

October 24, 2016

The Honorable Douglas A. Ducey
Governor of the State of Arizona
1700 West Washington
Phoenix, Arizona 85007

Dear Governor Ducey:

Laws 2013, First Regular Session, Chapter 202, Section 5 includes the following requirement:

For contract years 2015 through 2019, the Arizona health care cost containment system administration is required to report on the implementation of the new payment methodology authorized by this act, including any concerns raised by hospitals and any realized costs savings. The administration is required to submit its report by October 1 of each year to the governor, the president of the senate and the speaker of the House of Representatives, together with the chairpersons of the house and senate health committees.

In accordance with Laws 2013, First Regular Session, Chapter 202, AHCCCS replaced its 20-year old tiered per diem payment methodology with a diagnosis-related group (DRG) payment methodology effective October 1, 2014 for acute care hospitals. Unlike the tiered per diem methodology which makes payments based on the quantity of care, the DRG methodology makes payments based on the reason for admission and the severity of illness. This methodology is aligned with the administration's focus on improving care and shifting the focus to the quality of the services provided.

Beginning in 2013, AHCCCS contracted with Navigant Consulting to provide assistance in analyzing, acquiring and implementing a DRG-based inpatient hospital payment system. In conjunction with a workgroup of hospital representatives, from both urban and rural hospitals, and the Arizona Hospital and Healthcare Association, AHCCCS selected 3M's All Patient Refined (APR) DRG model. The APR-DRG grouper consists of more than 1,200 DRGs.

For the majority of in-state hospitals, the DRG base rate is a statewide standardized amount adjusted by hospital wage and labor indexes to account for different geographic areas. The administration also adopted several policy adjustors which further modify reimbursement based on the nature of the service (e.g., newborn, obstetric, psychiatric), and an outlier add-on payment for claims which exceed established cost thresholds. The fiscal impact on each individual hospital of the transition to an APR-DRG payment methodology is being phased in over a three-year period, using hospital-specific transition adjustors. AHCCCS will rebase the APR-DRG rates for an October 1, 2017 effective date.

Based on feedback from Navigant and the hospitals, AHCCCS excluded long-term acute care hospitals, rehabilitation hospitals, and psychiatric hospitals from the APR-DRG payment methodology. Long-term acute care hospitals, rehabilitation hospitals and psychiatric hospitals

continue to be reimbursed by per diem rates. AHCCCS will re-examine these exclusions as part of the rebase.

The AHCCCS Administration is able to report a smooth transition to the APR-DRG payment methodology, which accounts for approximately \$1.1 billion in Medicaid payments annually. Since implementation, hospitals have expressed few concerns. Below are several operational issues raised by hospitals, together with the administration's response.

Issue	Resolution
The administration's reimbursement policy with respect to hospital-to-hospital transfers was followed by a sharp reduction in such transfers for certain pediatric cases.	The administration clarified in its APR-DRG policy document and in Rule that the hospital-to-hospital transfer policy does not apply when the member is transferred for the purpose of receiving sub-acute services at the receiving hospital.
The administration's reimbursement policy document did not address in sufficient detail all the circumstances requiring the reporting of birth weight on a claim; implementation by the Managed Care Organizations (MCOs) was, in some cases, inappropriately resulting in non-payment of the claim.	The administration clarified in its policy document all the circumstances requiring the reporting of birth weight on a claim, and communicated that clarification directly to the hospitals and the MCOs.
The administration's requirements for claim submission when a member changes his health plan enrollment during an inpatient stay is, in some cases, preventing an outlier add-on where the outlier add-on would otherwise be appropriate.	The administration is researching this issue and a resolution is pending. AHCCCS has, on a case-by-case basis, instructed the receiving MCO to process the claim as if the member were enrolled with that MCO for the full inpatient stay.

In addition, some hospitals have asked whether AHCCCS plans to evaluate whether actual DRG payments differed substantially from the modeled payments developed as part of the transition analysis. Such a comparison will be part of the rebase.

In accordance with Laws 2013, First Regular Session, Chapter 202, Section 4, the Arizona Health Care Costs Containment System (AHCCCS) Administration designed a hospital payment methodology which would be budget neutral. Therefore, the administration anticipates no direct cost savings from the transition.

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Please feel contact Victoria Burns, Reimbursement Administrator, at (602) 417-4049 or via email at Victoria.Burns@azahcccs.gov if you have additional questions.

Sincerely,



Thomas J. Betlach
Director

cc: The Honorable Andy Biggs, President, Arizona State Senate
The Honorable David Gowan, Speaker, Arizona House of Representatives
The Honorable Heather Carter, Chairman House Health Committee
The Honorable Nancy Barto, Chairman, Senate Health and Human Services Committee
Christina Corieri, Senior Policy Advisor, Arizona Governor's Office
Lorenzo Romero, Director, Governor's Office of Strategic Planning and Budgeting
Beth Kohler, Deputy Director, AHCCCS
Richard Stavneak, Director, Joint Legislative Budget Committee