March 12, 2018

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 #18-004, 638 FQHC

Dear Mr. Wong:

Enclosed is State Plan Amendment (SPA) #18-003, 638 FQHC, which revises the State Plan to create an alternative payment methodology for 638 facilities which elect to be paid as FQHCs.

If you have any questions about the enclosed SPA, please contact Kyle Sawyer at (602) 417-4211.

Sincerely,

Elizabeth Lorenz
Assistant Director
Arizona Health Care Cost Containment System (AHCCCS)

cc: Blake Holt, CMS
Brian Zolynas, CMS

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 **FOR: Centers for Medicare and Medicaid Services**	1. TRANSMITTAL NUMBER: 18-004	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 April 1, 2018	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ 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: 42 CFR Part 447	7. FEDERAL BUDGET IMPACT: FFY 18: $0 FFY 19: $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Att. 4.19-B, 3 ,5, 7	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same

10. SUBJECT OF AMENDMENT:

Updates the State Plan to change the reimbursement rates for specialty drugs dispensed by IHS/638 facilities

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Elizabeth Lorenz 801 E. Jefferson, MD#4200 Phoenix, Arizona 85034
13. TYPED NAME: Elizabeth Lorenz	
14. TITLE: Assistant Director	
15. DATE SUBMITTED: 3/12/18	

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: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

center/clinic's rate will be established from the data that is available. If an existing center/clinic has inadequate data for both periods, they will be treated as a new center/clinic.

3) If the FQHC/RHC elects the BIPA methodology, and there is a change in scope of service, it will be the responsibility of the FQHC/RHC's to request AHCCCS to review services that have had a change to the scope of service. Adjustments will be made to the base rates on a case basis where the FQHC/RHC's can demonstrate that the increases or decreases in the scope of services is not reflected in the base rate and is not temporary in nature. If an FQHC/RHC requests a change in scope due to an increase in utilization for services included in the PPS, current utilization will be compared to the utilization used in the calculation of the PPS from appropriate rate adjustments. If it is determined that a significant change in the scope of service has occurred, the reasonable incremental cost per encounter from this change will be added to the PPS rate and a new rate will be established. A change will not be considered significant unless it impacts the base rate by 5% or more. This new rate will be effective on the date the change in scope of service was implemented.

4) If the FQHC/RHC elects ~~the~~ an Alternative Payment Methodology, then every 3rd year, beginning with the federal fiscal year beginning October 1, 2004, AHCCCS will rebase the rate. The calculation will conform to section 1902(a)(15)(c) of the Social Security Act. AHCCCS will use the data from the center/clinic's fiscal years that end during the two previous calendar years for the rebase rate calculations. The baseline rates for the two previous years will be calculated utilizing the provider's cost data for the center/clinic's fiscal years that end during those two previous calendar years. Costs included in the rebase rate calculation will include Medicaid covered services provided by the FQHC/RHC pursuant to a contract with a MCE. The two calculated previous year base rates will be averaged by calculating a simple average of the costs per encounter for the two previous years. The calculation is as follows:

$$\frac{\text{Total Medicaid costs previous year 1} + \text{Total Medicaid costs previous year 2}}{\text{Total visits previous year 1} + \text{Total visits previous year 2}} = \text{Average Cost Per Visit}$$

These base rates will then be indexed forward utilizing the PSI from the midpoint of the cost report periods being utilized, to the midpoint of the initial rate period. For the next two years thereafter, the PSI will be applied to the inflated-based rates at the beginning of each federal fiscal year (October 1st).

5) FQHCs/RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services, that are an estimate of the difference between the payments the FQHC/RHC receives from MCEs and the payments the FQHC/RHC would have received under the BIPA PPS methodology. At the end of federal fiscal year, the total amount of supplemental and MCE payments received by each FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCEs would have yielded under the PPS. The FQHC/RHC will be paid the difference between the PPS amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC, if the PPS amount exceeds the total amount of supplemental and MCE payments. The FQHC/RHC will refund the difference between the PPS amount calculated using the actual

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC, if the PPS amount is less than the total amount of supplemental and MCE payments.

___ The payment methodology for FQHCs/RHCs will conform to section 702 of the BIPA 2000 legislation.

_X_ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for a Prospective Payment System.

___ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology.

6) If a 638 FQHC elects an Alternative Payment Methodology then the 638 FQHC will be reimbursed the OMB outpatient rate for all FQHC services. The published rate is paid for up to five encounters/visits per recipient per day. Encounters/visits are limited to the AHCCCS-registered facilities that provide covered services to Medicaid members in a 638 FQHC. The encounters/visits will be differentiated based on the patient account numbers that are assigned for each encounter/visit. Encounters/visits include covered telemedicine services.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

Effective January 1, 2000, AHCCCS will reimburse the Indian Health Service (IHS) and tribal facilities except 638 FQHCs based on the following reimbursement methodologies reflected in Tables 1 and 2.

As the Tables 1 and 2 reflect, the methodologies may differ depending on a specific situation. The various situations are whether:

- the services include or exclude professional services.
- the service is provided by the IHS or a tribal facility
- the tribal facility is set up to bill outpatient services with specific coding and requests this format
- based on specific HCFA guidance (transportation).

TABLE 1 - IHS OUTPATIENT REIMBURSEMENT METHODOLOGY

Eligibility Type	Service	Billing Form/Codes	Reimbursement
Title XIX (Acute)	Outpatient Hospital	1500 / 00099	OMB Outpatient Rate
	Clinic	1500 / 00099	OMB Outpatient Rate
	Ambulatory Surgery Center	1500 / 00090-00098	OMB ASC Rate
	Professional Services	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
Title XIX (Long Term Care)	Outpatient Hospital	1500 / 00099	OMB Outpatient Rate
	Clinic	1500 / 00099	OMB Outpatient Rate
	Ambulatory Surgery Center	1500 / 00090-00098	OMB ASC Rate
	Professional Services	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
Title XIX (Behavioral Health)	Outpatient Hospital	1500 / 00099	OMB Outpatient Rate
	Clinic	1500 / 00099	OMB Outpatient Rate
	Professional Services	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule