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State/Territory Name: AZ

State Plan Amendment (SPA) #: 18-0009

This file contains the following documents in the order

listed:
1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

November 16, 2022

Jami Snyder, Director
Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, AZ 85034

RE: TN AZ-18-0009

Dear Director Snyder:

We have reviewed the proposed Arizona (AZ) State Plan Amendment (SPA) to Attachment 4.19-B AZ-18-0009, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 27, 2018. This plan amendment establishes an alternative payment methodology under the state's Differential Adjusted Payment (DAP) program to reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) for eligible encounters at enhanced rates when certain quality metrics are met.

Based upon the information provided by the State, we have approved the amendment with an effective date of October 1, 2018. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Blake Holt at 303-844-6218 or blake.holt@cms.hhs.gov.

Sincerely,

Todd McMillion

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: Centers for Medicare and Medicaid Services

1. TRANSMITTAL NUMBER: 18-009

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: October 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 19: $23,990
FFY 20: $23,577

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, pages 3a, 4, 4a, 4b, and 5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, pages 3a, 4, and 5

10. SUBJECT OF AMENDMENT:
Updates the State Plan to update the alternative payment methodology for federally qualified health centers to include quality measures

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: [signature]

13. TYPED NAME: Elizabeth Lorenz

14. TITLE: Assistant Director

15. DATE SUBMITTED: 9/27/18

16. RETURN TO:
Elizabeth Lorenz
801 E. Jefferson, MD#4200
Phoenix, Arizona 85034

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 27, 2018

18. DATE APPROVED: November 16, 2022

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL: Todd McMillion

21. TYPED NAME: Todd McMillion

22. TITLE: Director, Division of Reimbursement Review

23. REMARKS: 11/3/22 state concurs with pen and ink changes: Box 6: adding "SSA 1902(bb)(6)"; Box 8: adding "4(c) and 4(d)."

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Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

A. BIPA Methodology: AHCCCS will utilize the following payment methodology from January 1, 2001, forward.

1) **Prospective Payment System Baseline Rates.** AHCCCS will establish a baseline Prospective Payment System effective January 1, 2001. The calculation will conform to section 1902(bb) 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. If the FQHC/RHC rates are based on 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. 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 will be applied to these rates at the beginning of the federal fiscal year (October 1st).

2) **Prospective Payment System Baseline Rate for New Center/Clinic.** 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 2 CFR Part 200 as implemented by 45 CFR Part 75, and 42 CFR Part 413. 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) **Change in Scope of Service.** For all dates of services, if the FQHC/RHC elects the BIPA or the APM 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 are not reflected in the base rate and are not temporary in nature.

If an FQHC/RHC requests a change in scope due to a change in type, intensity, duration, and/or amount of services included in the PPS or APM, the new scope of services will be compared to the scope of services used in the calculation for 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

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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.

Managed Care Wrap

4) **Quarterly Supplemental Payments.** Beginning January 1, 2001, 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. Those payments 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 methodology.

5) **Annual Reconciliation.**

i. The following method applies from January 1, 2001 through September 30, 2018: 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 or APM 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.

ii. The following method applies for dates of service beginning October 1, 2018 : In September of each year, AHCCCS will perform a reconciliation of reimbursements from the prior fiscal year to ensure that each FQHC and RHC was reimbursed for that fiscal year an amount equal to the number of eligible visits times the applicable PPS per-visit rate calculated for the FQHC or RHC under this state plan. The reconciliation will be performed by calculating the total allowable payment each FQHC/RHC would receive under the per-visit rate established under the state plan for the fiscal year being reconciled and comparing it to the total amount of supplemental and MCE payments received for that fiscal year. The total allowable payment will be initially calculated by totaling the number of visits from AHCCCS approved claims and adjudicated encounter data for all dates of service from October 1 through September 30 of the fiscal year being reconciled and multiplying those visits by the FQHC's/RHC's applicable per-visit rate. Using the same claim and adjudicated encounter data, the total payments received will be initially calculated as the sum of all amounts paid on encounters by AHCCCS and its contracted MCEs, Medicare, and other third party payers, plus any quarterly supplemental payments made under Paragraph 4. AHCCCS will notify each FQHC/RHC in writing of the results of the comparison by the end of September. Following the notification, each FQHC/RHC may submit additional data or information to AHCCCS, including any payable visits, payments, or recoupments that the FQHC/RHC believes are not reflected in the AHCCCS approved claims and adjudicated encounter data, for consideration in calculating the final reconciliation amount. AHCCCS may adjust the calculated total allowable payment amount and/or the total payments received amount, based on the additional data or information and calculate the resulting final reconciliation for that fiscal year. For each FQHC/RHC, if the calculated total allowable payment is greater than the total payments received, the FQHC/RHC will be paid the difference by AHCCCS; if the calculated total allowable payment is less than the total payments received, the FQHC/RHC will refund the

