

## NOTICE OF PROPOSED RULEMAKING

### TITLE 9. HEALTH SERVICES

#### CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

##### **PREAMBLE**

**1. Sections Affected:**

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

**Rulemaking Action:**

**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. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the proposed rule:**

Notice of Rulemaking Docket Opening: [to be filled in by SOS editor]

As of the filing of this Notice of Proposed Rulemaking, there is also pending separate amendments to R9-22-712.71 regarding incremental payments for hospitals that qualify for a value-based purchasing adjustment. Additional amendments to that same rule are proposed herein; however, because the value-based purchasing amendments are not final as of this Notice of Proposed Rulemaking, those proposed amendments are not reflected in this rulemaking. Additional information regarding the value-based purchasing amendments 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

**4. The agency's contact person who can answer questions about the rulemaking:**

Name: Gina Relkin

Address: AHCCCS  
Office of Administrative Legal Services  
701 E. Jefferson, Mail Drop 6200  
Phoenix, AZ 85034

Telephone: (602) 417-4232  
Fax: (602) 253-9115  
E-mail: AHCCCSRrules@azahcccs.gov

**5. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**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 diagnosis- related group (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 Diagnosis Related Group (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 issue 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 standard 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:

<b>Rule Section (R9-22)</b>	<b>Description of Value Moved to Web</b>	<b>Current Values</b>	<b>Updated Values</b>
712.60(C ) 712.60(F)(1)	Reference to the version of the 3M APR-DRG classification system	Version 31	Version 34
712.62(B)	The amount of the statewide standardized amount of the base payment.	\$5,295.40	\$5,168.06
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

712.64(A)(2)	The amount of the DRG base payment for out of state hospitals.	\$5,184.75	\$5,157.58
712.65(A)	The multiplier for high-utilization hospitals	1.055	1.110
712.66	Multipliers for service policy adjustors.	Newborns: 1.55 Neonates: 1.10 Obstetrics: 1.55 Psychiatric: 1.65 Rehab: 1.65 Children - • Severity level 1 & 2: 1.25 • Severity levels 3 & 4 (2016): 1.60	Newborns: 1.55 Neonates: 1.10 Obstetrics: 1.55 Psychiatric: 1.65 Rehab: 1.65 Burns: 2.70 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
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
712.68(E)	The DRG marginal cost percentages for burns and all other claims.	Burns 90% All others 80%	Burns 90% All others 80%

**6. 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 with the publication of this Notice of Proposed Rulemaking.

**7. 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 of this state:**

Not applicable as the rulemaking will not diminish a previous grant to authority of a political subdivision of the state.

**8. The preliminary 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. 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. The agency does not anticipate that the proposed 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), 4 of the 106 hospitals listed reported fewer than one hundred full-time employees which qualifies those hospitals as "small businesses" under A.R.S. § 41-1001(21). Two of those hospitals have since ceased operations. The other 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.

**9. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:**

Name: Gina Relkin  
Address: AHCCCS  
Office of Administrative Legal Services  
701 E. Jefferson, Mail Drop 6200  
Phoenix, AZ 85034  
Telephone: (602) 417-4232  
Fax: (602) 253-9115  
E-mail: AHCCCSrules@azahcccs.gov

**10. The time, place, and nature of the proceedings to make, amend, repeal, or renumber the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**

Proposed rule language will be available on the AHCCCS website [www.azahcccs.gov](http://www.azahcccs.gov) the week of June 19, 2017. Please send written or email comments to the above address by the close of the comment period, 5:00 p.m., August 8, 2017.

Date: August 8, 2017  
Time: 1:00 p.m.  
Location: AHCCCS  
701 East Jefferson  
Phoenix, AZ 85034  
Nature: Public Hearing

Date: August 8, 2017  
Time: 1:00 p.m.  
Location: ALTCS: Arizona Long-Term Care System  
1010 N. Finance Center Dr, Suite 201  
Tucson, AZ 85710  
Nature: Public Hearing

Date: August 8, 2017  
Time: 1:00 p.m.  
Location: 2717 N. 4th St. STE 130  
Flagstaff, AZ 86004  
Nature: Public Hearing

**11. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**

No other matters have been prescribed.

**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:**

Not applicable.

**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:**

Not applicable.

**c. Whether a person submitted an analysis to the agency that compares the rule's impact on the competitiveness of business in this state to the impact on business in other states:**

Not applicable.

**12. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:**

Proposed 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.

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

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

**13. The full text of the rules follows:**

## Title 9. Health Services

### Chapter 22. Arizona Health Care Cost Containment System – Administration

#### Article 7. Standards for Payment

##### 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 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 system 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 published by the Administration on its 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 published by the Administration on its 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.
- ~~67.~~ 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. ~~4.25~~ For dates of discharge on or after January 1, 2016, for severity of illness levels 1 and 2,
- c. ~~4.60~~ 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 published by the Administration on its 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 published by the Administration on its 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 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, 2016 through September 30, 2017, 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, 2016. To qualify for the Inpatient VBP Differential Adjusted Payment, a hospital providing inpatient hospital services must meet the following criteria:
  - a. By June 1, 2016 May 15, 2017, the hospital must have executed an agreement with and electronically submitted admission, discharge, and transfer information, as well as data from the hospital emergency department, to a qualifying health information exchange organization, and
  - b. No sooner than January 4, 2016, and no later than February 29, 2016, CMS must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015; or, for a children's hospital that does not participate in the medicare electronic health record incentive program, no sooner than January 4, 2016, and no later than the date established by CMS, the administration must have approved the hospital's attestation demonstrating meaningful use stage 2 as described in 42 CFR 495.22 during an electronic health record reporting period in 2015.

#### **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 a public notice to the agency's website at least 30 days prior to the effective date of any update to allow for public comment consistent with federal requirements at 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.