Hospital Assessment Workgroup – FFY 2021

June 12, 2020

Directed Payments has a New Name

- AHCCCS is pleased to present the new name for directed payments:

Hospital Enhanced Access Leading To Health Improvements Initiative (HEALTHII) payments

  - No, we don't expect you to remember the full name, just HEALTHII payments
  - Refers only to the directed payments, not the added assessment

Financial Summary – Updated

Hospital Assessment	5/15	6/12 with Revised FMAP	Diff.
Baseline	$433.4	$433.1	($0.3)
Practitioners - Exp.	$21.1	$21.1	$0.0
Rebase	$79.0	$79.4	$0.4
Base Assessment	**$533.5**	**$533.6**	**$0.1**
New Assessment	$395.3	$376.3	($19.0)
Total Assessment	**$928.8**	**$909.9**	**($18.9)**
Directed Payment	$1,243.8	$1,225.5	($18.3)
Less Practioners & Rebase	($100.1)	($100.5)	($0.4)
Less New Assessment	($395.3)	($376.3)	$19.0
Net Benefit	**$748.4**	**$748.7**	**$0.3**
Eff. Rate Increase	*28.6%*	*28.6%*	*0.0%*

AHCCCS
Arizona Health Care Cost Containment System

Feedback Received – Concerns for Rural Hospitals

- We believe increasing rural rates up to 100% of costs would go a long way towards preserving access to rural health services across and would only require a small decrease to the rate enhancement for all other hospitals (AzHHA)

- We believe that increasing the CAH payments to 101% of costs would benefit rural partners (Copper Queen)

- As a general rule, rural hospitals have a much higher AHCCCS payor mix. We also have significantly higher costs associated with professional services due to our location and low volumes (Cobre Valley)

Feedback Received – Concerns for Rural Hospitals

- Some hospitals care for a high percentage of IHS recipients which are reimbursed through FFS payments. The directed payments are based on AHCCCS MCO payments (Cobre Valley)
- Consider allocating an enhanced portion for physicians and dentists from the assessment to rural providers (AzHHA)
- It is important to have a rate that is sustainable so that rural hospitals can afford to recruit and retain talented physicians. It is also vital to keep specialty physicians in rural communities so residents do not have to travel to get the quality care they deserve (Copper Queen)

Feedback Received – Other Hospitals Types

- Stand-alone specialty hospitals should receive payments for services rendered that are at least the same as the payments made to hospitals that provide similar services (AzHHA)

- Valleywise Health should receive at a minimum of the same payment rate as other urban hospitals (AzHHA)

Feedback Received – Methodology

- Unreimbursed costs already exceed $1 billion per year. These unpaid Medicaid costs will grow materially in the coming year due to the growing disparity between the reimbursement hospitals receive relative to their costs. This reinforces the need to establish a directed payment methodology that is based on hospitals' unreimbursed Medicaid costs (HSAA)

- The Alliance proposes the following reimbursement classes for directed payments: (1) private urban acute hospitals, (2) public urban acute hospitals, (3) rural hospitals, (4) high-American Indian Health Plan/Indian Health Service utilization rural hospitals, (5) freestanding children's hospitals and (6) specialty hospitals (HSAA)

Feedback Received – Methodology

- We request that AHCCCS pay four quarters of rate increase funding for the 2021 program year based on the Agency's actuarial estimates, and then reconcile these estimates based on actual utilization for the 2021 period (including 9 months of trailing claims). This can be achieved with an adjustment to the fourth quarter rate increase payments for the 2022 program year (HSAA)

Feedback Received – Carry Forward

- We recommend that AHCCCS utilize any base assessment carry-forward balance from the prior quarter to supplement the rate increase pool and increase the directed payments to hospitals accordingly. If AHCCCS is unable to do so, we recommend that AHCCCS utilize this balance to reduce hospitals' base assessment cost in the following quarter (HSAA)

- We respectfully request that the carry forward balance for 2021 be reported in a future Workgroup meeting (HSAA)

Assessment – Preliminary Version

- Uses same assessment basis – 2018 data
- Updated to assess freestanding children's hospitals at 5% of the urban acute care rate
- No other updates to variable rates and exclusions

HEALTHII Payments – Preliminary Version

- Fixed directed payment amount allocated to hospital class pools based on targeting a % of cost
  - Allocation methodology only - does not reflect a commitment to cost-based reimbursement
  - Resulting % allocation between payment pools is intended to be maintained in future years
    - Will evaluate annually, but not necessarily recompute as a % of costs each year

HEALTHII Payments – Preliminary Version

- Minimize "losing" hospital systems
- 6 HEALTHII payment pools, different from the assessment pools
- Different percentage increase for different pools
- Allocation to pools based on Medicaid pay-to-cost estimates

HEALTHII Payments – Preliminary Version

- Fixed directed payment amount allocated to pools
  - Payment amounts within each pool based on actual utilization
  - Allocation methodology only - does not reflect a commitment to cost-based reimbursement
  - Resulting % allocation between payment pools is intended to be maintained in future years
    - Will evaluate annually, but not necessarily update as a % of costs each year

HEALTHII Payments – Preliminary Model

	Targeted Pay-to-Cost	Proportion of Total Payments	Modeled Payment Increase	Net Eff Rate Increase	Net Gain
Total IP/OP Combined	87.7%	100%	51.2%	31.2%	$749 M
Rural Hospitals	100%	9.5%	62.2%	39.1%	$73 M
Rural Reservation - Adjacent	100%	5.3%	94.5%	64.8%	$45 M
Freestanding Children's	75%	1.1%	4.4%	3.7%	$11 M
Specialty	89%	2.2%	14.2%	12.2%	$23 M
Private Urban Acute	89%	80.3%	64.8%	38.8%	$590 M
Public Acute	70%	1.6%	15.8%	5.6%	$7M

Considerations

- Preliminary version does not necessarily reflect final version
  - Submit feedback to HospitalAssessmentProject@azahcccs.gov by June 19
- Payment timing and initial payment calculations have not yet determined (e.g. quarterly, estimated)
- Quality criteria to be discussed at next workgroup meeting

Timeline

- 6/19/20 Feedback deadline
- 6/26/20 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?