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difference to AHCCCS. Out-of-state FQHCs are exempt from this requirement. Out of State FQHC's are exempt from the reconciliation process and will not receive payments from AHCCCS or pay back overpayments.

B. Alternative Payment Methodologies

For any fiscal year after FY 2002, an FQHC/RHC may continue being paid under the baseline methodology under 1902(bb)(6) or may use an APM methodology other than the Medicaid BIPA PPS. In order for the APM methodology to be used, the following statutory requirements must be met. First, the APM must be agreed to by the State and by each individual FQHC/RHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is at least equal to the amount to which the center or clinic is entitled under Medicaid BIPA PPS rate. The PPS rate used for the comparison must include any modifications that occurred due to scope of service changes per 1902(bb)(3)(B) and must be increased by MEI per 1902(bb)(3)(A).

1. Alternative Payment Methodology (APM #1)

Effective October 1, 2001 FQHCs/RHCs electing APM 1 will be paid with the following methodology. For the period October 1, 2018 through September 30, 2023, only FQHCs that are Urban Indian Health Program (UIHP) and RHCs are eligible to be paid under this methodology.

a) **APM 1 Baseline Rates**. AHCCCS will establish a baseline APM 1 rate effective January 1, 2001. The calculation will conform to section 1902(bb) 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. 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. 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:

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

Every 3rd year, beginning with the federal fiscal year beginning October 1, 2004, AHCCCS will recalculate the base APM rate. The calculation will conform to section 1902(a)(15)(c) of the Social Security Act. 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. AHCCCS will use the data from the center/clinic's fiscal years that end during the two previous calendar years for the rebase APM rate calculations. The baseline APM 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 APM rebase rate calculation will include Medicaid covered services provided by the FQHC/RHC.

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The two calculated previous year APM 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:

$$\frac{\text{Total Medicaid costs previous year 1 + Total Medicaid costs previous year 2}}{\text{Total visits previous year 1 + Total visits previous year 2}} = \text{Average cost per visit}$$

The APM base rates calculated using the center/clinic's cost data will then be indexed forward from the midpoint of the cost report periods being used, to the midpoint of the initial rate period utilizing the Physician Service Index (PSI) subcomponent of the Medical Care component of the Consumer Price Index. For the next two years thereafter where a rebase to the APM does not occur, the PSI will be applied to the inflated based APM rates at the beginning of each federal fiscal year (October 1st). If the rate calculated under this Alternative Payment Methodology during any year is less than what the FQHC or RHC would receive under the BIPA including any scope of service adjustments per 1902(bb)(3)(B) and increased by MEI per 1902(bb)(3)(A), the rate for the FQHC or RHC will be the PPS rate.

b) **Baseline Rate for New Center/Clinic**. For a center/clinic that becomes a FQHC or RHC after FY 2000, AHCCCS will calculate the initial rate using the APM 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 2 CFR Part 200 as implemented by 45 CFR Part 75, and 42 CFR Part 413. 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.

c) **Change in Scope of Service**. See Paragraph A3

d) **Quarterly Supplemental Payments**: See Paragraph A4

e) **Annual Reconciliation**. See Paragraph A5.

