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. State developed fee schedule rates are the same for both governmental and non-governmental providers, unless otherwise noted on the reimbursement pages. AHCCCS rates are effective for dates of service on or after October 1, 2022. AHCCCS rates are published on the agency's website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/ and apply to the following services: 1) Outpatient Hospital; 2) Laboratory; 3) Pharmacy; 4) Hospice; 5) Clinic Services, including Freestanding Ambulatory Surgery Centers and Freestanding Dialysis Centers; 6) Migrant Health Center, Community Health Center and Homeless Health Center Services, Home Health Services, including Durable Medical Equipment, Supplies and Prosthetic Devices; 7) Diagnostic, Screening and Preventive Services; 8) EPSDT Services; 9) Freestanding Birth Centers; 10) Behavioral Health; 11) Family Planning; 12) Physician; 13) Nurse-Midwife; 14) Pediatric and Family Nurse Practitioner; 15) Other Licensed Practitioner; 16) Dental; 17) Vision; 18) Respiratory Care; 19) Transportation; 20) Private Duty Nurse; 21) Other Practitioners; 22) Physical Therapy; 23) Occupational Therapy; 24) Services for individuals with speech, hearing and language disorders; 25) Prosthetic devices; 26) Screening; 27) Preventative; 28) Rehabilitation.

Outpatient Hospital Services

From July 1, 2004 through June 30, 2005, AHCCCS shall reimburse a hospital by applying a hospital-specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona Department of Health Services by more than 4.7 per cent for dates of service effective on or after July 7, 2004, the hospital-specific cost-to-charge ratio will be reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7 per cent, the effective date of the increased charges will be the effective date of the adjusted AHCCCS cost-to-charge ratio.

For dates of service beginning July 1, 2005, AHCCCS shall reimburse hospitals for outpatient acute care hospital services from a prospective fee schedule, by procedure code, established by AHCCCS. Hospitals with similar characteristics (peer groups) such as: rural/CAH designation, bed size, pediatric emphasis, special needs hospitals, public ownership, GME programs or Level I Trauma Centers, may be paid percentage adjustments above the fee schedule amount not to exceed the total payments received under comparable circumstances pursuant to Medicare upper limits. Rural hospitals, defined as hospitals in Arizona, but outside Maricopa and Pima counties, may be paid an adjustment above the fee schedule amount not to exceed the total payments received under comparable circumstances pursuant to Medicare upper limits.

Services that do not have an established fee specified by the AHCCCS' outpatient hospital prospective fee schedule will be paid by multiplying the charges for the service by a statewide outpatient cost-to-charge ratio. For dates of service July 1, 2005 through September 30, 2011, the statewide outpatient cost-to-charge ratio is computed from hospitals' 2002 Medicare Cost Reports.

For dates of service beginning October 1, 2011, the statewide cost-to-charge ratio calculation shall equal either the CMS Medicare Outpatient Urban or the CMS Medicare Outpatient Rural Cost to Charge Ratio for Arizona. The urban cost-to-charge ratio will be used for hospitals located in a county of 500,000 residents or more and for out-of-state hospitals. The rural cost-to-charge ratio will be used for hospitals located in a county of fewer than 500,000 residents.

Hospitals shall not be reimbursed for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis, if the eligible person 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 inpatient reimbursement.

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

Rebase

AHCCCS will rebase the outpatient hospital fee schedule every five years.

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Rate Updates

Notwithstanding the methods and rates as otherwise described, for claims with dates of service between April 1, 2011 and September 30, 2011, all payments for outpatient hospital services will be reduced by 5% of the payment that would otherwise have been made under the methodology in effect as of October 1, 2010, as described above.

For claims with dates of service effective from October 1, 2011 to September 30, 2015, all payments for outpatient hospital services will be reduced by 5% under the methodology in effect as of October 1, 2011. For claims with dates of service effective October 1, 2015 to September 30, 2016, all payments for outpatient hospital services will be made using the methodology in effect as of September 30, 2015 resulting in a year to year 0% aggregate impact on Outpatient Hospital Rates. For claims with dates of service effective on or after October 1, 2022, outpatient hospital services will be made according to the AHCCCS fee schedule located on the AHCCCS website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/. These fees were updated October 1, 2022 for a 0% aggregate impact.

Effective for dates of service September 1, 2020 through September 30, 2020, AHCCCS is implementing a 10% rate increase to the FFS fee schedules identified above for in office vaccination codes, and administration codes related to influenza.

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

Out-of-State Hospitals

Out-of-state hospitals will be paid for covered outpatient services by applying the outpatient hospital fee schedule and methodology.

