DRG 2014
Public Comments

Numb:	**Date/ Commentor:**	**Comment:**	**Response:**
1.	04/29/14 Tina Meredith Hacienda Health Care	There is a potential negative impact the DRGs will have on Los Niños Hospital. More specifically, the transfer payments. We will always have transfer payment DRGs for every admission since our children are referred from other hospitals that will have used up most if not all the payment days associated. Can Los Niños Hospital be made an exception? Is it possible to be allowed to start a new APR-DRG for each admission, excluding us from the transfer DRGs? Health plans will be able to encounter their data using the new methodology but Los Niños Hospital will be compensated for care provided.	Proposed Rule R9-22-712.67(E) states: The hospital the member is transferred to will receive a full DRG payment regardless of the DRG payment made to the transferring hospital. There is no 25 day inpatient day limit effective with dates of discharge on and after October 1, 2014. Thus there will be no situation in which payment days will be used up. See R9-22-204(B).
2.	04/25/14 Sandy Price IASIS health care	The IASIS facilities fully support the comments from AzHHA concerning the APR-DRG proposed rule A.R.S. 36-2903.01	Noted.
3.	04/28/14 Greg Vigdor AzHHA	There are some substantial policy changes contained in the proposed rule that were not discussed in DRG Workgroup or by the Legislature when the enabling legislation was vetted and enacted. These include, for example, the readmissions penalty and elimination of the annual inflation factor. We believe these issues warrant additional work and discussion with	The Administration did present policy decisions related to the readmissions penalty made by the Administration in December 17, 2013 at a DRG workgroup. The material can be found at: http://www.azahcccs.gov/commercial/Downloads/PaymentPolicyIssues121713.pdf

		stakeholders prior to implementation.	The annual inflation faction is addressed under response to comment 5.
4.	04/28/14 Greg Vigdor AzHHA	Preamble – EIS **We recommend that the second sentence include the words "to the state" after the phrase economic impact, to better reflect the intention and impact of the proposed rulemaking.** The last paragraph of this section outlines a proposed two-year transition period, which we strongly support. However, the proposed rules do not appear to incorporate this transition period. **As such, we request that the two-year transition period be added to the rules to prevent any confusion as to the intent of the AHCCCS Administration**.	The Administration agrees to add words "to the state" . Updated preamble. Although the AHCCCS Administration contemplates a 2 year transition period, no specific time period is specified in rule to provide the Agency flexibility. The specific factor used for each hospital will be published on AHCCCS' website.
5.	04/28/14 Greg Vigdor AzHHA	R9-22-712.76 Interim Claims In some cases, because of extraordinary lengths of stay, hospitals will ask for interim payments. The proposed rate of $500 prescribed in R9-22-712.76, subsection B, is far below the actual average per-diem reimbursement rate, which based on the March 21, 2014 model developed by AHCCCS, is $1,341. **Based on the model, we suggest the interim claim payment rate be increased from $500 to $1,300 per day**.	Hospitals submitting interim claims are required to void those claims (resulting in a recoupment of the interim payments) and resubmit a single claim that covers the entire length representing a complete and accurate description of the services rendered which will be reimbursed under the DRG methodology. Payment of interim claims at the average per diem rate will not adequate incentives hospitals to void the interim claims and submit a final claim. In consultation with consultants retained by the Administration, we conclude that a $500 per diem payment for interim claims addresses the immediate cash flow needs of the hospital and provides the appropriate incentive for the submission of a complete and accurate final claim that will be reimbursed under the DRG methodology.
6.	04/28/14 Greg Vigdor AzHHA	R9-22-712.40 and R9-22-712.81 While the Legislature has chosen to suspend inflation funding due to recent budget shortfalls, we do not believe this signals legislative intent to authorize the AHCCCS Administration to permanently eliminate	In Arizona Laws 2012, 2nd Regular Session, Chapter 122, Section 7, the Legislature end-dated annual adjustment of tiered per diem payments. It did not suspend inflation. In addition, the legislature did not grant AHCCCS the explicit or implicit authority to provide for an automatic adjustment for inflation of inpatient rates through