2. Alternative Payment Methodology (APM #2) for Dates of Service October 1, 2018 – September 30, 2023 for in-state Non-UIHP FQHCs.

a) Baseline APM rate. AHCCCS will establish a baseline APM rate for each FQHC. The baseline APM 2 rate will be equal to the greater of the FQHC's federal fiscal year 2018 APM 1 rate or the FQHC's federal fiscal year 2016 APM 1 rate and must include any changes attributable to Scope Changes, multiplied by the inflation statistic for the Physicians' Services Index (PSI) subcomponent of the Medical Care Services Component of the Consumer Price Index (CPI) published by the Bureau of Labor Statistics for the 12-month period ending March 31, 2018. This methodology must result in a payment to the center or clinic that is *at least equal* to the amount to which the center or clinic is entitled under Medicaid BIPA PPS rate. The PPS rate used for the comparison must include any modifications that occurred due to scope of service changes per 1902(bb)(3)(B) and must be increased by MEI per 1902(bb)(3)(A).

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Current Individual FQHC APM 2 Rate x (1.000 + PSI inflation) = Next Year's Individual FQHC APM 2 Rate.

Annually thereafter, the rate for each FQHC will be adjusted effective October 1 of the given year by multiplying the current rate by the PSI for the 12-month period ending March 31 of that year.

b) Differential Adjusted Payment Calculation. For an FQHC that demonstrates attainment of the Minimum Performance Standard (MPS) for one or more of the selected clinical quality measures described in paragraph B2c, as reported for each FQHC in the Uniform Data System (UDS) Report to the Bureau of Primary Health Care of the Health Resources and Services Administration (HRSA), the previous year's rate will be adjusted by a Differential Adjusted Payment factor in accordance with paragraph B2c. Annually thereafter, the rate for each FQHC will be adjusted effective October 1 of the given year by multiplying the current rate by the PSI for the 12-month period ending March 31 of that year, and multiplying the result by the sum of 1.000 plus the applicable Differential Adjusted Payment (DAP) factor for the current year. This methodology must result in a payment to the center or clinic that is at least equal to the amount to which the center or clinic is entitled under Medicaid BIPA PPS rate. The PPS rate used for the comparison must include any modifications that occurred due to scope of service changes per 1902(bb)(3)(B) and must be increased by MEI per 1902(bb)(3)(A). The calculation is as follows:

Current Individual FQHC APM 2 Rate for FQHCs that attain the DAP= (The previous years' rate) x (1.000 + PSI inflation for the 12-month period ending 3/31 of the current year) x (1.000 + Applicable DAP)

In any given year, if the PSI for the 12-month period ending March 31 is less than 0%, the PSI adjustment will be 0%, or if greater than 5%, the PSI adjustment will be 5%. If the rate calculated under APM 2 is less than the rate the FQHC would receive under the Prospective Payment System (PPS), increased by MEI per 1902(bb)(3)(A) and including any scope of service adjustments per 1902(bb)(3)(B), the rate for that FQHC will be the PPS rate.

c) Differential Adjusted Payment Qualification. Differential Adjusted Payment factors will be based on the FQHC's demonstrated attainment of the MPS for one or more of the selected clinical quality measures, as reported for each FQHC in the UDS Report to HRSA. Each FQHC will receive a DAP value of 0.005 for each MPS attained, for a total DAP factor of 0.000, 0.005, 0.010, or 0.015. The clinical quality measures, minimum performance standards, and their DAP values are published on the AHCCCS website at this location: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/FQHC-RHC.html and are effective 10/1/18.

In order to be considered for a DAP factor effective October 1 annually, no later than April 30 of the same year, an FQHC will provide AHCCCS with its UDS Report submitted to HRSA for calendar year 2017. Annually thereafter, on or before April 30 of each year, the FQHC will provide AHCCCS with its UDS Report submitted to HRSA for the prior calendar year. All determinations necessary for application of the DAP for an FQHC will be based on the UDS submitted to AHCCCS by the FQHC. UDS Table 4 data will be utilized to identify FQHCs that

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meet the threshold for identified patient characteristics, and performance on clinical quality measures cited at the website above will be extracted from UDS Table 6B and UDS Table 7.