Specialty Rates

- **Laboratory Services**

AHCCCS'' outpatient hospital fee schedule will not exceed the reimbursement amounts authorized for clinical laboratory services under Medicare as set forth in 42 CFR 447.362. AHCCCS' rates are published on the agency's website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

- **Pharmacy Services**

1. CMS covered outpatient drugs including specialty drugs, that are prescribed by an authorized prescriber and dispensed by a Retail Community, Long-term Care or Specialty Pharmacies, will be reimbursed at the lesser of:
    a. The usual and customary charge to the public, or
    b. The AHCCCS Fee-For-Service's established Maximum Allowable Cost (MAC) for the drug plus a professional dispensing fee, or
    c. The current National Average Drug Acquisition Cost (NADAC) for the drug plus a professional dispensing fee, or
    d. The contracted rates between AHCCCS and the FFS Pharmacy Benefit Manager plus a professional dispensing fee.

All of the above logic will apply to:

1. Drugs Dispensed by an Urban Indian Health Center not participating in the 340B Drug Pricing Program
2. Drugs not dispensed by a Retail Community Pharmacy and dispensed primarily through the mail,
3. 340B entities submitting claims for drugs purchased that are not available for purchase through the 340B Drug Pricing Program.
4. 340B entities dispensing medication to a member and the member is not a patient of the 340B entity.

For drugs purchased through the 340B Drug Pricing Program for members who qualify under the 340B program (FR Vol. 61 #207):

1. 340B entities are required to submit 340B claims at their Actual Acquisition Cost (AAC) for physician administered drugs and drugs dispensed to members.
2. The 340B entity shall be reimbursed at the lesser of AAC or the 340B Ceiling Price plus a professional dispensing fee.
3. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B Contract Pharmacies are not covered, unless the AHCCCS Administration has a contractual arrangement or there is a demonstrated need approved by AHCCCS that requires participation by a 340B Entity Contracted Pharmacy.

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

For Federal Supply Schedule purchased drugs, the provider shall be reimbursed at no more than their actual acquisition cost plus a professional dispensing fee.

For drugs purchased at Nominal Pricing, the provider shall be reimbursed at the actual acquisition cost plus a professional dispensing fee.

The professional dispensing fee for all of the above pharmacy reimbursement methodologies is $10.11 for CMS Covered Outpatient Drugs including specialty medications, $15.34 for compounded prescriptions when a CMS Covered Outpatient Drug is an ingredient in the compound.

All Indian Health Service and Tribal 638 pharmacies are paid according to the methodology in Attachment 4.19B "REIMBURSEMENT FOR INDIAN HEALTH SERVICE AND TRIBAL 638 HEALTH FACILITIES" section.

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

Physician Administered Drugs will be reimbursed using the following methodology:

1. Physician billing:
   For non-chemotherapy drugs that are priced on the Medicare Part B Drug Schedule, AHCCCS sets its FFS rates as 95% of the Medicare Part B rate. For chemotherapy drugs and drugs that are not priced on the Medicare Part B Drug Schedule, AHCCCS sets its rates as 80.75% of the Average Wholesale Price.

2. Outpatient Hospital billing:
   For all drugs that are priced on the Medicare Outpatient Prospective Payment System fee schedule, AHCCCS sets its FFS rates as 80% of the Medicare OPPS rate. For drugs that are not priced on the Medicare Outpatient Prospective Payment System fee schedule, AHCCCS sets its FFS rates equal to the FFS rates for physician billing methodology as defined in subsection 1- Physician billing.

3. Ambulatory Surgery Center billing:
   For all drugs that are priced on the Medicare Ambulatory Surgery Center Fee Schedule, AHCCCS sets its FFS rates as 95% of the Medicare ASC Fee Schedule rate.

4. Investigational/experimental drugs are not reimbursed by AHCCCS.

5. AHCCS will meet the reimbursement requirements of Federal Upper Limit (FUL) defined drugs in the aggregate by reviewing that the NADAC does not exceed the FUL levels.

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

AHCCCS reimburses for chiropractor services and personal care services using a capped fee schedule. Personal care services are described in Attachment 3.1-A Limitations, page 2(a). Payment is the lesser of the provider's charge for the service or the capped fee amount established by AHCCCS. AHCCCS' rates are published on the agency's website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

- **Hospice**

AHCCCS reimburses for the hospice benefit, including routine home care, continuous home care, inpatient respite care and general inpatient care at the AHCCCS Fee Schedule rates published on the agency's website described on page 1, first paragraph of Attachment 4.19B. Effective January 1, 2016:

- Routine Home Care (RHC) will be reimbursed at one of two rates depending on the number of days in the episode of care, such that a higher rate will apply to the first 60 days of RHC and a lower rate will apply to days sixty-one and beyond. A gap of sixty days or more in hospice care will begin a new episode of care.
- A Service Intensity Add-On (SIA) add-on payment will be made for a visit by a social worker or registered nurse when provided during RHC in the last seven days of a member's life for up to 4 hours per day of service. The SIA will be an hourly rate equal to the hourly rate for continuous home care.

The hospice rates are developed based on the Medicaid Hospice Payment Rates and Hospice Wage Indices authorized by section 18 14(i)(c)(ii) of the Social Security Act, and published annually by CMS.

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

Medication-Assisted Treatment (MAT) Pursuant to section 1905(a)(29) of the Social Security Act

1905(a)(29) MAT counseling therapy and services are reimbursed using the methodology found in Attachment 4.19-B page 5c.

