STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING FEE-FOR-SERVICE PAYMENT RATES FOR LONG TERM CARE FACILITIES

I. General Provisions

A. Purpose

This State Plan Amendment establishes the reimbursement system for fee-for-service payments to nursing facilities where payments are made directly by the Arizona Long Term Care System (ALTCS) or the acute care program. The method of updating the per diem rates established under this plan from year to year is amended effective for dates of service beginning October 1, 2005.

Nursing facility services provided by facilities owned or operated by the Indian Health or tribes under PL 93-638 are reimbursed for each Medicaid day at the outpatient All-Inclusive Rate as published in the Federal Register.

B. Reimbursement Principles

1. Providers of nursing facility care are reimbursed based on a prospective per diem reimbursement system designed to recognize members in four levels:

- Level 1
- Level 2
- Level 3
- Ventilator dependent, sub-acute and other specialty care.

Fee-for-service payments for services to members in nursing facilities who are ventilator dependent, sub-acute or receiving other specialty care are based on negotiated rates. Negotiated rates are based on the rates paid by program contractors for specialty care services and member service needs.

Reimbursement for Levels 1, 2 and 3 is based on a three component system:

- Primary Care - The primary care cost component reflects direct member care including wages, benefits and salaries for registered nurses (RNs), licensed practical nurses (LPNs), and nurse aides.

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- Indirect Care - Non-nursing, non-capital related activities of the nursing facility are included in the indirect care component. The activities reflected in this component are further removed from the delivery of member care and are less likely to vary based on the acuity level of an individual member (e.g., supplies, housekeeping, laundry, and food).

- Capital - The capital cost component includes depreciation, leases, rentals, interest and property taxes.

2. AHCCCS makes no fee-for-service payments to Intermediate Care Facilities for the Mentally Retarded (ICF/MR). ICF/MR services are reimbursed by the program contractor providing statewide Medicaid services for the developmentally disabled which is the Department of Economic Security/Division of Developmental Disabilities.

3. The AHCCCS fee-for-service program reimburses qualified providers of nursing facility services based on the individual Medicaid member's days of care multiplied by the lesser of the charge for the service or the applicable per diem rate for that member's classification, less any payments made by a member or third parties.

4. Reimbursement rates determined under this plan are effective for services rendered on or after October 1, 2005.

II. Rate Determination for Nursing Facilities

Per diem reimbursement for nursing facility services to members in Levels 1, 2 and 3 shall be the sum of three prospectively determined rate components:

A. Data Sources

1. Primary Care

When recalculation of the per diem reimbursement rates are determined appropriate by the Administration, several sources of data may be used in the calculation of the primary care rate component.

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- Arizona Pre-admission Screening (PAS) instruments (initial and reassessments) from the most recent six month period preceding the effective date of the rate. The data set excludes physician override cases. The PAS and reassessment instruments measure a member's level of functioning based on individual scores for Activities of Daily Living (ADL) items and medical service items.

- The Maryland Time and Motion Study of nursing time requirements by functional level and for specific nursing services and treatments.

- Salary and benefits for RNs, LPNs, and nurse aides from cost and/or wage reports submitted by Arizona nursing facilities for cost report years ending in the calendar year preceding the effective date of the rate.

- Primary care cost data from cost reports submitted by Arizona nursing facilities for cost report years ending in the calendar year preceding the effective date of the rate.

- BLS Employment Cost Index (ECI).

Because the primary care component varies by member level of care and geographic location, a total of six primary care rates are developed. An individual rate is developed for each of the member levels of care, 1 through 3, and these rates are adjusted for geographic wage variations in urban and rural areas. Maricopa, Pima and Pinal are defined as urban; the remaining 12 counties are defined as rural. Wage data is obtained from cost reports and does not depend in any way on Medicare wage indices.

2. Indirect Care Component

When recalculation of the per diem reimbursement rates is determined appropriate by the Administration, several sources of data may be used in the calculation of the indirect care component:

- The indirect care component from the previous rate year.