d) **Baseline Rate for New Center/Clinic.** For a provider that becomes a FQHC after September 30, 2018 and elects this APM, AHCCCS will calculate the initial rate using the baseline APM 2 rate for an established FQHC in the same or an adjacent area with a similar caseload and applying the annual PSI adjustments which have occurred since the establishment of that baseline rate. To ensure that the current baseline APM rate is greater than or equal to the PPS rate, a calculation will be performed to compare the two rates. If the newly established rate is less than the PPS rate, the PPS rate will be used. On October 1 of the first federal fiscal year in which the new FQHC is able to provide AHCCCS with its cost reports for two full years of operation as an FQHC, AHCCCS will calculate a new baseline APM 2 rate using the provider's Medicare Cost Report data. Costs included in the new baseline APM 2 rate calculation will include Medicaid covered in-scope FQHC services provided by the FQHC. The two calculated previous year APM 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:

   Average cost per visit=
   (Total Medicaid costs previous year 1 + Total Medicaid costs previous year 2)/ (Total visits previous year 1 + Total visits previous year 2)

   The APM 2 baseline rate calculated using the center/clinic's cost data will then be indexed forward from the midpoint of the cost report periods being used, to the midpoint of the initial rate period utilizing the Medicare Economic Index. A new FQHC will become eligible to be considered for a DAP factor, in accordance with Paragraph B2b and B2c, in the first year in which the new FQHC provides to AHCCCS by April 30 of that year a full year UDS Report submitted to HRSA. If the rate calculated under this Alternative Payment Methodology during any year is less than what the FQHC would receive under the BIPA including any scope of service adjustments per 1902(bb)(3)(B) and increased by MEI per 1902(bb)(3)(A), the rate for the FQHC or RHC will be the PPS rate.

e) **Change in Scope of Service**. See Paragraph A3
f) **Quarterly Supplemental Payments**: See Paragraph A4.
g) **Annual Reconciliation.** See Paragraph A5 ii.

3**. Out-Of-State FQHC/RHC's that Elect Alternative Payment Methodology (APM #3)**

Beginning with dates of service on and after October 1, 2018, AHCCCS will utilize the following payment methodology for out-of-state Federally Qualified Health Centers and Rural Health Clinics that elect the Alternative Payment Methodology. For any out-of-state FQHC/RHC, during both the initial and annual rate setting process, if the rate calculated under the APM is less than the rate the out-of-state FQHC or RHC would receive under the Prospective Payment System (PPS), increased by MEI per 1902(bb)(3)(A) and including any scope of service adjustments per 1902(bb)(3)(B), the rate for that FQHC or RHC will be the PPS rate. The rate for an out-of-state FQHC or RHC that does not

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elect the Alternative Payment Methodology will be determined in accordance with paragraphs A1 through A2.

a) For an out-of-state FQHC, AHCCCS will calculate the initial rate as the baseline APM rate for an established FQHC in the bordering Arizona county adjusted by the annual PSI adjustments which have occurred since the establishment of that baseline rate. Annually thereafter, the rate for the FQHC will be adjusted effective October 1 of the given year by multiplying the current rate by the PSI for the 12-month period ending March 31 of that year. If there is more than one FQHC in the bordering Arizona County, or if there are no FQHCs in the bordering Arizona county, AHCCCS will use the baseline rate for the established FQHC that is nearest in distance to the out-of-state FQHC. In any given year, if the PSI for the 12-month period ending March 31 is less than 0%, the PSI adjustment will be 0%, or if greater than 5%, the PSI adjustment will be 5%.

b) For an out-of-state RHC, AHCCCS will calculate the initial rate as the fiscal year 2019 APM rate for an established RHC in the bordering Arizona county adjusted by the annual PSI adjustments which have occurred since the establishment of the fiscal year 2019 rate. Annually thereafter, the rate for the RHC will be adjusted effective October 1 of the given year by multiplying the current APM rate by the PSI for the 12-month period ending March 31 of that year. If there is more than one RHC in the bordering Arizona county, AHCCCS will use the fiscal year 2019 rate for the established RHC that is nearest in distance to the out-of-state RHC. If there are no RHCs in the bordering Arizona county, the out-of-state RHC will be treated as an out-of-state RHC. In any given year, if the PSI for the 12-month period ending March 31 is less than 0%, the PSI adjustment will be 0%, or if greater than 5%, the PSI adjustment will be 5%.

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

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