Reimbursement for unbundled MAT prescribed drugs and biologicals used to treat opioid use disorder will be reimbursed using the same methodology as described for covered outpatient drugs in Attachment 4.19-B, page 2- 2(b) for drugs that are dispensed or administered.

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

- **Organ Transplantation**

AHCCCS shall negotiate contracts with hospitals qualified to perform covered organ and hematopoietic cell transplantation services. Reimbursement is based on a fixed price per type of transplant, by component, which may include stop-loss provisions. Component reimbursement is based on provider cost reports. At no time will payment for the entire case exceed a hospital's billed charges. The follow-up time period lasts until the transplant team releases the member, not to exceed 60 days post-transplant.

- **Specialty Services**

AHCCCS may negotiate contracts for specialized hospital services, including but not limited to: subacute, neonatalogy, neurology, cardiology and burn care. Rates are determined based on provider cost information and at no time will contracted rates exceed billed charges

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

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:

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

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 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

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

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

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.

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

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).

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

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

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

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

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.

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

When AHCCCS reimburses for the following public and private provider services, payment is the lesser of the provider's charge or the capped fee amount established by AHCCCS. The current Arizona Medicaid Fee Schedule is located at www.azahcccs.gov/commercial/ProviderBilling/rates/rates.aspx.

For both private and public providers, AHCCCS reimburses the following services as described in Attachment 3.1-A Limitations, using this methodology:

- **Clinic Services, including Freestanding Ambulatory Surgery Centers and Freestanding Dialysis Centers**
- **Freestanding Birth Centers**
- **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**: Effective CYs 2013 and 2014, reimbursement rates for services meeting the requirements of 42 CFR 447.400(a) can be found at Attachment 4.19-B, pages 5(d-g).
- **Nurse-Midwife services**
- **Pediatric and Family Nurse Practitioner Services**

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

- **Other Licensed Practitioner Services**
  - OLP-Pharmacist: AHCCCS-registered pharmacies will be reimbursed for all AHCCCS covered immunizations and anaphylaxis agents administered by licensed pharmacists within the scope of their practice. AHCCCS will provide an administration fee for pharmacies administering the vaccine. The administration fee can be found on the AHCCCS website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/pharmacy.html
  - OLP-Emergency Medical Care Technician: EMCT personnel providing Treat and Refer services through an AHCCCS-registered Treat and Refer entity whereby the entity will be reimbursed for Treat and Refer services subject to the available rates located at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
- **Dental Services**
- **Vision Services** (including eye examinations, eyeglasses and contact lenses)
- **Diagnostic, Screening and Preventive Services**
- **Respiratory Care Services**
- **Transportation Services (see page 5h for information about ambulance rates)**
- **Private Duty Nurse Services**
- **Other practitioner's services**
- **Physical therapy**
- **Occupational therapy**
- **Services for individuals with speech, hearing and language disorders**
- **Prosthetic devices**
- **Screening services**
- **Preventative services**
- **Rehabilitation services**
- **EPSDT services**
- **Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women: The rates for these services are included in the fee schedules listed under this Attachment associated with the relevant provider services.**

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 are effective for services provided on or after October 1, 2022. All rates are published at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☒ The rates reflect all Medicare site of service and locality adjustments.

The rates do reflect Medicare site-of-service adjustments. There are no locality adjustments applicable to Arizona.

☐ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.

The rates do reflect the Medicare geographic adjustment for Arizona. There are no locality adjustments applicable to Arizona.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: _____

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

Arizona will use a fee schedule calculated by the state based on the January 2013 release in conjunction with the 2009 conversion factor. Arizona will not further adjust the fee schedule to account for Medicare changes throughout the year.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly ☐semi-annually ☐annually

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

90465-90468, 99261-99263, 99271-99275, 99289-99290, 99293-99303, 99311-99313, 99321-99323, 99331-99333, 99351-99353, 99361-99362, 99371-99373, 99376, 99406-99409, 99431-99433, 99435-99436, 99438, 99440, 99444, 99450, 99455-99456.

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

90460; 99224-99226: added January 1, 2011;

99485-99486: added January 1, 2013;

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☒ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: $15.97.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: _____.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on _December 31, 2014_____ but not prior to December 31, 2014. All rates are published at http://www.azahcccs.gov/commercial/ProviderBilling/rates/rates.aspx

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on _December 31, 2014_____ but not prior to December 31, 2014. All rates are published at http://www.azahcccs.gov/commercial/ProviderBilling/rates/rates.aspx

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

The following is a description of methods and standards for determining the payment rates for ambulance transportation services included in the transportation bullet listed in Attachment 4.19-B, page 5b. Except as otherwise noted below, AHCCCS uses a uniform methodology in reimbursing both governmental and private providers for ambulance emergency and non-emergency transportation services.

