

December 17, 2020

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 #20-028, "NF DAP"

Dear Mr. Wong:

Enclosed is State Plan Amendment (SPA) #20-028, NF DAP, which updates the State Plan to update the NF DAP program, effective October 1, 2020. Please see below for information regarding the fiscal analysis, as well as public comment and Tribal Consultation requirements:

Public Comment:

- https://www.azahcccs.gov/AHCCCS/PublicNotices/
- <u>https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/DAP\_Final\_Notice\_CYE2021\_Revised\_09282020.pdf;</u>

Tribal Consultation:

- https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html
- <u>https://www.azahcccs.gov/AmericanIndians/Downloads/Consultations/Meetings/2020/MASTER</u> SLIDESHOWSpecialTCDAP.pdf
- <u>https://www.azahcccs.gov/AmericanIndians/Downloads/Consultations/Meetings/2020/08</u> 132020\_QuarterlyTribalConsultation.pdf

Fiscal Analysis:

	FFS Estimates	Federal Funds	
NF DAP-	796,900	595,000 74	1.67%

\*Estimate is based on all populations blended FMAP for FFY21.

\*\*Estimate assumes COVID PHE increased FMAP for 3 of 4 quarters in FFY21.

If you have any questions about the enclosed SPA, please contact Alex Demyan at (602) 417-4130.

Sincerely,

Dana Flannery Assistant Director Arizona Health Care Cost Containment System (AHCCCS)

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	1. TRANSMITTAL NUMBER: 20-028	2. STATE Arizona		
FOR: Centers for Medicare and Medicaid Services	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 5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):	4. PROPOSED EFFECTIVE DATE October 1, 2020			
□ 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:	7. FEDERAL BUDGET IMPACT:	ementamenti		
42 CFR Part 447	FFY 2020: \$0 <b>595,000</b> FFY 2021: \$0			
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):			
Attachment 4.19-D Page 9(b)	Attachment 4.19-D Page 9(b)			
10. SUBJECT OF AMENDMENT: Updates the State Plan to update the NF DAP program.				
<ul> <li>11. GOVERNOR'S REVIEW (Check One):</li> <li></li></ul>	OTHER, AS SPEC	IFIED:		
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:			
AAES	Dana Flannery 801 E. Jefferson, MD#4200 Phoenix, Arizona 85034			
13. TYPED NAME:				
Dana Flannery 14. TITLE:				
Assistant Director				
15. DATE SUBMITTED:				
December 17, 2020				
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:				

## **INSTRUCTIONS FOR COMPLETING FORM CMS-179**

Use Form CMS-179 to transmit State plan material to the regional office for approval. A separate <u>typed</u> transmittal form should be completed for each plan/amendment submitted.

Block 1 -Transmittal Number - Enter the State Plan Amendment transmittal number. Assign consecutive numbers on a calendar year basis (e.g., 92-001, 92-002, etc.).

Block 2 - State -Type the name of the State submitting the plan material.

Block 3 - Program Identification - Title XIX of the Social Security Act (Medicaid).

Block 4 - Proposed Effective Date - Enter the proposed effective date of material.

Block 5 -Type of Plan Material - Check the appropriate box.

Block 6 - Federal Statute/Regulation Citation - Enter the appropriate statutory/regulatory citation.

Block 7 - Federal Budget Impact - 7(a) - Enter 1st Federal Fiscal Year (FFY) impacted by the SPA & estimated Federal share of the cost of the SPA (in thousands) for 1st FFY. 7(b) - Enter 2nd FFY impacted by the SPA & estimated Federal share of the cost for 2nd FFY. See SMM section 13026.

Block 8 - Page No.(s) of Plan Section or Attachment - Enter the page number(s) of plan material transmitted. If additional space is needed, use bond paper.

Block 9 - Page No.(s) of the Superseded Plan Section or Attachment (if Applicable) - Enter the page number(s) (including the transmittal sheet number) that is being superseded. If additional space is needed, use bond paper.

Block 10 - Subject of Amendment - Briefly describe plan material being transmitted.

Block 11 - Governor's Review - Check the appropriate box. See SMM section 13026 B.