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- Indirect care cost data from cost reports submitted by Arizona nursing facilities for cost report years ending in the calendar year preceding the effective date of the rate.
- Consumer Price Index (Medical Care Services).

The indirect care component is a single statewide rate that does not vary by member level of care or geographic area.

3. Capital Component

When recalculation of the per diem reimbursement rate is determined appropriate by the Administration, several sources of data may be used in the calculation of the capital component:

- Capital component from the previous rate year.
- Capital cost data from cost reports submitted by Arizona nursing facilities for cost report years ending in the calendar year preceding the effective date of the rate.
- Skilled Nursing Facility Total Market Basket published by Data Resources Inc. (DRI).
- Construction cost index such as the RS Means Construction Cost Index.

The capital component also is a single statewide rate that does not vary by member level of care or geographic area.

The sections that follow provide specific details on the methodology used to calculate each of these rate components.

B. Rate Computation.

The following computations were used to update rates effective on and after October 1, 2005.

1. Primary Care

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The steps used to calculate the primary care component include:

- Step 1 - Classify Members. Members are grouped into Levels 1, 2, or 3 using a numeric score and weight assigned to each item on the PAS and reassessment instruments using a process called discriminant analysis. During the analysis each individual is assigned, based on their PAS record, to a member class reflecting the resources required by the member. In addition, a standard base amount of nursing minutes is assigned to each patient regardless of assessment score for meal preparation, night shift, etc.

- Step 2 - Evaluate Use of Services. After the ventilator dependent/sub-acute members are removed, the remaining members are evaluated using PAS data to quantify the types of services they need.

- Step 3 - Determine Nursing Time. Service needs are translated into time requirements using the Maryland Time and Motion Study. The linkage of member need and nursing time may be slightly modified based on a review of time assessments in prior years and variations in ADL measurements.

- Step 4 - Calculate Nursing Staff Times. Staff time equals the sum of nursing time, ADL weight plus an allocation of overhead. The result is an estimate of the fraction of an hour needed to provide nursing care in each member class. This is broken down into RN care, LPN care and nurse aide care.

- Step 5 – Assign Level of Care 1, 2, or 3. Medical and functional assessment data from the PAS instrument are used to assign each patient a medical and functional score. Based on these scores, patients are classified into a level of care. 4% of the members with the highest scores in each class are moved to the next highest level of care.

- Step 6 – Compute Average Nursing Minutes for each Level of Care. The total RN, LPN, and Nurse Aide time required for all patients in the same level of care are averaged.

- Step 7 - Translate Nursing Time into the Rate. In this step, the nursing times are translated into the rate component by multiplying the number of

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minutes for each nursing level for each level of care by average hourly wages.

Wage data information is obtained from cost report and/or wage data submitted by Arizona nursing facilities for reporting years ending in the calendar year preceding the effective date of the rate. Wage data for registry nursing is included in these wage calculations but is capped based on thresholds of average urban and rural registry hour utilization. All wages associated with registry hours at or below the thresholds are included in the rate calculations.

- Step 8 - Inflate. Using the DRI market basket index, wages are inflated to the midpoint of the fiscal year in which the rate becomes effective (the end of the first quarter of the calendar year). Inflation is applied before outliers are excluded.

- Step 9 - Calculate Level of Care Rates for Urban and Rural. At the conclusion of this Step, six primary care rates exist. Rates for the three levels of care vary by geographic area.

2. Indirect Care Component

The steps to calculate the statewide average indirect rate per day include:

a) For each facility total capital costs are subtracted from total facility costs to determine costs without capital.

b) These remaining costs are inflated to the midpoint of the rate year using the Consumer Price Index (Medical Care Services).

c) Facility specific inflated direct care wage costs are subtracted from the value above to derive facility specific indirect costs.

d) For each facility the total indirect costs are divided by the total nursing facility days to calculate an indirect cost per day. An adjustment factor is applied to those facilities with an occupancy rate of less than 85% (based on total nursing facility bed days).