1) Ground Ambulance Rates set by the Arizona Department of Health Services (ADHS)

ADHS regulates ambulance companies in Arizona (except for those owned and operated by American Indian tribes and federal agencies) licensing and rate setting. ADHS sets rates based on data submitted by providers including direct and indirect costs, reimbursable and non reimbursable charges, utilization data, and public payer settlements. ADHS offers annual provider rate adjustments based upon the Arizona Ambulance Inflation factor (AIF). The AIF is comprised of the average annual change in the CPI-U for transportation (50%) and for medical care (50%). The transportation category is composed of such things as motor vehicles (new and used), motor fuel, parts and equipment, maintenance and repair and public transportation The medical care category is composed of such things as medical care commodities, medical care services – professional, hospital and related services.

For dates of service prior to October 1, 2009, AHCCCS will reimburse ambulance companies at 80.0% of the ADHS established rate. For dates of service beginning October 1, 2009 through March 31, 2011, AHCCCS will reimburse those providers at 76% of the ADHS established rate. For dates of service beginning April 1, 2011 through September 30, 2011, AHCCCS will reimburse those providers at 72.2% of the ADHS established rate. For dates of service beginning October 1, 2011 through September 30, 2012, AHCCCS will reimburse those providers at 68.6% of the ADHS established rate in effect as of July 7, 2011. For dates of service beginning October 1, 2012 through September 30, 2013, AHCCCS will reimburse those providers at 68.6% of the ADHS established rate in effect as of August 2, 2012 and are posted at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

For dates of service beginning October 1, 2013 through September 30, 2014, AHCCCS will reimburse those providers at 68.6% of the ADHS established rate in effect as of August 2, 2013 and are posted at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
For dates of service beginning October 1, 2014 through September 30, 2015, AHCCCS will reimburse those providers at 74.74% of the ADHS established rate in effect as of August 2, 2014 and are posted at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
For dates of service beginning October 1, 2015 through September 30, 2016, AHCCCS will reimburse those providers at 68.59% of the ADHS established rate in effect as of August 2, 2015 and are posted at www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
For dates of service beginning October 1, 2016 through September 30, 2017, AHCCCS will reimburse those providers at 68.59 % of the ADHS established rate in effect as of July 1, 2016 and are posted at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
For dates of service beginning October 1, 2017 through September 30, 2018, AHCCCS will reimburse those providers at 68.59 % of the ADHS established rate in effect as of July 1, 2017 and are posted at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
For dates of service beginning October 1, 2018 through September 30, 2019, AHCCCS will reimburse those providers at 68.59 % of the ADHS established rate in effect as of July 1, 2017 and are posted at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS
For dates of service beginning October 1, 2019 through September 30, 2020, AHCCCS will reimburse those providers at 68.59% of the ADHS established rate in effect as of July 1, 2019 and are posted at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/.
For dates of service beginning October 1, 2020 through September 30, 2021, AHCCCS will reimburse those providers at 68.59% of the ADHS established rate in effect as of July 1, 2020 and are posted at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/.
For dates of service beginning October 1, 2021 through September 30, 2022, AHCCCS will reimburse providers at 68.59% of the ADHS established rate in effect as of July 1, 2021, and posted at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

For dates of service beginning October 1, 2022 through September 30, 2023, AHCCCS will reimburse providers at 68.59% of the ADHS established rate in effect as of July 1, 2022, and posted at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

2) Ground Ambulance Rates set by AHCCCS

a) AHCCCS establishes ground ambulance rates for out-of-state companies, companies operated by American Indian tribes except those described in paragraph b or which have a CON and are reimbursed according to reimbursement methodology 1), and federal agencies such as the National Park Service that operates ambulances in Grand Canyon National Park and Lake Mead National 5(i)
Recreation Area. Rates were initially established in 1994 based on the average (mean) reimbursement rates paid by commercial insurance companies. Ground Ambulance Fee Schedule Rates are posted on the AHCCCS website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/ , effective October 1, 2022

b) Effective October 1, 2018, rates for ground ambulance services provided by an I.H.S. provider or a tribally owned or operated provider with a section 638 agreement that does not have a Certificate of Necessity (CON) issued by the Arizona Department of Health Services (ADHS), will be the higher of:

(1) the weighted average of the provider-specific rates as set by ADHS that are in effect on July 1, 2018, for each provider that has been issued a CON weighted by utilization of each ground transportation service code derived from both paid claims and encounters for the 12 months ending September 30, 2017; and (2) the weighted average of the provider-specific rates as set by ADHS that are in effect on July 1, 2018, for each provider that has been issued a CON weighted by utilization of each ground transportation service code derived from only paid claims for the 12 months ending September 30, 2017. The higher of the two methodologies will then be multiplied by 68.59% to establish the AHCCCS rate for each ambulance service. Beginning October 1, 2021, if the methodology produces a rate for the Basic Life Support (BLS) that is equal to or exceeds the Advanced Life Support (ALS) rate, the ALS rate shall be set at 107.5% of the calculated BLS rate. This is applicable to Basic Life Support Codes A0428 & A0429 and Advanced Life Support Codes A0426, A0427, A0433, and A0434. Ground ambulance services provided by an I.H.S. provider or a tribally owned or operated provider with a section 638 agreement that have a Certificate of Necessity (CON) issued by the Arizona Department of Health Services (ADHS) will be reimbursed according to reimbursement methodology 1). These rates will be adjusted with an effective date of October 1 of each subsequent year using the provider-specific rates in effect on July 1 as set by ADHS for each ground ambulance provider that has been issued a CON and utilization data for paid claims and encounters for the 12 months ending September 30th of the previous year.