		inflation funding moving forward and to replace it with an "access to care standard." The proposed regulations should include flexibility for updates that are approved through the appropriation process in the normal legislative process.	rule. In the event that the Legislature appropriates additional funds in future fiscal years for this purpose and assuming that an increase is consistent with federal requirements for the establishment of rates that are consistent with efficiency and economy, the Administration will address adjustments as provided for in proposed rule R9-22-712.81 or through future amendments to this rule as necessary. AHCCCS is required to establish a program within its annual appropriation and limit capitation rate increases to no more than 3 percent in fiscal years 2015, 2016, and 2017 (see Arizona Laws 2014 Chapter 11, § 28). The access to care standards are required by federal law 42 USC 1396a(a)(30)(A).
7.	04/28/14 Greg Vigdor AzHHA	R9-22-712.81 **We urge the Administration to include an annual inflation factor in the proposed rulemaking, consistent with prior AHCCCS practices and Medicare, and we propose the following language for R9-22-712.81:** ***"In addition to the other updates provided for in sections R9-22-712.60 through R9-22-712.80 the Administration shall, beginning on October 1, 2015, and every succeeding year adjust the inpatient standard rate by the Global Insight Prospective Hospital Market Basket Inflation Index***." **Similar language should be added for hospitals that will continue to be paid on a per diem basis, such as rehabilitation, psychiatric and long term acute care hospitals.**	See the above response.
8.	04/28/14 Greg Vigdor	R9-22-712.40 R9-22-712.40, as amended, and R9-22-712.81, as proposed, would replace a pre-existing statutory	The proposed rule R9-22-712.40 does not replace annual inflation for outpatient hospital services. The Administration amended the rule R9-22-712.40 effective July 18, 2012 to end- date the

	AzHHA	inflation factor (the DRI factor developed by Global Insights) with an "access to care" standard. **We further urge the Administration, beginning October 1, 2015, to reinstate the annual update in R9-22-712.40 for outpatient payments, and propose the following language for Subsection C:** ***"Annual update for Outpatient Hospital Fee Schedule. Beginning on October 1, 2015 AHCCCS shall adjust outpatient fee schedule rates by the Global Insight Prospective Hospital Market Basket Inflation Index."***	requirement for annual inflation as of September 30, 2011. In Arizona Laws 2012 Chapter 299 §19, the Arizona Legislature end-dated annual adjustments for inflation for outpatient hospital services provided as of September 30, 2011. The Administration lacks authority to do so in rule. See also number 5.
9.	04/28/14 Greg Vigdor AzHHA	At a minimum, the AHCCCS Administration should annually evaluate the adequacy of payment rates to hospitals relative to full costs, not variable costs, and report these findings to the Legislature.	Consistent with federal requirements, 42 CFR 447.204,, and as reflected in R9-22-712.40(G) and R9-22-712.81, and subject to sufficient legislative appropriations for that purpose, the Administration will evaluate its reimbursement methodologies to ensure that rates are consistent with efficiency, economy and quality of care and are sufficient to enlist enough hospital provides so that care is available to the same extent as to the general population in the same geographic area.
10.	04/28/14 Greg Vigdor AzHHA	R9-22-712.62 Subsection C requires claims to be assigned a "Pre-HCAC" DRG code, which is derived from all diagnosis and surgical procedure codes, and a "post-HCAC" DRG code, which excludes codes associated with HCACs or OPPCs. The DRG code with the lower relative weight will be used to process the claim. The definition of HCACs in the proposed rule appears to align with the list of HCACs in the current AHCCCS non-payment policy. And, while we believe the intent is to limit non-payment to situations in which the HCAC is not present on admission, this is not clearly set forth in the proposed rule. **We request the Administration to clarify that non-payment for HCACs is restricted to reimbursement for services in which the HCAC is**	The Administration agrees, subsection C1 has been updated to indicate the HCAC was not present on admission.

		not present on admission.	
11.	04/28/14 Greg Vigdor AzHHA	Similarly the proposed rule states that OPPCs "*include* a wrong surgical or other invasive procedure performed on a patient …….the use of the term "include" implies that the list is not definitive. The proposed regulations therefore allows the Administration or its contractors to expand the list to additional conditions or procedures that they deem provider-preventable, without the benefit of public input or on an ad hoc basis. **We urge the Administration to replace the term "include" with "are."** Any changes to the list of OPPCs should be addressed in subsequent rulemakings with additional public input.	The Administration agrees and has made a corresponding change. The definitions of both OPPC and HCAC have been moved to R9-22-701.
12.	04/28/14 Greg Vigdor AzHHA	R9-22-712.62 (C) (2) defines an OPPC as occurring in *any health care setting*. While this aligns with the federal definition and current Administration policy generally, it is confusing in the context of this rule—the purpose of which is to establish an inpatient hospital payment methodology. We are unsure how an OPPC in an outpatient setting could be coded with a DRG. **With this in mind, we recommend that the definition of OPPC in R9-22-712.62 be limited to the inpatient setting. Non-payment procedures related to OPPCs occurring in outpatient settings should be prescribed in separate outpatient rules**.	The Administration agrees and has updated subsection C2 by removing "occurring in any health care setting". The definition of OPPC has been moved to R9-22-701.
13.	04/28/14 Greg Vigdor AzHHA	As a general policy matter, we urge the Administration to appoint an advisory committee consisting of quality experts, including hospital representatives, to advise the Administration on policies relating to nonpayment for HCACs and OPPCs and other value based purchasing quality metrics. In recent years, there has been a significant increase in evidence-based practices and knowledge relating to quality measurements, particular	Thank you for your suggestion.