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e) The facility-specific indirect costs per day are weighted by Title XIX nursing facility days to determine each facilities total Medicaid indirect costs. The sum of these weighted costs is used to calculate the statewide average indirect care cost per day. Facilities' with average indirect costs per day plus or minus 2 standard deviations from the mean are excluded.

3. Capital Component

The steps to calculate the statewide capital per day rate include:

a) The average cost of constructing a new nursing facility bed is determined by reference to a national source for construction costs such as the R. S. Means Construction Cost Index.

b) The weighted average age of nursing facility beds in use by each facility is calculated from data supplied by providers via survey and/or cost report.

c) Calculate the total current value of nursing facility beds by taking the current cost of a new bed and depreciating it by the average age of beds in each facility.

d) Apply a rate of return, such as the current Treasury Note rate plus a risk factor, to the total current value, to arrive at the fair rental value. The fair rental value method establishes a current value of the facility based on current construction costs and the age of the facility. The age of the facility is based on the original construction cost, adjusted for additions and capital improvements which effectively reduce the age of the facility. Depreciation is recognized at 1% per year.

When the current value of the facility has been determined based on current costs and the age of the facility adjusted for replacements and improvements, then a rate of return is applied to determine the fair rental value for a one year period. The imputed rate of return used to calculate the fair rental value is currently the ten-year Treasury Bond composite rate plus 2%

e) Add the total fair rental value of all facilities. Divide the total fair rental value by the nursing facility inpatient days, adjusted to a minimum occupancy rate of

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85% for each facility, then add in the per day historic costs for property taxes and insurance to determine the statewide average capital component.

4. Total Rate
The per diem nursing facility rates are calculated by summing the primary care, indirect care, and capital cost components. These rates vary by member level of care and geographic area due to the primary care components.

5. Rate Update
Effective October 1, 2002 and each year thereafter, fee-for-service rates for nursing facilities will be updated by applying an inflation factor or factors to the rate components in effect for the prior year. This method of adjusting fee-for-service rates is consistent with the method used by AHCCCS for other medical services. For rates effective from October 1, 2011 to September 30, 2013, and from October 1, 2015 and thereafter, no inflation factor will be applied.

Below are the AHCCCS FFS Nursing Facility Per Diem Rates effective on and after January 1, 2023:

Level of Care	Revenue Code	Urban Rate	Rural Rate	Flagstaff
LOA/Therapeutic**	0183	$208.29	$201.79	$207.77
LOA/Nursing Home**	0185	$208.29	$201.79	$207.77
Level I	0191	$208.29	$201.79	$207.77
Level II	0192	$227.71	$219.91	$226.40
Level III	0193	$270.10	$261.45	$269.19

*AHCCCS has designated nursing facilities in the Arizona counties of Pima, Pinal, and Maricopa as Urban to be paid at the AHCCCS Urban Rate. All other counties inside or outside of Arizona are designated as Rural and are paid at the AHCCCS Rural Rate (except Flagstaff ,which is paid at the rate specified above).
**This LOA rate only applies to reserved beds at Nursing Facilities

III. Other Provisions

A. Provider Appeals
Nursing facility providers have the right to request an informal rate reconsideration in accordance with the ALTCS Rules. Appeals are allowed for the following reasons:

- Extraordinary circumstances (as determined by the Director).
- Provision of specialty care services directed at members with high medical needs.
- Unique or unusually high case mix.

Appeals are made in writing to the Director. Appeals which are granted become effective no earlier than the date the appeal was requested.

B. Cost and Wage Reporting
AHCCCS uses cost and wage reports filed by the nursing facilities in the State of Arizona as a basis for these rate calculations.

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C. Audit Requirements

The AHCCCS periodically conducts audits of the financial and statistical records of participating providers. Specifications for the audits are found in the Arizona Long Term Care System (ALTCS) Uniform Accounting and Reporting System and Guide for Credits of ALTCS Contractors and Providers.

D. Rates Paid

Fee-for-service reimbursement for nursing facilities is made in accordance with methods and standards which are specified in this attachment of the State Plan.

