September 27, 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 #18-009, FQHC Alternative Payment Model

Dear Mr. Wong:

Enclosed is State Plan Amendment (SPA) #18-009, FQHC Alternative Payment Model, which revises the alternative payment model available to federally qualified health centers to be based on quality measures.

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: 18-009	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: Att. 4.19B, Pages 3a-5	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same

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: 	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: 9/27/18	

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:	

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

A. 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)(l5)(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:

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

   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

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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) For the period October 1, 2018 through September 30, 2023, if an FQHC other than an Urban Indian Health Program (UIHP) or Indian Health Service 638 (638) FQHC elects the Alternative Payment Methodology, the FQHC's rate will be determined in accordance with paragraph B. For all other periods, and for UIHP-FQHCs and RHCs, 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) For the period January 1, 2001 through September 30, 2018, 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

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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.

B. Beginning October 1, 2018 and ending September 30, 2023, AHCCCS will utilize the following payment methodology for in-state FQHCs except for UIHP and 638 FQHCs.

1) AHCCCS will establish a baseline Prospective Payment System (PPS) rate for each FQHC equal to the greater of the FQHC's federal fiscal year 2018 rate and the FQHC's federal fiscal year 2016 rate, 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. 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 B2, 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 baseline PPS rate will be adjusted by a Differential Adjusted Payment factor in accordance with paragraph B2. Annually thereafter, the PPS rate for each FQHC will be adjusted effective October 1 of the given year by multiplying the current PPS 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. The calculation is as follows:

Current Individual FQHC PPS Rate x PSI inflation x (1.000 + Applicable DAP Factor) = Next Year's Individual FQHC PPS Rate

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%.

2) 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.

In order to be considered for a DAP factor, no later than April 30, 2018, 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 meet the threshold for identified patient

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

3) For a provider that becomes a FQHC after September 30, 2018, AHCCCS will calculate the initial PPS rate using the baseline PPS 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 PPS rate. For 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 a FQHC, AHCCCS will calculate a new baseline PPS rate using the formula described in paragraph A1. A new FQHC will become eligible to be considered for a DAP factor 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.

4) For the period October 1, 2018 through September 30, 2020, AHCCCS will not adjust the FQHC PPS rates except as described in paragraphs B1 through B3. For the period October 1, 2020 through September 30, 2023, if an FQHC believes there has been a significant change in its scope of services, the FQHC may submit a request for review of its PPS rate, and AHCCCS will review the request according to the process described in paragraph A3, provided the FQHC has made no more than two such requests during this period.

C. Beginning October 1, 2018, AHCCCS will utilize the following payment methodology for out-of-state Federally Qualified Health Centers and Rural Health Clinics.

1) For an out-of-state FQHC, AHCCCS will calculate the initial PPS rate as the baseline PPS 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 PPS rate. Annually thereafter, the PPS rate for the FQHC will be adjusted effective October 1 of the given year by multiplying the current PPS 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 PPS rate for the established FQHC that is nearest in distance to the out-of-state FQHC.

~~1)~~2) For an out-of-state RHC, AHCCCS will calculate the initial PPS rate as the fiscal year 2019 PPS 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 PPS rate. Annually thereafter, the PPS rate for the RHC will be adjusted effective October 1 of the given year by multiplying the current PPS 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 PPS 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 FQHC.

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D. Beginning October 1, 2018, FQHCs/RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly supplemental payments, in the same manner as prior to October 1, 2018, for the cost of furnishing such services that are an estimate of the difference between the payments the FQHC/RHC receives from the MCEs and the payments the FQHC/RHC would receive under the applicable PPS methodology. At the end of each federal fiscal year, AHCCCS will calculate each FQHC's/RHC's costs by totaling the number of visits from AHCCCS paid claim and adjudicated encounter data for that fiscal year and multiplying the result by the FQHC's/RHC's PPS rate for the same fiscal year. The total cost for each FQHC/RHC will be compared to the total amounts paid from AHCCCS paid claim and adjudicated encounter data for that fiscal year, including any amounts paid by Medicare and other third party payers, plus any quarterly supplemental payments made under this paragraph. For each FQHC/RHC, if the total calculated cost is greater than the total payments, the FQHC/RHC will be paid the difference; if the calculated cost is less than the total payments, the FQHC/RHC will refund the difference. Upon notification of the preliminary reconciliation amount calculated by AHCCCS based on paid claim and adjudicated encounter data, each FQHC/RHC may submit additional data or information to AHCCCS for consideration in the determination of the final reconciliation amount. Out-of-state FQHCs and RHCs are exempt from the requirements of this paragraph.

___ 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.

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