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State/Territory Name: Arizona

State Plan Amendment (SPA) #: AZ-22-0024

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

Financial Management Group

November 10, 2022

Jami Snyder, Director
Arizona Health Care Cost Containment System
801 E. Jefferson
Phoenix, AZ 85034

RE: Arizona SPA 22-0024

Dear Ms. Snyder:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 22-0024. This amendment, effective October 1, 2022, updates All Patient Refined Diagnosis Related Group (APR-DRG) reimbursement for inpatient hospital services.

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 22-0024 is approved effective October 1, 2022. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Mark Wong at (415) 744-3561 or mark.wong@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

Enclosures

DEPARTMENT OF HEALTH ANDHUMAN SERV CES
CENTERS FOR MED CARE & MED CA D SERV CES

FORM APPROVED
OMB No 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22 - 0024

2. STATE: AZ

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 447, Subpart C

6. FEDERAL BUDGET IMPACT (Amounts n WHOLE do ars)
a. FFY 23 $ 3,762,529
b. FFY: 24 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A page 19, 20 and 21

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19A page 19, 20 and 21

9. SUBJECT OF AMENDMENT
Updates the state plan DRG rates, effective October 1, 2022.

10. GOVERNOR S REVIEW *(Check One)*

- [x] GOVERNOR S OFFICE REPORTED NO COMMENT
- [ ] SPECIFIED: COMMENTS OF GOVERNOR S OFFICE ENCLOSED
- [ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- [✔] OTHER, AS

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Dana F annery

13. TITLE
Ass stant D rector

14. DATE SUBMITTED: October 11, 2022

15. RETURN TO
Dana F annery
801 E. Jefferson St., MD # 4200
Phoen x, AZ 85034

FOR CMS USE ONLY

16. DATE RECEIVED
October 11, 2022

17. DATE APPROVED
November 10, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

FORM CMS-179 (09/24)

Instructions on Back

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

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, 2022 at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGrates.html.

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 published by Medicare on September 18, 2020 for the Medicare inpatient prospective payment system for the fiscal year October 1, 2020 through September 30, 2021, 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, 2022 at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGrates.html.

STATE OF ARIZONA
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INPATIENT HOSPITAL CARE

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, 2015. 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 1.110 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 AHCCCS-covered inpatient days 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, 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, 2016 and December 31, 2016, and received less than $2 million in add-on payment for outliers for the fiscal year beginning October 1, 2015.These calculations include both Fee-For-Service and Managed Care Organization data. Secondly, and in addition to the provider policy adjustor if it applies, Effective October 1, 2022 AHCCCS will apply one of nine service policy adjustors where the claim meets certain conditions. The nine service policy adjustors, the conditions to which they apply, and the adjustment values are described below:

1. Normal newborn DRG codes: 1.70
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. Burns DRG codes: 4.00
7. Claims for patients under age 19 assigned DRG codes other than those described in items 1 through 6 above and with severity of illness level 1 or 2: 1.25
8. Claims for patients under age 19 assigned DRG codes other than those described in items 1 through 6 above and with severity of illness level 3 or 4: 2.40
9. All Other Adjustor: 1.025

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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, 2022 at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGrates.html.

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.