E. Nursing Facility Supplemental Payments

Effective October 1, 2012, nursing facilities that are located in Arizona with Arizona Medicaid utilization will receive a quarterly supplemental payment to compensate providers for costs of covered services furnished to Arizona Medicaid beneficiaries to improve access to care.

1. Each nursing facility's supplemental payment shall be determined as follows:

a) On a quarterly basis, AHCCCS shall determine the aggregate supplemental payment amount for all nursing facilities by:

i. Determining the total amount from the nursing facility provider assessment fund for the quarter, which is the assessment amount collected from providers in accordance with paragraph E.2.
ii. Subtracting one percent of the total estimated assessments, and
iii. Dividing the difference of subsections (a)(i) and (a)(ii) by (1 minus the appropriate federal medical assistance percentage (FMAP).

b) AHCCCS shall calculate the quarterly supplemental payment to each nursing facility that has Arizona Medicaid utilization per paragraph (b)(i) below, excluding facilities outside of Arizona, ICF/IIDs and Arizona Veteran's Homes, by:

i. Determining each facility's proportion of Medicaid resident bed days to total nursing facility Medicaid resident bed days for all facilities by utilizing adjudicated claims and encounter data for the most recent 12 month period, including appropriate claims lag. The most recent 12 month period is defined as the contiguous 12-month period that ends six months prior to the month in which the Medicaid resident bed days are pulled. AHCCCS will pull the Medicaid resident bed day data in the first quarter of each payment year.
ii. Multiplying subsections (b)(i) and (a)(iii)
iii. Determining the fee-for-service share of the amount in (b)(ii) by applying a ratio of the facility's Medicaid fee-for-service bed days to the facility's total Medicaid bed days. The remaining share pertains to Medicaid managed care services; Medicaid managed care services are reimbursed separately by AHCCCS through capitation payments.

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(c) AHCCCS shall make quarterly supplemental payments to eligible nursing facility providers after the assessment quarter. The fee-for-service quarterly supplemental payment will be made directly to each eligible nursing facility. If the fee-for-service quarterly supplemental payment amount is less than $25 for an individual facility, no fee-for-service quarterly supplemental payment will be made.

(d) A facility must be open on the date the supplemental payment is made in order to receive a payment.

(e) During the quarter ending March 31, 2015, an additional quarterly payment adjustment will be made that is equal to the difference between what the quarterly payment would be if the pool amount was determined under paragraph 2 below effective January 1, 2015 and what the quarterly payment would be if the pool amount was determined based on paragraph 2 as it was in effect prior to January 1, 2015.

2. The nursing facility assessment to be collected from each nursing facility is as follows:

(a) The assessment is imposed on non-Medicare patient days as allowed for under 42 CFR 433.68(d);
(b) The assessment imposed is $15.63 per non-Medicare day except:
   i. Continuing Care Retirement Communities, ICF/IIDs, IHS and Tribal 638 nursing facilities, Arizona Veteran's Homes, and facilities located outside of Arizona will not be assessed;
   ii. Facilities with 58 or fewer total beds will not be assessed; and
   iii. Facilities with annual Medicaid days greater than or equal to the number required to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2) will be assessed at a rate of $1.80 per non-Medicare day.

The patient days used in the computations are derived from the Nursing Facility Uniform Accounting Report (UAR) Cost Reports filed with the Arizona Department of Health Services. Calculations for the assessment will be made once per year in August, using the most recently filed UAR as of August 1 immediately preceding the start of the assessment year. Only those facilities with a full year UAR will be assessed. The computed annual assessment amount will be divided by four and imposed on a quarterly basis.