		in the hospital setting. Private and public quality experts, including those at CMS have begun to reassess some of the HCAC measures included in Arizona's state plan. An expert advisory panel could assist the Administration in developing provider-related quality metrics and other policies that are based on the best available evidence and clinical knowledge. We would welcome the opportunity to work with the Administration on this endeavor.	
14.	04/28/14 Greg Vigdor AzHHA	R9-22-712.71 indicates that the final DRG payment and DRG outlier add-on payment will be "…established to limit the financial impact to individual hospitals…and to account for improvement in documentation and coding that are expected as a result of the transition." The model AHCCCS has provided does not mention, nor does the rulemaking include any other mention of accounting for improvement in documentation and coding. **In order to avoid future confusion and uncertainty we recommend that the Administration clarify:** **1. How it intends to demonstrate that there has been an actual improvement in documentation and coding; and** **2. If an adjustment for the impact is built into the model, what the amount is and how it was computed.** **We recommend that this be delineated out in the rulemaking and the model.**	The purpose of R9-22-712.71 is to provide notice to hospitals that adjustments will be made for improvements in documentation and coding and to limit the financial impact to individual hospitals due to the transition from tiered per diem payments to DRG based payments. However the values for the coding and hospital-specific adjustments are part of the capped fee schedule which is exempt from the requirements of formal rule-making and which will provide for flexibility. ARS 41-1005(A)(9). The hospital specific values that are being used in subsections A and B are published on AHCCCS' website. Consistent with federal requirements, any changes to the values in future years during the transition will be preceded by public notice and an opportunity for comments. 42 CFR 447.205(?) Information on the documentation and coding improvement factor and transition factor was presented to the hospital DRG workgroup on December 17, 2013. That information is posted on the AHCCCS website at: http://www.azahcccs.gov/commercial/Downloads/AZDRGWorkgroup121713.pptx and provides further detail regarding these questions.
15.	04/28/14 Greg Vigdor AzHHA	R9-22-712.78 Hospitals have no idea what criteria will be used to determine whether a readmission is preventable by a hospital, nor who will make this determination. It is	The determination whether a readmission is preventable is a medical determination that is made on a case by case basis. The initial determination will be made by the medical director of the healthplan

		essential for cost effective, quality care that there be clear, transparent, standardized, evidence-based criteria for determining what readmissions are preventable, and that these decisions not be made on an ad hoc basis.	or the Administration and is subject for review through the hearing process.
16.	04/28/14 Greg Vigdor AzHHA	**We urge the Administration to delay implementation of a readmissions payment policy until it can convene a panel of quality experts, including representatives from hospitals, to advise the Administration on best practices for reducing Medicaid readmissions, including making recommendations on the appropriate criteria for determining which types of readmissions are preventable.**	It would be inconsistent with federal law and the Administration's statutory mandate to control costs for the Administration to reimburse hospitals for inpatient services that would have been unnecessary but for some action or inaction on the part of the hospital. 42 USC 1396a(a)(30)(A) and ARS 36-2907(D).
17.	04/28/14 Greg Vigdor AzHHA	**R9-22-712.77** Subsection A should be amended as follows, to parallel AHCCCS policy and avoid confusion: A. Except as provided for in subsection (b), for any claim for inpatient services with an admission date and discharge date that are the same calendar date, the claim shall be processed as an outpatient claim using the default outpatient cost-to-charge ratio and the hospital shall be reimbursed under R9-22-712.10 through R9-22-712.50. Hospitals are not being required to rebill claims as outpatient claims in order to be paid pursuant to the subsection.	The Administration amended the rule to improve clarity.
18.	04/28/14 Greg Vigdor AzHHA	**R9-22-712.74** R9-22-712.74 states that DRG payments are subject to cost avoidance, including "for claims for ancillary services covered by Part B Medicare." We do not understand the purpose for the rule. As the rule itself states, it appears wholly duplicative of the R9-22-1003; ordinary rules of regulatory construction by courts	Because part B of Medicare reimburses certain inpatient hospital services in a manner different from DRG's, this rule was added to clarify that consistent with R9-22-1003 payment otherwise due under the DRG reimbursement methodology will be reduced by any payments received through part B for the same inpatient services.

		would conclude that something different than or in addition to R9-22-1003 is intended. If that is true, we cannot tell what it is. The rule should be eliminated or AHCCCS should explain its purpose and effect and give the public opportunity to comment. we do not understand why AHCCCS is singling out "Part B only" claims for separate discussion of cost avoidance. Specifically we cannot tell if AHCCCS intends this "cost avoidance for claims for ancillary services" to operate any different than the current reimbursement methodology (AHCCCS inpatient allowable – Part B payment = net payment to hospital). If some new payment approach or formula is contemplated, it should be subject to public comment.	
19.	04/28/14 Greg Vigdor AzHHA	**R9-22-712.75** We request that the following changes be made to R9-22-712.75 Subsection A: A. . . . but is not discharged because an appropriate placement outside the hospital is not available for any reason, including the contractor's administrative or operational delays, or the member cannot be safely discharged . . . This language parallels the language of Subsection B, and equalizes the financial risk of inaction; currently, there is no incentive for contractors to timely respond to requests for placement assistance or authorizations for post-hospital services. We also request that Subsection E be clarified to indicate that payment should be made for all medically necessary services provided on administrative days, and not only payment at a base, non-inclusive, rate for the "level of care." This comes up most frequently with nursing facility days, for which the daily rate is	The Administration has revised the proposed rule to address your concern. The rule is intended to provide reimbursement at the same rate that would have been paid had the patient been discharged to an appropriate level of care.

		frequently not inclusive of all services.	
20.	04/28/14 Greg Vigdor AzHHA	**R9-22-701** Under R9-22-701, we suggest that definitions be added for APR-DRG, and the Medicare Wage Index, including which versions are being relied on. We also recommend that the Medicare Wage Index be updated annually. We recommend the Administration consider updating the definition of "Revenue Code" by replacing "UB – 92" with "UB-04". In addition we recommend the Administration add a definition of "administrative days." It is used as early as page 23 (R9-22-703(D) (1)), but not defined until page 59(R9-22-712.75(A));	The Wage Index is defined in R9-22-712.62(B). APR-DRG is described in R9-22-712.60(C). APR-DRG – The Administration has reviewed the proposed rule and determined that the more general term DRG and the more specific term APR-DRG are used appropriately throughout the rule. Revenue Code definition has been updated. Administrative Days – A cross-reference has been included under R9-22-703. APR DRG payments are made up of multiple components, none of which will be changing on an annual basis (except the outlier CCRs). All the components will be under review at rebase. One of the Administration's goals is for the DRG payment methodology to have a budget neutral impact to the State of Arizona (subject to the State's obligation under federal law to establish rates that are consistent with efficiency, economy, quality and access to care). An automatic adjustment to select components of the methodology conflicts with the ability of the Administration to ensure budget neutrality in future years.
21.	04/28/14 Greg Vigdor AzHHA	Several sections of the proposed rulemaking refer to "DRG" rather than "APR-DRG". Unless the more general term is warranted, we recommend that the Administration consider replacing "DRG" with "APR-DRG" in these sections. (For example, see R9-22- 703, subsection K, where the proposed rule refers to DRG rate, when it should instead state APR-DRG rate, and R9-22-712.61, subsection B, where the rule refers to DRG methodology, when it should instead state APR-DRG methodology.)	See above.

22.	05/14/14 Susan Watchman Gammage and Burnham	In A.A.C. R9-22-712.61(B), you use the phrase "primary diagnosis upon admission." But that confounds two codes and fields on the UB -- box 66 which is used for the "primary diagnosis code" (determined at or after discharge) and box 69, which is the "admitting diagnosis" (what they think is going on at admission). The current AHCCCS and ADHS policy is driven by "primary diagnosis code." We had a matter go through hearing because a RBHA was asserting that the current policy was not clear and it believed their responsibility was driven by the admitting code, or required both to be in the range. They were incorrect, as confirmed in the decision. The language you are using in these proposed regs now creates the very ambiguity the RBHA asserted was there before and wasn't that is, do you mean the admitting dx code (new approach) or the primary dx code (current approach).	The Administration agrees with the comment and will remove "upon admission" from the rule language.