DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
REGION IX

75 Hawthorne Street
Suite 408
San Francisco, CA 94105

DEC 15 2003

Anthony D. Rodgers, Director
Arizona Health Care Cost Containment System
801 E. Jefferson
Phoenix, AZ 85034

Dear Mr. Rodgers:

Enclosed is an approved copy of Arizona State plan amendment (SPA) 03-007. The SPA establishes an alternative methodology for reimbursing Federally Qualified Health Centers and Rural Health Clinics. I am approving this SPA with the requested effective date of January 1, 2001.

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 & Children's Health

Enclosure

cc:
~~Joan Peterson, CMS, CMSO, FCHPG~~
Elliot Weisman, CMS, CMSO, PCPG (two copies)

AHCCCS/RECEIVED
DIRECTOR'S OFFICE
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cc: TR
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State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

- **Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs)**

AHCCCS will utilize the following payment methodology from January 1, 2001, forward.

1) AHCCCS will establish a baseline Prospective Payment System effective January 1, 2001. The calculation will conform to section 1902(a)(15)(c) of the Social Security Act. AHCCCS will use the center/clinic's fiscal year that ends during calendar year 1999 and 2000 for the base rate calculations. Each FQHC/RHC may elect to have rates adjusted by either the BIPA 2000 methodology, or the Alternative Payment Methodology. If the FQHC/RHC elects the BIPA methodology, the Medicare Economic Index (MEI) at the beginning of each federal fiscal year (October 1st) will be used to update rates on a prospective basis. If the FQHC/RHC elects the Alternative Payment Methodology, the Physician Service Index (PSI) subcomponent of the Medical Care component of the Consumer Price Index at the beginning of each federal fiscal year (October 1st) will be used to update rates on a prospective basis. Under either methodology, the baseline rates for 1999 and 2000 will be calculated based on the provider's cost data for the center/clinic's fiscal year that end during calendar year 1999 or 2000. Costs included in the base rate calculation will include all Medicaid covered services provided by the center/clinic. The calculated 1999 and 2000 base rates will be averaged by calculating a simple average of the costs per encounter for 1999 and 2000. The calculation is as follows:

$$\frac{\text{Total Medicaid costs 1999} + \text{Total Medicaid costs 2000}}{\text{Total visits 1999} + \text{Total visits 2000}} = \text{Average Cost Per Visit}$$

These base rates will then be indexed forward utilizing the MEI, from the midpoint of the cost report period being utilized, to the midpoint of the initial rate period (January 1, 2001 through September 30, 2001). Annually thereafter, the MEI for those FQHCs/RHCs selecting the BIPA methodology, or the PSI for those FQHCs/RHCs selecting the Alternative Payment Methodology, will be applied to the inflated-based rates at the beginning of the federal fiscal year (October 1st). AHCCCS and the FQHCs/RHCs have agreed to supplement payments to the FQHCs/RHCs payments once the PPS baseline is established, if necessary.

2) For a center/clinic that becomes a FQHC or RHC after FY 2000, AHCCCS will calculate the initial rate using data from an established FQHC or RHC in the same or adjacent area with a similar caseload. Absent an existing FQHC or RHC with a similar caseload, the center/clinic rate will be based on projected costs subject to tests of reasonableness. Costs would be subjected to reasonable cost definitions as outlined in Section 1833(a)(3) of the Act. If a center/clinic has inadequate cost data for one of the base periods, that 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

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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 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 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.

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