The methodology described in paragraph 2(b) is the following:

- AHCCCS FFS rate = the greater of (Methodology 1 weighted average rate * 0.6859) or (Methodology 2 weighted average rate * 0.6859).
- Methodology 1 weighted average rate = (C + D) / (A + B)
- Methodology 2 weighted average rate = C / A

Where:

A = FFY 2017 total units billed for the service on FFS claims

B = FFY 2017 total units billed for the service on MCO encounters

C = FFY 2017 total reimbursements for the service on FFS claims

D = FFY 2017 total reimbursements for the service on MCO encounters

After the above methodology is calculated if BLS is = to/or greater than ALS, then BLS Rate * 1.075 = ALS Rate

3) Air Ambulance Rates

AHCCCS establishes reimbursement rates for air ambulance services. For claims with dates of service on or before December 31, 2015, the reimbursement rates are based on a cost study of Air Ambulance Costs conducted in 2000 to establish the initial rates for specialty and non-specialty transports, and are adjusted periodically based on the Consumer Price Index for Other Medical Professionals, the CPI for Transportation, and the Federal Aviation Administration forecast of jet fuel prices. For claims with dates of service from January 1, 2016 through September 30, 2016, the reimbursement rates are based on a study of non- specialty transport and mileage ambulance rates in other western states, setting the AHCCCS rates for non-specialty transports and mileage only equal to the average rate among the states studied. However, rates for specialty transports remain unchanged from those in effect on December 31, 2015. Reimbursement rates for air ambulance services were increased by 8.1% for dates of service after October 1, 2019. For dates of service after October 1, 2022, reimbursement rates for base rate Fixed Wing Transport and Rotary Wing Transport were increased by 17.7% and the Neonatal Transport base rate was increased by 7.9%. For dates of service after October 1, 2022, air ambulance rates can be found at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

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, through the 1115 Demonstration Waiver, 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 a blend of an AHCCCS-developed case management model and historical cost information for this specific population. The model considers case management case load requirements and costs and is rebased annually.

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.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

AHCCCS will reimburse the Indian Health Service (IHS) and tribal facilities based on the following reimbursement methodologies reflected in Tables 1 and 2. The AHCCCS capped fee schedule can be found at the following link: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/. The Effective date for the AHCCCS fee schedule can be found on 4.19B page 1.

As the Tables 1 and 2 reflect, the methodologies may differ depending on a specific situation. The various situations are whether:

- the services include or exclude professional services.
- the service is provided by the IHS or a tribal facility
- the tribal facility is set up to bill outpatient services with specific coding and requests this format
- based on specific CMS guidance (transportation).

TABLE 1 - IHS OUTPATIENT REIMBURSEMENT METHODOLOGY

Eligibility Type	Service	Billing Form/Codes	Reimbursement
Title XIX (Acute)	Outpatient Hospital	1500 / 00099	Outpatient All-inclusive Rate
	Clinic	1500 / 00099	Outpatient All-inclusive Rate AHCCCS Capped Fee Schedule
	Ambulatory Surgery Center	1500 / 00090-00098	AHCCCS Capped Fee Schedule
	Professional Services	1500 / HCPCS/CPT codes	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

Title XIX (Long Term Care)	Outpatient Hospital	1500 / 00099	Outpatient All-inclusive Rate
	Clinic	1500 / 00099	Outpatient All-inclusive Rate AHCCCS Capped Fee Schedule
	Ambulatory Surgery Center	1500 / 00090-00098	AHCCCS Capped Fee Schedule
	Professional Services	1500 / HCPCS/CPT codes	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	
Title XIX (Behavioral Health)	Outpatient Hospital	1500 / 00099	Outpatient All-inclusive Rate
	Clinic	1500 / 00099	Outpatient All-inclusive Rate AHCCCS Capped Fee Schedule
	Professional Services	1500 / HCPCS/CPT codes	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

TABLE 2 - '638 TRIBAL FACILITY OUTPATIENT REIMBURSEMENT METHODOLOGY

Eligibility Type	Service	Billing Form/Codes	Reimbursement
Title XIX (Acute)	Outpatient Hospital (including professional services) (or) Outpatient Hospital (excluding professional services)	1500 / 00099 (or) UB-92 – Specific revenue codes	Outpatient All-inclusive Rate (or) Statewide Cost to Charge Rate
	Clinic (including professional services) (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	Outpatient All-inclusive Rate (or) AHCCCS Capped Fee Schedule
	Ambulatory Surgery Center (including professional services) (or) Ambulatory Surgery Center (excluding professional services)	1500 / 00090-00098 (or) 1500 / CPT codes	AHCCCS Capped Fee Schedule)
	Professional Services (services included in procedure bill)	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost
Title XIX (Long Term Care)	Outpatient Hospital (including professional services (or) Outpatient Hospital (excluding professional services)	1500 / 00099 (or) UB-92 / Specific revenue codes	Outpatient All-inclusive Rate (or) Statewide Cost to Charge Rate

