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| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: Centers for Medicare and Medicaid Services | | 1. TRANSMITTAL NUMBER: 15-002 | 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, 2015 | |
| 5. TYPE OF PLAN MATERIAL (<i>Check One</i>): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT | | | |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>) | | | |
| 6. FEDERAL STATUTE/REGULATION CITATION: 1927(b) | | 7. FEDERAL BUDGET IMPACT: FFY 15: \$1,030,000 FFY 16: \$1,030,000 | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Att. 4.19-D, page 9(a) | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Same | |
| 10. SUBJECT OF AMENDMENT: Updates the Nursing Facility assessment dollar amounts in State Plan. | | | |
| 11. GOVERNOR'S REVIEW (<i>Check One</i>): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:  | | 16. RETURN TO: Monica Coury 801 E. Jefferson, MD#4200 Phoenix, Arizona 85034 | |
| 13. TYPED NAME: Monica Coury | | | |
| 14. TITLE: Assistant Director | | | |
| 15. DATE SUBMITTED: March 19, 2015 | | | |
| 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 PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARIZONAMETHODS AND STANDARDS FOR ESTABLISHING FEE-FOR-SERVICE PAYMENT
RATES FOR LONG TERM CARE FACILITIES

(c) AHCCCS shall make quarterly supplemental payments to nursing facility providers after the assessment quarter. The fee-for-service quarterly supplemental payment will be made directly to each nursing facility. If the fee-for-service quarterly supplemental payment amount is less than \$25 for an individual facility, no fee-for-service quarterly supplemental payment will be made.

(d) A facility must be open on the date the supplemental payment is made in order to receive a payment.

(e) During the quarter ending March 31, 2015, an additional quarterly payment adjustment will be made that is equal to the difference between what the quarterly payment would be if the pool amount was determined under paragraph 2 below effective January 1, 2015 and what the quarterly payment would be if the pool amount was determined based on paragraph 2 as it was in effect prior to January 1, 2015.

2. The nursing facility assessment to be collected from each nursing facility is as follows:

- (a) The assessment is imposed on non-Medicare patient days as allowed for under 42 CFR 433.68(d);
- (b) The assessment imposed is ~~\$7.50~~10.50 per non-Medicare day except:
 - i. Continuing Care Retirement Communities, ICF/MRs, ~~and IHS and Tribal 638 nursing facilities, and Arizona Veteran's Homes~~ will not be assessed;
 - ii. Facilities with 58 or fewer total beds will not be assessed; and
 - iii. Facilities with ~~43,500 or more~~ annual Medicaid days greater than or equal to the number required to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2) will be taxed at a rate of ~~\$1.00~~1.40 per non-Medicare day.

The patient days used in the computations are derived from the Nursing Facility Uniform Accounting Report (UAR) Cost Reports filed with the Arizona Department of Health Services. Calculations for the assessment will be made once per year in August, using the most recently filed UAR as of August 1 immediately preceding the start of the assessment year. The computed annual assessment amount will be divided by four and imposed on a quarterly basis.

TN No. ~~12-01015-002~~

Supersedes

Approval Date _____

Effective Date ~~October 1, 2012~~January 1, 2015

TN No. ~~N/A~~12-010