DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration
Region IX

Refer to: MCD-RHR

75 Hawthorne St.
Suite 401
San Francisco, CA 94105

MAR 27 2001

Phyllis Biedess, Director
Arizona Health Care Cost Containment System
801 E. Jefferson
Phoenix, AZ 85034

Dear Ms. Biedess:

Enclosed is an approved copy of Arizona State plan amendment #00-016, regarding reimbursement of Federally Qualified Health Centers (FQHCs). I am approving this SPA with the requested effective date of October 1, 2000. However, please note that Arizona is still required to submit a new SPA which conforms to the prospective payment system for FQHCs and Rural Health Clinics enacted into law under section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000. As explained in HCFA's January 19, 2001 letter to State Medicaid Directors, the forthcoming SPA must be received by HCFA by March 31, 2001, to be effective January 1, 2001. Your staff has advised us that Arizona's section 702 SPA is in preparation and will be submitted timely.

If you have any questions, please have your staff contact Ronald Reepen at (415) 744-3601.

Sincerely,

Linda Minamoto
Associate Regional Administrator
Division of Medicaid

Enclosures

cc: Joan Peterson, HCFA, CMSO, FCHPG (with enclosures)
Elliot Weisman, HCFA, CMSO , PCPG (with enclosures)

AHCCCS/RECEIVED
DIRECTOR'S OFFICE
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State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

The following is a description of methods and standards for determining payment rates for specific services when payments are made directly to providers. Fee-for-services payments are made in accordance with the Arizona Health Care Cost Containment System Fee-For-Service Provider Manual and are subject to the limitations set forth in Attachment 3.1-A of the State Plan.

- **Outpatient Hospital Services**

Beginning with dates of service on and after March 1, 1993, AHCCCS shall reimburse hospitals for outpatient acute care hospital services by multiplying covered charges on an approved claim times the hospital-specific outpatient Medicaid cost-to-charge ratio. The cost reporting and claims data used for computation of the cost-to-charge ratio initially is the same as that described for inpatient hospital services in Attachment 4.19-A. Outpatient cost-to-charge ratios are computed for each hospital by determining the charges and costs associated with treating AHCCCS members in an outpatient hospital setting. Operating and capital costs are considered for the outpatient cost-to-charge ratio computations for each hospital. Medical education costs are excluded from the computation of outpatient cost-to-charge ratios because medical education costs are paid separately, as defined in Attachment 4.19-A.

Hospitals shall not be reimbursed for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis, if the member is admitted as an inpatient to the same hospital directly from the emergency room, observation or other outpatient department. The emergency room, observation, and other outpatient hospital services provided before the admission are included in the tiered per diem payment.

Outpatient hospital payments shall be subject to the quick pay discounts and the slow pay penalties described in Attachment 4.19-A.

Annual Update

AHCCCS shall rebase the outpatient hospital cost-to-charge ratio at least every one to four years using updated Medicare Cost Reports, and claim and encounter data.

New Hospitals

New hospitals, as defined in Attachment 4.19-A, will be assigned the statewide average outpatient hospital cost-to-charge ratio.

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Out-of-State Hospitals

Out-of-state hospitals will be paid the lesser of: a negotiated discount rate, the Arizona outpatient hospital statewide average cost-to-charge ratio, or if reasonably and promptly available, the Medicaid rate in effect on the date of service in the state in which the hospital is located.

Specialty Rates

The Administration may negotiate special contracted rates for outpatient hospital services provided in specialty facilities.

- **Laboratory Services and X-Ray**

AHCCCS' capped fee amounts will not exceed the reimbursement amounts authorized for clinical laboratory services under Medicare as set forth in 42 CFR 447.342.

- **Pharmacy Services**

Reimbursement is subject to the limitations set forth in 42 CFR 447.331 through 447.332.

- **EPSDT Services Not Otherwise Covered in the State Plan**

AHCCCS reimburses for chiropractor services using a capped fee schedule. Payment is the lesser of the provider's charge for the service or the capped fee amount established by AHCCCS.

AHCCCS reimburses for personal care services using a capped fee schedule. Payment is based on the lesser of the provider's charge for the service or the capped fee schedule established by AHCCCS.

AHCCCS reimburses for hospice services, including routine home care, continuous home care, inpatient respite care and general inpatient care. Payment is based on the annual hospice rate established by the Health Care Financing Administration.

- **Organ Transplantation**

As authorized in Attachment 3.1-E, AHCCCS reimburses for organ transplant services which are medically necessary and not experimental based on a competitive bid and/or negotiated flat rate process in accordance with State law. The rates are inclusive of hospital and professional services. If the service is provided in another state, AHCCCS will pay that state's approved Medicaid rate for the service or the negotiated rate, whichever is lower.

