March 4, 2019

Ms. Jami Snyder  
Director  
Arizona Health Care Cost Containment System  
801. E. Jefferson  
Phoenix, AZ 85034

Dear Jami:

Thank you for the opportunity to comment on the AHCCCS Administration’s CYE 2020 Differential Adjusted Payment (DAP) proposal contained in the Preliminary Public Notice dated Jan. 31, 2019. I am responding on behalf of the Arizona Hospital and Healthcare Association (AzHHA). AzHHA is a statewide association of more than 80 hospital, healthcare and affiliated health system members. We represent short-term acute care, behavioral health, post-acute care, and critical access hospitals, as well as their affiliated clinics and staff.

After consultation with members, we would like to share the following feedback on the proposal.

Hospital, Provider Type 2

As mentioned in our Nov. 27, 2018 response to the CYE 2020 DAP Request for Information, we are somewhat hesitant to recommend or opine on specific metrics, and instead recommend the AHCCCS Administration convene an expert panel that can advise the Administration on a multi—year approach for incorporating validated performance measures and benchmarks into a DAP program that align with the Administration’s quality strategy and DAP principles. Our letter outlined the reasons why we believe such an expert panel or “technical advisory group,” is crucial to developing a mature DAP program. We continue to support this approach.

Nevertheless, our Nov. 27th comment letter noted a rising concern regarding sepsis in the acute care setting. The Administration’s Jan. 31, 2019 preliminary DAP notice incorporates a Medicare-benchmarked sepsis metric. We appreciate the Administration focusing on sepsis. We strongly believe this is an area where Arizona hospital’s have an opportunity to improve outcomes. Having said this, we would once again urge the Administration to convene the aforementioned expert panel, which could advise the Administration on sepsis metrics that utilize the most recent reported data and may therefore be a better measure of current
hospital performance. This approach is equally true, if not more so, for the serious complication performance metric.

The Medicare serious complication performance metric is attractive on its face, since it is a composite score that takes into account a number of preventable hospital associated conditions. However, members and quality staff have reported concerns with the CMS methodology for calculating the PSI-90 measurement. CMS has made a number of changes to the metric’s technical specifications over the years, but there continue to be calls for additional revisions. Moreover, some of the data included in the composite score are quite old, and not a good reflection of current hospital performance.

Finally, AzHHA recommends that the Administration re-evaluate pediatric preparedness certification for continued inclusion as a DAP metric. This program has much merit, but we are unclear how this certification fits into the overall AHCCCS quality strategy. Recent changes to the certification requirements will require certain hospitals to invest significant resources or replace staff in order to comply. Hospitals in communities with small pediatric populations and limited resources will be at a financial disadvantage and may chose to forgo certification. This does not mean they are not committed to serving pediatric patients with the highest quality of care. Rather, this commitment is shown through participation and investment in other programs.

Critical Access Hospitals (CAHs)

Administration staff requested AzHHA provide feedback on alternative metrics for CAHs, since these facilities are not required to participate in the Medicare inpatient quality reporting program. Those that choose to participate have too low of volume for performance to be publicly reported. As such, CAHs are not likely to have any sepsis or PSI-90 data for the Administration to pull from the Medicare website.

We have discussed possible CAH metrics with the Arizona Center for Rural Health (CRH), which administers the Medicare Beneficiary Quality Improvement Project (MBQIP) for Arizona’s CAHs. We are in general agreement with the CRH staff that participation in an antimicrobial stewardship program would be an appropriate measure for AHCCCS to consider. We believe it will meet most, if not all, of the Administration’s DAP principles. There are reporting and data extracting timelines to consider, which the Administration would need to discuss with the CRH’s MBQIP point of contact, Jill Bullock. We are not certain if the CRH itself will be able to extract data and provide third party attestation for benchmarking purposes, but we believe this is a good place to start the conversation.

Psychiatric Hospitals

An issue that inpatient psychiatric facilities (IPFs) continue to raise is the legal barrier that 42 CFR, Part 2 (Part 2) plays in their ability to share patient data with the health information exchange and other healthcare providers. Part 2 applies to any individual or entity that is federally assisted and holds itself out as providing, and provides, alcohol or drug abuse
diagnosis, treatment, or referral for treatment (42 CFR § 2.11). The regulations restrict the disclosure and use of patient records to the extent those records would identify the patient as being treated for or having a substance use disorder. Disclosure of this information—even for treatment—requires patient consent. Because IPFs almost universally are Part 2 providers, they are heavily limited in transmitting patient records to the health information exchange. This means that participation in the health information exchange is of limited value for this patient population—until we can convince the federal government to amend Part 2 regulations.

In the meantime, IPFs will continue to encourage patients to consent to sharing their information with other providers. However, this is not always an easy task, and it is a legal hindrance that general acute care hospitals and other non-Part 2 providers do not face. With this in mind, we recommend that the Administration consider alternative metrics to HIE participation for psychiatric hospitals—at least until such time as we can get the federal government to change 42 CFR, Part 2. Members have recommended metrics contained in the hospital-based inpatient psychiatric services (HBIPS) core measure set. An expert panel of quality experts would be able to provide additional information on benchmarking HBIPS data and how best to extract hospital performance.

**Integrated Clinics**

We strongly support the inclusion of a DAP metric for integrated clinics (Provider Type IC). But we also believe that this type of integration should be incentivized across the continuum. Many outpatient treatment centers (OTCs), such as rural health centers, primary care clinics, and federally qualified health center look-a-likes, have begun integration projects with behavioral health services. These clinics—many of which are hospital-based—meet all state licensing requirements for OTCs, but bill under Provider Type 02 for various reasons, including integrated medical staff bylaws and policy manuals. Given the high priority that AHCCCS has placed on physical-behavioral health integration, we believe the Administration should look to developing a DAP incentive that can be implemented across provider types.

Thank you again for the opportunity to comment on the CYE 2020 DAP preliminary notice. Please do not hesitate to contact me if you have any questions.

Sincerely,

[Signature]

Debbie Johnston
Senior Vice President, Policy Development