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

	Clinic(including professional services (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	Outpatient All-inclusive Rate (or) AHCCCS Capped Fee Schedule
	Professional Services (services included in procedure billed)	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
	HCBS Services	1500 / HCPCS or AHCCCS specific codes	AHCCCS Capped Fee Schedule
	Transportation (Air & Ground)	1500 / HCPCS codes	AHCCCS Capped Fee Schedule
	Transportation (Non-Ambulance)	1500 / HCPCS/AHCCCS specific codes	AHCCCS Capped Fee Schedule
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost
Title XIX (Behavioral Health)	Outpatient Hospital (including professional services) (or) Outpatient Hospital (excluding professional services)	1500 / 00099 (or) UB-92 / Specific revenue codes	Outpatient All-inclusive Rate (or) Statewide Cost to Charge Rate
	Clinic (including professional services) (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	Outpatient All-inclusive Rate (or) AHCCCS Capped Fee Schedule
	Professional Services	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
	Transportation (Air & Ground)	1500 / HCPCS codes	AHCCCS Capped Fee Schedule
	Transportation (Non-Ambulance)	1500 / HCPCS/AHCCCS codes	AHCCCS Capped Fee Schedule
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

The published rate is paid for up to five (5) encounters/visits per recipient per day. Encounters/visits are limited to the AHCCCS-registered facilities that provide covered services to Medicaid members in an IHS or tribal 638 health facility. The encounters/visits will be differentiated based on the patient account numbers that are assigned for each encounter/visit. Encounters/visits include covered telemedicine services.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

Alternative Payment Methodology for Tribal Facilities Recognized as 638 FQHCs

If a 638 FQHC elects an Alternative Payment Methodology then the 638 FQHC will be reimbursed an outpatient all-inclusive rate for all FQHC services. The published rate is paid for up to five encounters/visits per recipient per day. Encounters/visits are limited to the AHCCCS-registered facilities that provide covered services to Medicaid members in a 638 FQHC. The encounters/visits will be differentiated based on the patient account numbers that are assigned for each encounter/visit. Encounters/visits include covered telemedicine services.

AHCCCS will establish a Prospective Payment System (PPS) methodology for the 638 FQHCs so that the agency can determine on an annual basis that the published, all inclusive rate is higher than the PPS rate. The PPS rate will be established by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads. The 638 FQHCs would not be required to report its costs for the purposes of establishing a PPS rate.

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

DIRECT MEDICAID REIMBURSEMENT FOR CERTAIN MEDICAID SERVICES PROVIDED BY A PARTICIPATING LOCAL EDUCATION AGENCY (LEA)

A. Reimbursement Methodology for School-Based Health and Related Services.

Local Education Agencies (LEAs) that elect to participate are reimbursed for certain medical services on a cost basis. These services are:

1. Speech-Language Pathology Services
2. Occupational Therapy Services
3. Physical Therapy Services
4. Nursing Services
5. Specialized Transportation Services
6. Behavioral Health Services
7. Personal Care Services
8. Audiology Services
9. Physician Services
10. Nurse Practitioner Services

All costs described within this methodology are for Medicaid services provided by qualified personnel or a qualified healthcare professional listed in Attachment 3.1-A Limitation, paragraph 4.b.ix of the Medicaid state plan.

All reimbursable services must meet the service definitions as described in the AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Fee-For-Service Provider Manual. These services must be:

- Identified in:
    - An Individualized Education Program (IEP);
    - An Individualized Family Service Plan (IFSP);
    - Other Medical Plans of Care:
        - A Section 504 plan;
        - Any other documented individualized health or behavioral health plan or as otherwise determined medically necessary otherwise

B. Direct Medical Payment Methodology

LEAs will be reimbursed on a cost basis consistent with a certified public expenditure (CPE) reimbursement methodology. On an interim basis, LEAs will be reimbursed the federal share of the lesser of the rate contained in the AHCCCS fee-for-service (FFS) schedule or the amount billed by the LEA, minus an AHCCCS administrative fee and a TPA processing fee as identified in the LEA's participation agreement with the TPA.

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

In accordance with the annual cost reconciliation process, the sum of the interim payments before fees are deducted will be reconciled with the federal share of the Medicaid portion of the total costs certified by the LEA.