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- **Federally Qualified Health Centers (FQHCs)**

The payment methodology is effective October 1, 1997 and will continue through September 30, 2004. It provides a quarterly payment per member per month (PMPM) to all FQHCs in Arizona which have accepted the terms of the payment agreement. Clinics that achieve FQHC status after implementation of the payment agreement will be offered this method of reasonable cost reimbursement. The terms of reimbursement to a new FQHC shall be consistent with the existing agreement with the FQHCs unless there is a justifiable reason to make a change.

The AHCCCS Office of Managed Care (OMC) will collect the FQHC member month information from the health plans on a calendar quarter basis and review the information for reasonableness based on historic FQHC enrollment. Reports from the health plans to AHCCCS will be due 60 days after the end of the quarter. A check will be generated by AHCCCS for each FQHC that includes the FQHC's calculation of the supplemental payment which is the total member months reported for the FQHC multiplied by the applicable supplemental payment per member per month. AHCCCS will make every effort to provide the payments to the FQHCs approximately one month after the reports are due from the health plans.

The initial capitation amount will be $1.75 PMPM statewide. This capitation payment is a supplemental payment provided by AHCCCS for all members who are assigned to FQHCs for primary care services, regardless of the payment methodology agreed to between the FQHC and the Health Plan. The payment is made in compliance with the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 which require states to supplement health plan reimbursement to the FQHCs. The $1.75 will be reduced each year beginning in the contract year ending FY 2000 based on the schedule for phasing out reasonable cost reimbursement in accordance with the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999. The PMPM amount with the phase-out percentages applied will be as follows:

| CONTRACT YEAR | PHASE-OUT PERCENTAGE | PMPM AMOUNT |
|---|---|---|
| 1998 through 1999 | No Phase-out | $1.75 |
| 2000 | 95% | $1.66 |
| 2001 | 95% | $1.66 |
| 2002 | 95% | $1.66 |
| 2003 | 90% | $1.58 |
| 2004 | 85% | $1.49 |

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

- **Christian Science Sanitoria**

There are two types of Christian Science Sanitoria services: inpatient Christian Science Sanitoria services and Sanitoria extended care services. Inpatient Christian Science Sanitoria services are considered to be furnished by a sanitorium in its capacity as a hospital. Payment for inpatient Christian Science sanitoria services may be no more than the Medicare cost reimbursement under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Sanitoria extended care services are services furnished by a Christian Science sanitorium in its capacity as a skilled nursing facility. Payment for sanitoria extended care services shall be made in accordance with the AHCCCS fee-for-service payment rates specified in Attachment 4.19-D of the State Plan.

When AHCCCS reimburses for the following services, payment is the lesser of the provider's charge or the capped fee amount established by AHCCCS. AHCCCS reimburses the following services using this methodology:

- **Clinic Services, including Freestanding Ambulatory Surgery Centers, Freestanding Dialysis Centers and Freestanding Birthing Centers**
- **Rural Health Clinic Services**
- **Migrant Health Center, Community Health Center and Homeless Health Center Services**
- **Home Health Services, including Durable Medical Equipment, Supplies and Prosthetic Devices**
- **Behavioral Health Services**
- **Family Planning Services**
- **Physician Services**
- **Nurse-Midwife services**
- **Pediatric and Family Nurse Practitioner Services**
- **Other Licensed Practitioner Services**
- **Dental Services**
- **Vision Services** (including eye examinations, eyeglasses and contact lenses)

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- **Therapies and Related Services**
- **Diagnostic, Screening and Preventive Services**
- **Respiratory Care Services**
- **Transportation Services**
- **Private Duty Nurse Services**
- **Christian Science Nurse Services**

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

The following is a description of the methods and standards for determining the payment rate for case management services to the target group identified in Supplement 1 to Attachment 3.1-A.

DES/DDD is reimbursed, on a per member per month basis beginning October 1, 1997, to provide case management services to persons with developmental disabilities enrolled in the acute care program. AHCCCSA developed the per member per month capitation rate based on an analysis of average per member per month case management expenditures during the twelve month period from October 1, 1996 through September 30, 1997. Annually, this base rate is reviewed and updated, as necessary, by applying the inflation factor developed for the case management component of the ALTCS developmentally disabled capitation rate. Both the ALTCS developmentally disabled and the target group members are assigned to the same case managers. The inflation rate is determined by AHCCCSA's consulting actuaries based on data sources that include analysis of historic and future trends in case management expenditures, audited financial statements and case load requirements.

DES/DDD will be paid monthly on a capitated basis. This payment will be based on the capitation rate times the number of recipients verified as enrolled in the acute care program, as of the first of each month. The capitation payment will be made no later than ten working days after receipt of the DES/DDD data transmission.