February 26, 2018

Mark Wong
Division of Medicaid and Children's Health Operations
U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

RE: Arizona SPA #18-002, DRG Rebase

Dear Mr. Wong:

Enclosed is State Plan Amendment (SPA) #18-002, DRG Rebase, which revises the State Plan to rebase the DRG rates, effective January 1, 2018.

If you have any questions about the enclosed SPA, please contact Kyle Sawyer at (602) 417-4211.

Sincerely,

Elizabeth Lorenz
Assistant Director
Arizona Health Care Cost Containment System (AHCCCS)

cc: Blake Holt, CMS
Brian Zolynas, CMS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: Centers for Medicare and Medicaid Services**	1. TRANSMITTAL NUMBER: 18-002	2. STATE Arizona
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE January 1, 2018	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 447	7. FEDERAL BUDGET IMPACT: FFY 17: $2,326,900 FFY 18: $2,332,600
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Att. 4.19-A, 19-21, 24	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same

10. SUBJECT OF AMENDMENT:

Updates the State Plan to rebase the DRG rates.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Elizabeth Lorenz 801 E. Jefferson, MD#4200 Phoenix, Arizona 85034
13. TYPED NAME: Elizabeth Lorenz	
14. TITLE: Assistant Director	
15. DATE SUBMITTED: 2/26/18	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:
23. REMARKS:	

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, 2016~~January 1, 2018 at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGrates.html
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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 used in the Medicare inpatient prospective payment system for the fiscal year October 1, 2013 through September 30, 2014, 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, 2016~~January 1, 2018 at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGrates.html

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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, 20150. 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 1.110055 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 at least 46,112 AHCCCS-covered inpatient days during the fiscal year beginning October 1, 2010 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, 2011 and December 31, 2011. 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 January 1, 20187, AHCCCS will apply one of seven nine service policy adjustors where the claim meets certain conditions. The seven nine service policy adjustors, the conditions to which they apply, and the adjustment values are described below:

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. Burns DRG codes: 2.70
7. Claims for patients under age 19 assigned DRG codes other than those described in items 1 through 5 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 5 above and with severity of illness level 3 or 4: 1.9452.30
9. All Other Adjustor: 1.025

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

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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 January 1, 2018~~October 1, 2016~~ 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.

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K. Length of Stay Defined

For purposes of inpatient hospital reimbursement, the length of stay is equal to the total number of calendar days of an inpatient stay beginning with the date of admission and ending with the date of

discharge or transfer, but not including the date of discharge or transfer unless the patient expires. A claim for inpatient services with an admission date and discharge date that are the same calendar date will be processed and reimbursed as an outpatient claim, unless the patient expired on the date of discharge.

~~L. Documentation and Coding Improvement and Transition Adjustment Factors~~

~~A DCI and transition adjustment factor will be applied to each claim for an inpatient hospital stay. The DCI and transition adjustment factor is a hospital-specific value established to limit the financial impact to individual hospitals of the transition to a DRG payment methodology, by phasing in the impact over two years, with full implementation in the third year, and to account for improvements in documentation and coding that are expected as a result of the transition. The DCI and transition adjustment factors are published as part of the AHCCCS capped fee schedule and posted on the AHCCCS website as of October 1, 2016 at~~

~~https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGrates.html~~

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M. DRG Final Payment

The DRG final base payment is the lesser of the DRG initial base payment determined under paragraph G and the DRG transfer payment determined under paragraph I, and multiplied by a proration factor if applicable~~, and further multiplied by the DCI and transition factor~~. The DRG final outlier add-on payment is the outlier add-on payment determined under paragraph H, and multiplied by a proration factor if applicable~~, and further multiplied by the DCI and transition factor~~. The DRG final payment amount is equal to the DRG final base payment amount plus the DRG final outlier add-on payment amount.