Block 12 - Signature of State Agency Official -Authorized State official signs this block.

Block 13 -Typed Name -Type name of State official who signed block 12.

Block 14 -Title -Type title of State official who signed block 12.

Block 15 - Date Submitted - Enter the date you mail plan material to RO.

Block 16 - Return To -Type the name and address of State official to whom this form should be returned.

Block 17-23 (FOR REGIONAL OFFICE USE ONLY).

Block 17 - Date Received - Enter the date plan material is received in RO. See ROM section 6003.2.

Block 18 - Date Approved - Enter the date RO approved the plan material.

Block 19 - Effective Date of Approved Material - Enter the date the plan material becomes effective. If more than one effective date, list each provision and its effective date in Block 23 or attach a sheet.

Block 20 - Signature of Regional Official -Approving RO official signs this block.

Block 21 -Typed Name -Type approving official's name.

Block 22 -Title -Type approving official's title.

Block 23 - Remarks - Use this block to reference pen and ink changes, a partial approval, more than one effective date, etc. If additional space is needed, use bond paper.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB number for this information collection is 0938-0193. The time required to complete this information collection is the stimated to average 1 hour per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attr: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21224-1850.

Attachment 4.19-D Page 9(b)

# STANDARDS FOR ESTABLISHING FEE-FOR-SERVICE

METHODS AND STANDARDS FOR ESTABLISHING FEE-FOR-SERVICE PAYMENT RATES FOR LONG TERM CARE FACILITIES

## F. Nursing Facility Differential Adjusted Payment

As of October 1, 202019 through September 30, 20219 (Contract Year Ending (CYE) 20219), Provider type 22 nursing facilities that are located in Arizona with Arizona Medicaid utilization that meet AHCCCS established value based performance metrics requirements below will receive one or both of the Differential Adjusted Payments described below The Differential Adjusted Payment Schedule represents a positive adjustment to the AHCCCS Fee-For-Service rates. These payment adjustments will occur for all dates of service in CYE 20219 only. The purpose of the Differential Adjusted Payment is to distinguish facilities which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth.

- 1. To qualify for the Differential Adjusted Payment, a nursing facility must meet the following criteria:
  - a) Must be an AHCCCS registered provider type 22; and
  - b) Must be at or below the Arizona average percent of High-Risk Residents with Pressure Ulcers (Long Stay) based on the facility's performance results for long-stay, high-risk residents with Stage II-IV pressure ulcers reported in MDS 3.0 for this CMS Nursing Home Quality Measure metric as of <u>May 12April 30</u>, 202019.
  - c) On May 12April 30, 202019, AHCCCS will download data from the Medicare Nursing Home Compare website for the percent of long-stay residents with a urinary tract infection (UTI). Facility results will be compared to the Arizona Average results for the measure. Facilities with percentages less than or equal to the state-wide average score will qualify for the DAP increase.
- Nursing facilities that meet the requirements described in subsection 1 shall be eligible to receive a differential adjusted payment. Eligible nursing facilities as described in 1.b. will receive a 1% increase to its fee-for-service reimbursement rate for October 1, 202019 through September 30, 202120.

Nursing facilities that meet the requirements described in subsection 1 shall be eligible to receive a differential adjusted payment. Eligible nursing facilities as described in 1.c. will receive a 1% increase to its fee-for-service reimbursement rate for October 1, 202049 through September 30, 202120.

#### Exemptions:

IHS and 638 tribally owned and/or operated facilities, including nursing facilities are exempt from this initiative based on payments primarily at the all-inclusive rate.

### **Payment Methodology**

For Provider Type 22 nursing facilities, the fee-for-service payment rates will be increased by 1.0% if they meet the Pressure Ulcer requirements outlined in F.1.b and by 1.0% if they meet the UTI performance requirements outlined in F.1.c. A Provider Type 22 facility meeting both Pressure Ulcer and UTI requirements will receive a combined 2.0% increase. These increases do not apply to supplemental payments.

TN No. 19-01520-028 Supersedes Approval Date: \_\_\_\_\_ TN No. 18-01819-015

Effective Date: October 1, 202019