C. Data Capture for the Cost of Providing Health-Related Services
Total direct and indirect costs, less any federal payments for these costs, will be captured utilizing the following data:
   a. Medicaid School Based Claiming Cost Reports received from LEAs;
   b. Arizona Department of Education (ADE) Unrestricted Indirect Cost Rate (UICR);
   c. The results of the Random Moment Time Studies (RMTS) including:
      i. The calculated Direct Medical Services IEP/IFSP RMTS percentage;
      ii. The calculated Direct Medical Service provided under Other Medical Plans of Care RMTS percentage.
   d. LEA specific Medicaid IEP Ratios.
      i. Medicaid IEP or IFSP Ratio;
      ii. Medicaid Ratio for Other Medical Plans of Care.

D. Data Sources and Cost Finding Steps

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1) Allowable Costs: Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by LEAs excluding transportation personnel (costs for transportation personnel are reported as defined in Section E). These direct costs will be calculated on a LEA-specific level and will be reduced by any federal payments for these costs (other than the interim payments), resulting in net direct costs.

   The source of this financial data will be audited by the Uniform System of Financial Records (USFR) Chart of Accounts kept at the LEA level. Costs will be reported on an accrual basis.

2) Indirect costs are determined by applying the LEA's specific UICR to its net direct costs. The Arizona Department of Education is the cognizant agency for LEAs and approves unrestricted indirect cost rates for LEAs for the United States Department of Education. LEAs are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate. An indirect cost rate is not applied to purchased or contracted costs that already include an indirect cost component. The indirect cost rate is calculated from costs that are not included in the allowable reported expenditures so there is no duplication of costs.

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Indirect Cost Calculation:
Multiply the ADE UICR by the net direct costs applicable for dates of service in the rate year.

3) Time Study Percentages: A CMS-approved time study is used to determine the percentage of time that medical service personnel spend on IEP/IFSP and Other Medical Plans of Care, Direct Medical Services, general and administrative time, and all other activities.

   The RMTS methodology will utilize two cost pools.
   - Cost pool A for Direct Medical Services (other than personal care services) provided by eligible staff and other medical services providers.
   - Cost pool B for Direct Medical Services provided by personal care service providers only.

   The RMTS will generate the Direct Medical Services Time Study percentages for each cost pool and percentages for each cost pool will be applied separately to the costs associated with:
   - Direct Medical Services provided pursuant to an IEP/IFSP.
   - Direct Medical Services provided pursuant to Other Medical Plans of Care.

   The use of the CMS-approved time study methodology assures that no more than 100 percent of time and costs are captured and that the time study is statistically valid per 2 CFR Part 200.

4) Medicaid Enrollment Ratio Determination
   Two distinct Medicaid Enrollment Ratios will be established for each participating LEA - the Medicaid IEP/IFSP Enrollment Ratio and the Medicaid Enrollment Ratio for Other Medical Plans of Care.

   Medicaid IEP/IFSP Enrollment Ratio:
   To determine the Medicaid IEP/IFSP Enrollment Ratio, the names, gender, and birthdates of students with a Direct Medical Service prescribed on an IEP/IFSP identified from the AHCCCS LEA's Enrollment October 1 Count Report are matched against the Medicaid enrollment file. The numerator will be the number of Medicaid enrolled students with a Direct Medical Service prescribed on an IEP/IFSP and the denominator will be the total number of students with a Direct Medical Service prescribed on an IEP/IFSP. The Medicaid IEP/IFSP Ratio will be calculated for each participating LEA on an annual basis.

   Medicaid Enrollment Ratio for Other Medical Plans of Care:
   To determine the Medicaid Enrollment Ratio for Other Medical Plans of Care, the names, gender, and birthdates of all students from the AHCCCS LEA's Enrollment October 1 Count Report are matched against the Medicaid enrollment file. The numerator will be the number of Medicaid enrolled students in the LEA and the denominator will be the total number of students in the LEA. The Medicaid Enrollment Ratio will be calculated for each participating LEA on an annual basis.

5) Calculation Medicaid Portion of Costs Associated with Direct Medical Services

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Calculation of the Medicaid Direct Medical Service costs pursuant to an IEP/IFSP:
Multiply the sum of net LEA direct costs and indirect costs by the statewide IEP/IFSP time study percentages for each cost pool, then multiply those products by the Medicaid IEP/IFSP Enrollment Ratio.

Calculation of the Medicaid Direct Medical Service costs pursuant to Other Medical Plans of Care:
Multiply the sum of net LEA direct costs and indirect costs by the statewide Other Medical Plans of Care time study percentages for each cost pool, then multiply those products by the Medicaid Enrollment Ratio for Other Medical Plans of Care.

E. Specialized Transportation Services Payment Methodology

School based specialized transportation is defined as a medically necessary service (as outlined in the IEP/IFSP of an enrolled Medicaid beneficiary) provided in a specially-adapted vehicle that has been physically-adjusted or designed (e.g., wheelchair lifts, ramps, etc.,) to accommodate special needs children in the school-based setting. Note: The presence of only an aide (on a non-adapted bus/vehicle) or seat belts does not make a vehicle specially-adapted.