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Nursing Facility Differential Adjusted Payment

As of October 1, 2022 through September 30, 2023 (Contract Year Ending (CYE) 2023), provider type 22 nursing facilities that are located in Arizona with Arizona Medicaid utilization that meet AHCCCS established value-based performance metrics requirements below will receive one or both of the Differential Adjusted Payments described below. The Differential Adjusted Payment Schedule represents a positive adjustment to the AHCCCS Fee-For-Service reimbursement rates. These payment adjustments will occur for all dates of service in CYE 2023 only. The purpose of the Differential Adjusted Payment is to distinguish facilities which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth.

a. Health Information Exchange

Nursing facilities that meet the following milestones are eligible to participate in this DAP initiative and earn a 1.0% DAP increase. In order to qualify, by April 1, 2022 the facility must have submitted a LOI to the HIE, in which it agrees to achieve the following milestones by the specified dates:

i. *Milestone #1:* No later than April 1, 2022, the facility must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
ii. *Milestone #2:* No later than April 1, 2022, facilities that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.
iii. *Milestone #3:* No later than December 31, 2022, the facility must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information) from within the nursing facility; continuity of care documents reflecting a summary of care within the nursing facility including (if applicable): laboratory and radiology information; medication information; immunization data; active problem lists (diagnosis); social history; treatments and procedures conducted during the stay; advanced directives; active allergies; and basic patient demographic data including assigned provider, emergency contact and payer. For facilities that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be April 1, 2023.
iv. *Milestone #4:* By the facility's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data

suppliers, the facility must complete the following COVID-19 related milestones, if they are applicable:

1. Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
2. Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
3. Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.

v. Milestone #5: No later than April 1, 2023, the facility must have actively accessed, and continue to access on an ongoing basis, patient health information via a qualifying HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the facility's EHR.

For any milestone that includes electronic submission of patient information, the information transferred to the qualifying HIE must be actual patient data; the transfer of test data does not fulfill these requirements. It must include all patient data, including behavioral health data and data covered by 42 C.F.R. Part 2.

In order to receive the 1.0% DAP increase for HIE participation a facility must submit a LOI to the HIE by April 1, 2022 to the following email address: DAP@healthcurrent.org

If a facility has already achieved one or more of the CYE 2023 milestones as of April 1, 2022, the LOI must include a commitment by the facility to maintain its participation in those milestone activities for the period April 1, 2022 through September 30, 2023. The LOI must list each facility that the Nursing Facility requests to participate in this DAP initiative and must include the AHCCCS IDs for each listed facility. In all cases, the Nursing Facility must submit the AHCCCS IDs for each listed facility as part of the LOI or must email the associated AHCCCS IDs to the email addresses noted.

If a facility submits a LOI and receives the 1.0% DAP increase for CYE 2023 but fails to achieve one or more of the HIE milestones by the specified date or fails to maintain its participation in the HIE milestone activities, that facility will be ineligible to receive an HIE DAP for dates of service from October 1, 2023 through September 30, 2024 (CYE 2024) if a DAP is available at that time.

b. Urinary Tract Infection Performance Measure (1.0%)

Nursing facilities that meet or fall below the statewide average percentage for the Urinary Tract Infection (UTI) performance measure will qualify for a 1.0% DAP increase. On March 15, 2022, AHCCCS will download data from the Medicare Provider Data Catalog website for the percent of long-stay residents with a UTI. Facility results will be compared to the Arizona average results for the measure. Facilities with percentages less than or equal to the statewide average score will qualify for the DAP increase.

Exemptions

IHS and 638 tribally owned and/or operated facilities, including nursing facilities are exempt from this initiative based on payments primarily at the all-inclusive rate.

Payment Methodology

For provider type 22 nursing facilities, the fee-for-service payment rates will be increased by 1.0% if they meet the UTI requirements and by 1.0% if they meet the HIE requirements. A Provider Type 22 facility meeting both UTI and HIE requirements will receive a combined 2.0% increase. These increases do not apply to supplemental payments.

Facilities which submitted an LOI and received an increase for CYE 2022 but failed to achieve one or more milestones in the LOI or failed to maintain its participation in the milestone activities are ineligible to receive a DAP in CYE 2023.

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The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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IV. Temporary Rate Reduction

Notwithstanding the methods and rates as otherwise described in this attachment, for dates of service effective from October 1, 2011 to September 30, 2013, payments will be at the payment rates in effect as of September 30, 2011, reduced by 5%.

Payments for services provided by the Indian Health Service or Tribal 638 Health facilities are not subject to this 5% rate reduction.