

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 #20-026, “Other Provider Rates”**

Dear Mr. Wong:

Enclosed is State Plan Amendment (SPA) #20-026, Other Provider Rates, which updates the State Plan Other Provider rates, 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/>
- [https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/Final\\_NOPI\\_Rate\\_Changes\\_20201001.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/Final_NOPI_Rate_Changes_20201001.pdf);

Tribal Consultation:

- <https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html>
- [https://www.azahcccs.gov/AmericanIndians/Downloads/Consultations/Meetings/2020/08132020\\_QuarterlyTribalConsultation.pdf](https://www.azahcccs.gov/AmericanIndians/Downloads/Consultations/Meetings/2020/08132020_QuarterlyTribalConsultation.pdf)

Fiscal Analysis:

|                       | FFS Estimates | Federal Funds |        |
|-----------------------|---------------|---------------|--------|
| Other Provider Rates- | 21,219,400    | 16,519,300    | 77.85% |

\*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)



## INSTRUCTIONS FOR COMPLETING FORM CMS-179

Use Form CMS-179 to transmit State plan material to the regional office for approval. A separate typed 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.

---

State: ARIZONA  
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
OTHER TYPES OF CARE

---

---

Rate Update:

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers for other types of care. The agency's fee schedule rates were set as of October 1, 2020~~19~~ and are effective for services provided on or after that date. All rates are published at: <https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/>.

---

TN No. 20-026

Supersedes

TN No. 19-018

Approval Date: \_\_\_\_\_ Effective Date: October 1, 2020