December 8, 2023

Executive Deputy Director Carmen Heredia
Arizona Health Care Cost Containment System
801 E. Jefferson
Phoenix, AZ 85034

Dear Executive Deputy Director Carmen Heredia:

Thank you for the opportunity to comment on the proposed model for HEALTHII payments related to quality metrics. The Arizona Hospital and Healthcare Association held several meetings to discuss the proposal. The overwhelming feedback from hospitals has been a request to move much more cautiously with the program to ensure that the new components of the program are well thought through and do not negatively impact access to care for AHCCCS recipients.

General recommendations were:

- **Hospitals reiterated their request to be provided enough notice to make positive impacts between the baseline year and the performance year.** The metrics were finalized in April 2022, yet AHCCCS has proposed using October 2021-September 2022 as the performance period. Choosing a performance year that was half over before the quality metrics were chosen does not provide hospitals sufficient time to make meaningful changes.

- **AHCCCS should adopt a data validation pilot program with data submitted for the first two years and not move forward to paying for performance until AHCCCS and hospitals have had sufficient time to validate data and ensure meaningful results.** This is consistent with the process CMS implements for most of its quality metrics. It would further allow AHCCCS to ensure that the quality metrics which were chosen are meaningful and do not inadvertently impact access to care. For example, behavioral health hospitals that increase the number of adolescents served may see an increase in restraint and/or seclusion usage. Before medicating adolescents, behavioral health hospitals must first obtain consent from parents/guardians. In some cases, this can take time, especially when adolescents are in the custody of the Arizona Department of Child Safety. When awaiting approval, sometimes behavioral health hospitals use restraints and/or seclusion to protect the safety of the patients and staff. Additionally, hospitals with a special needs unit or who take involuntary patients may see higher fluctuations with restraints and/or seclusions depending on changes in acuity and/or patient volume.

- **AHCCCS should significantly reduce the amount of HEALTHII payments tied to quality metrics.** AHCCCS is currently proposing that approximately $330 million, or 19% of net HEALTHII payments, be tied to quality metrics. This is far larger than the $20-$50 million initially proposed in early 2023 or the no more than 3-5% proposed by AHCCCS in 2021. It is our understanding that this far surpasses any percentage which CMS ties to quality metrics and is significantly more than almost any state ties to quality metrics.

- **The performance weight subtotal should be reconsidered for Short Stay Hospitals, Long Term Acute Care Hospitals, Behavioral Health Hospitals, and General Acute Care Hospitals.** These hospitals could lose more than 1/3 of payments based on performance metrics, while other types of hospitals are at-risk for only 25%. Unlike other performance metrics implemented by AHCCCS and CMS, hospitals are providing the state match.

- **Finally, AzHHA hospitals once again reiterates the need for an on-going quality group, comprised of quality experts from the healthcare delivery system which would help develop a long-term strategic plan**. This would bring the right people to the table to ensure that quality metrics and the way in which they are collected are meaningful and can positively impact healthcare for AHCCCS recipients. AHCCCS should also consider having additional conversations with experts at the federal level who can add insights on the implementation of CMS quality metrics and lessons learned as they have been moving to pay-for-performance.

In addition to these recommendations, Critical Access Hospitals are particularly concerned about moving to pay-for-performance, instead of pay-for-reporting for OP-18 Median Time from ED Arrival to ED Departure. Fluctuations exist for a variety of reasons, including losing a doctor in a rural area—it is often much more challenging to replace a doctor in rural areas. CAHs suggested that it may make sense to compare the median time to urban hospitals as opposed to other rural hospitals but would first recommend additional review before implementing.

Once again, we greatly appreciate the continued opportunity to provide comments. Please feel free to reach out to me at aupston@azhha.org if you have any additional questions. Thank you for your time and consideration.

Sincerely,

Amy Upston
Director of Financial Policy and Reimbursement

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