inpatient stay but is eligible for subsequent days during the inpatient stay, the proration factor is equal to the number of Medicaid-eligible days divided by the DRG national average length of stay for the assigned DRG code.
2. Where the patient is eligible for Medicaid on the first day of the inpatient stay but is ineligible for one or more days prior to or on the date of discharge, the proration factor is equal to the number of Medicaid-eligible days plus one day divided by the DRG national average length of stay for the assigned DRG code.

If the calculated proration factor is greater than one, the proration factor used for the payment calculation will be one. The DRG prorated payment is equal to the DRG base payment multiplied by the proration factor, where the DRG base payment for this purpose is the lesser of the DRG initial base payment determined under paragraph G and the DRG transfer payment determined under paragraph I. The DRG prorated outlier add-on payment is equal to the outlier add-on payment determined under paragraph H multiplied by the proration factor. Notwithstanding paragraph K, for the purpose of paragraphs J.1 and J.2 above, the day of discharge is included in determining the number of Medicaid-eligible days during an inpatient stay.

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K. Length of Stay Defined

For purposes of inpatient hospital reimbursement, the length of stay is equal to the total number of calendar days of an inpatient stay beginning with the date of admission and ending with the date of discharge or transfer, but not including the date of discharge or transfer unless the patient expires. A claim for inpatient services with an admission date and discharge date that are the same calendar date will be processed and reimbursed as an outpatient claim, unless the patient expired on the date of discharge.

L. Documentation and Coding Improvement and Transition Adjustment Factors

A DCI and transition adjustment factor will be applied to each claim for an inpatient hospital stay. The DCI and transition adjustment factor is a hospital-specific value established to limit the financial impact to individual hospitals of the transition to a DRG payment methodology, by phasing in the impact over two years, with full implementation in the third year, and to account for improvements in documentation and coding that are expected as a result of the transition. The DCI and transition adjustment factors are published as part of the AHCCCS capped fee schedule and posted on the AHCCCS website as of October 1, 2014 at http://www.azahcccs.gov/commercial/ProviderBilling/rates/APRDRG.aspx.

M. DRG Final Payment

The DRG final base payment is the lesser of the DRG initial base payment determined under paragraph G and the DRG transfer payment determined under paragraph I, multiplied by a proration factor if applicable, and further multiplied by the DCI and transition factor. The DRG final outlier add-on payment is the outlier add-on payment determined under paragraph H, multiplied by a proration factor if applicable, and further multiplied by the DCI and transition factor. The DRG final payment amount is equal to the DRG final base payment amount plus the DRG final outlier add-on payment amount.

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N. Interim Payments

For an inpatient stay with a length of stay greater than 29 days, the hospital may submit interim claims for each 30 day period during the inpatient stay. In this case, the hospital will be reimbursed for interim claims at a per diem rate of $500 per day. Following discharge of the patient, the hospital must void all interim claims and AHCCCS will recoup the interim payments. Final payment will be determined under the DRG payment methodology.

O. New Hospitals

The DRG base rate for a new hospital is calculated in the same manner as other Arizona hospitals if the hospital's wage index and labor-related share are available in the Medicare inpatient prospective payment system; otherwise, the DRG base rate is the statewide standardized amount adjusted by applying the wage index and labor-related share appropriate to the physical location of the hospital. Likewise, the outlier cost-to-charge ratio for a new hospital is determined in the same manner as other Arizona hospitals if the hospital's operating cost-to-charge ratio is contained in the Medicare inpatient prospective payment system impact file; otherwise, the Arizona statewide urban or rural default operating cost-to-charge ratio, whichever is appropriate to the physical location of the hospital, will be added to the Arizona statewide capital cost-to-charge ratio to derive the outlier cost-to-charge ratio.

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P. Administrative Days and Readmissions

1. Administrative days are days of a hospital stay in which a patient does not meet the criteria for an acute inpatient stay, but is not discharged because an appropriate placement outside the hospital is not available or the patient cannot be safely discharged or transferred. Administrative days are reimbursed at the rate the claim would have paid had the services not been provided in an inpatient hospital setting but had been provided at the appropriate placement. In certain circumstances, a member has unique medical or behavioral health needs, and the cost of the care for those unique needs is not factored into the rate otherwise established for the appropriate non-hospital inpatient placement. In such circumstances, AHCCCS negotiates with the hospital for a rate no less than the rate for the appropriate non-hospital inpatient placement and no more than the rate that would otherwise be paid for a hospital inpatient stay, taking into consideration the comparable fee for service rate for the unique services.

2. If a patient is readmitted, without prior authorization, to the same hospital that the patient was discharged from within 72 hours and the DRG code assigned to the claim for the prior admission has the same first three digits as the DRG code assigned to the claim for the readmission, then payment for the claim for the readmission will be disallowed if a medical review determines the readmission could have been prevented by the hospital.