



Janice K. Brewer, Governor
Thomas J. Betlach, Director

Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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September 30, 2011

Cheryl Young
Centers for Medicare and Medicaid Services
75 Hawthorne St., 5th Floor
San Francisco, California 94105

Dear Ms. Young:

Enclosed is State Plan Amendment (SPA) #11- 016, effective July 1, 2011, which updates the State Plan to include non-payment for provider-preventable conditions. The package includes:

- Form 179
- CMS Preprint (Sec. 4.19A) with tracked changes
- CMS Preprint (Sec. 4.19A) clean copy
- Documentation of Tribal Consultation

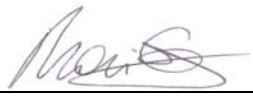
Because Medicaid implementation of the rule was extended until July 1, 2012, AHCCCS did not intend to submit a related SPA at this time. Therefore, the current package does not include details such as standard funding and access-to-care responses.

Please contact Christine Goldberg at (602) 417- 4616 with questions or comments.

Sincerely,

Monica Coury
Assistant Director
Office of Intergovernmental Relations

cc: Jessica Schubel
Brian Burdullis

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: Centers for Medicare and Medicaid Services		1. TRANSMITTAL NUMBER: 11-016	2. STATE Arizona
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2011	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903		7. FEDERAL BUDGET IMPACT: FFY 2012: Undetermined FFY 2013: Undetermined	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Section 4.19-A, p. 59a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): NA	
10. SUBJECT OF AMENDMENT: Updates the State Plan to include standards of payment for healthcare acquired conditions.			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Monica Coury 801 E. Jefferson, MD#4200 Phoenix, Arizona 85034	
13. TYPED NAME: Monica Coury			
14. TITLE: Assistant Director			
15. DATE SUBMITTED: September 30, 2011			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

State/Territory: Arizona**Citation**

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

Payment Adjustment for Provider Preventable Conditions

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

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

X Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

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Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 ____

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.

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____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan:

TN No. 11-016

Supersedes

Approval Date _____ Effective Date July 1, 2011TN No. NA

CMS ID: 7982E

State/Territory: Arizona

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1136. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN No. 11-016

Supersedes

TN No. NA

Approval Date _____ Effective Date July 1, 2011