Hospital Assessment Workgroup – FFY 2021

May 15, 2020

Overview

- Updated Assessment Amounts
- Financial Parameters
- Key Decisions for Directed Payments
- Timeline of Activities

Base Assessment - Rebase

- Updated estimates due to COVID-19 & economic impacts
- Base assessment amount will increase by $100.1M, from $433.4M to $533.5M for FFY 2021
  - $71.3M for AHCCCS Budget Rebase, assuming 16.5% MM growth
  - $18.1M for orig. estimate of expansion cost for practitioner rates
  - $3.0M for additional cost of practitioner rates due to enrollment
  - $7.7M due to Tobacco MSA shortfall to be backfilled
- Shifting assessment basis from State Fiscal Year to Federal Fiscal Year to align with Directed Payments

New Assessment

- New assessment amount will be $395.3M
  - $316.8M for Directed Payments
  - $4.0M for Directed Payments administration
  - $64.0M for orig. estimate of non-exp. cost for practitioner rates
  - $10.5M for additional cost of practitioner rates due to enrollment
- FFY 21 Total Assessment amount is $928.8M
- Assumes enhanced FMAP does not apply to FFY 21

Financial Parameters

- Ensure sufficient funding available for base assessment to fund expansion population costs
- Implement Direct Payments to result in same net benefit to hospitals as originally anticipated
- Ensure total assessment is within federal limit of 6.0%

Financial Summary

Hospital Assessment	Original	Current	Diff.
Baseline	$433.4	$433.4	($0.0)
Practitioners - Exp.	$18.1	$21.1	$3.0
Rebase	-	$79.0	$79.0
Base Assessment	**$451.5**	**$533.5**	**$82.0**
New Assessment	$352.5	$395.3	$42.8
Total Assessment	**$804.0**	**$928.8**	**$124.8**
Directed Payment	$1,119.0	$1,243.8	$124.8
Less Practioners & Rebase	($18.1)	($100.1)	($82.0)
Less New Assessment	($352.5)	($395.3)	($42.8)
Net Benefit	**$748.4**	**$748.4**	**$0.0**
Eff. Rate Increase	*28.6%*	*28.6%*	*0.0%*

Directed Payments – Key Decisions

- Rate Increase Methodology
- Payment Methodology
- Assessment Considerations
- Quality Criteria and Evaluation Plan

Submit feedback to HospitalAssessmentProject@azahcccs.gov by May 26

Rate Increase Methodology

- Define reimbursement / payment classes or categories of providers
  - Not necessarily same as assessment categories
- Evaluate basing increase on % of cost, % of Average Commercial Rate (ACR), or other basis
  - Increase applies only to MCO claims
- Will evaluate impact to each hospital system

Payment Methodology

- Outside of base MCO capitation rates
- Quarterly Lump Sum payments based on estimates
- Fixed dollar v. Fixed % options
- Reconciliation to actual utilization

Assessment Considerations

- Use same assessment basis – 2018 data
- Evaluate current variable rates and exclusions
- Ensure total amount is within 6.0% federal limit in current period as well as over the long-term

Quality Criteria & Evaluation Plan

- CMS requires provider performance measures connected to Quality Strategy and Evaluation Plan
- Intend to request simplified approach for Year 1
- Years 2-3 – targeted measures based on input
  - Establish a component of the rate increase that is value based

Tentative Directed Payments Timeline

- 5/26/20 Initial feedback deadline
- 6/4/20 Workgroup meeting
- 6/24/20 Workgroup meeting
- By 6/30/20 Model finalized
- 7/1/20 438.6(c) Pre-Print due to CMS
- August 2020 Post proposed rule
- September 2020 Post final rule
- 10/01/20 Implement

Questions?