LEAs will be reimbursed for specialized transportation services on a cost basis consistent with a CPE reimbursement methodology. On an interim basis, LEAs will be reimbursed the federal share of the lesser of the rate contained in the AHCCCS FFS schedule or the amount billed by the LEA, minus an AHCCCS administrative fee and a TPA processing fee as identified in the LEA's provider participation agreement.

In accordance with the cost reconciliation process, the sum of the interim payments before fees are deducted will be reconciled with the federal share of the Medicaid portion of the total costs certified by the LEA.

Transportation to and from school may be claimed as a Medicaid service when the following conditions are met:

1) Specialized transportation is specifically listed in the IEP/IFSP as a required service;
2) The child requires specialized transportation in a vehicle with physical adaptations designed to accommodate an individual with a disability;
3) A Medicaid eligible service is provided on the day that the specialized transportation is billed; and
4) The service billed only represents one-way trip(s) on the specially adapted transportation for a Direct Medical Service listed in the IEP/IFSP;
5) The LEA must be registered with AHCCCS as a transportation provider and must meet the same provider qualifications as all AHCCCS transportation providers (e.g., proof of insurance and licensure of school bus drivers).

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Transportation costs included on the Cost Report worksheet will only include those personnel and non-personnel costs associated with specialized transportation reduced by any federal payments for these costs (other than the interim payments), resulting in net costs for transportation. The Cost Report includes costs for the following:

1. Bus Drivers/Aides
2. Mechanics/Mechanic Assistant
3. Substitute Drivers
4. Fuel/Oil
5. Repairs & Maintenance
6. Lease/Rentals
7. Insurance Costs
8. Purchased Professional Transportation Services and/or Equipment
9. Depreciation

The source of this financial data will be audited by the Uniform System of Financial Records (USFR) Chart of Accounts kept at the LEA level. Costs will be reported on an accrual basis.

When LEAs are not able to discretely identify the specialized transportation costs from the general education transportation costs, a specialized transportation cost discounting methodology will be applied. A rate will be established and applied to the total transportation cost of the LEA. This rate will be based on the Total IEP/IFSP Special Education Students in LEA Receiving Specialized Transportation divided by the Total Students in the LEA Receiving General Transportation. The result of this rate (% of total students receiving transportation that are IEP/IFSP students requiring specialized transportation) multiplied by the Total LEA Transportation Cost will be included on the cost report.

This cost will be further discounted by the ratio of eligible Medicaid Enrolled Special Education IEP/IFSP One-Way Trips divided by the total number of Special Education IEP/IFSP One-Way Trips. This data will be provided from bus logs. The process will ensure that only one-way trips for Medicaid enrolled Special Education children with IEP/IFSP's are billed and reimbursed.

F. The Cost Reconciliation Process

The cost reconciliation process must be completed within twenty-four months of the end of the Cost Report due date (up to 5 months after the state fiscal year ends). Effective with reporting of SFY 2023 activity, the cost reconciliation and settlement processes are to be completed within nineteen months of the Cost Report due date (up to 5 months after the state fiscal year ends). The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the LEA’s Medicaid interim payments during the reporting period as documented in the

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Medicaid Management Information System (MMIS).

1. Annual Cost Report Process

The annual Cost Report process is the first step in the cost reconciliation process. For Medicaid services provided in schools during the state fiscal year (July 1 through June 30) each LEA must complete an annual Cost Report. The Cost Report is due up to five months after the fiscal year ends. At the discretion of AHCCCS, LEAs may be granted up to a one month extension.

The primary purposes of the LEA provider's cost report are to:

1) Document the LEA provider's total CMS approved Medicaid-allowable costs of delivering Medicaid coverable services using a CMS approved cost allocation methodology.
2) Reconcile the annual interim payments to the LEA provider's total CMS approved, Medicaid-allowable costs using a CMS approved cost allocation methodology.

The annual Medicaid Cost Report includes a Certification of Funds Public Expenditure Form certifying the LEA's actual, incurred costs/expenditures. All filed annual Cost Reports are subject to desk review by AHCCCS or its designee.

2. The Cost Settlement Process

- If the sum of the interim payments to a LEA (before fees are deducted) exceeds the federal share of the Medicaid portion of the actual, certified costs for the delivery of school based health services, the LEA is required to return an amount equal to the overpayment (less the associated AHCCCS administrative fee) to the State. Overpayments will be paid by the LEAs promptly to AHCCCS.

- If the federal share of the Medicaid portion of a LEA's actual, certified costs exceed the sum of the interim payments before fees are deducted, AHCCCS will pay the LEA the difference (less the AHCCCS administrative fee)

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Reserved for future use.

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Citation

42 CFR 447,434,438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustments for Provider Preventable Conditions

The Medicaid Agency meets the requirements of 42 CFR Part 447, Subpart A, and sections1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Sections 4.19-B

__X__Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

_____Additional Other Provider Preventable Conditions identified below.

For OPPCs: AHCCCS will identify potential OPPCs via codes and modifiers used on outpatient and professional claims, and perform medical review. The OPPC services identified through medical review will not be reimbursed. AHCCCS will not claim FFP for expenditures for OPPC services.