June 30, 2020

Brian Zolynas
Division of Medicaid and Children's Health Operations
U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

RE: Arizona SPA #20-011, IHS/638 NF AIR

Dear Mr. Zolynas:

Enclosed is Arizona State Plan Amendment (SPA) #20-011, IHS/638 NF AIR, which revises the State Plan to change the reimbursement for nursing facility services provided to American Indians by facilities owned or operated by the Indian Health or tribes under PL 93-638 to reflect the outpatient All-Inclusive Rate (AIR) as published in the Federal Register. Please utilize the following links for information regarding Tribal Consultation and public notice requirements:

Tribal Consultation:
https://www.azahcccs.gov/AmericanIndians/Downloads/Consultations/Meetings/2020/05072020Presentation.pdf

https://www.azahcccs.gov/AmericanIndians/Downloads/Consultations/Meetings/2020/06042020SpecialTCPresentation.pdf

Public Notice:
https://www.azahcccs.gov/AHCCCS/PublicNotices/NursingFacility-AllInclusiveRate-AIR.html

If you have any questions about the enclosed SPA, please contact Alex Demyan at (602) 417-4130.

Sincerely,

Dana Flannery
Assistant Director
Arizona Health Care Cost Containment System (AHCCCS)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: Centers for Medicare and Medicaid Services

1. TRANSMITTAL NUMBER: 20-011

2. STATE: Arizona

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: October 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR Part 447

7. FEDERAL BUDGET IMPACT:

FFY 2020: $0
FFY 2021: $13,014,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, Page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D, Page 1

10. SUBJECT OF AMENDMENT:

To change the reimbursement for nursing facility services provided to American Indians by facilities owned or operated by the Indian Health or tribes under PL 93-638 to reflect the outpatient All-Inclusive Rate (AIR) as published in the Federal Register.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Dana Flannery

14. TITLE:
Assistant Director

15. DATE SUBMITTED:
June 30, 2020

16. RETURN TO:

Dana Flannery
801 E. Jefferson, MD#4200
Phoenix, Arizona 85034

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:

INSTRUCTIONS FOR COMPLETING FORM CMS-179

Use Form CMS-179 to transmit State plan material to the regional office for approval. A separate typed transmittal form should be completed for each plan/amendment submitted.

Block 1 -Transmittal Number - Enter the State Plan Amendment transmittal number. Assign consecutive numbers on a **calendar year** basis (e.g., 92-001, 92-002, etc.).

Block 2 - State -Type the name of the State submitting the plan material.

Block 3 - Program Identification -Title XIX of the Social Security Act (Medicaid).

Block 4 - Proposed Effective Date - Enter the proposed effective date of material.

Block 5 -Type of Plan Material - Check the appropriate box.

Block 6 - Federal Statute/Regulation Citation - Enter the appropriate statutory/regulatory citation.

Block 7 - Federal Budget Impact - 7(a) - Enter 1st **Federal Fiscal Year** (FFY) impacted by the SPA & estimated Federal share of the cost of the SPA (in thousands) for 1st FFY. **7(b)** - Enter 2nd FFY impacted by the SPA & estimated Federal share of the cost for 2nd FFY. See SMM section 13026.

Block 8 - Page No.(s) of Plan Section or Attachment - Enter the page number(s) of plan material transmitted. If additional space is needed, use bond paper.

Block 9 - Page No.(s) of the Superseded Plan Section or Attachment (if Applicable) - Enter the page number(s) (including the transmittal sheet number) that is being superseded. If additional space is needed, use bond paper.

Block 10 - Subject of Amendment - Briefly describe plan material being transmitted.

Block 11 - Governor's Review - Check the appropriate box. See SMM section 13026 B.

Block 12 - Signature of State Agency Official -Authorized State official signs this block.

Block 13 -Typed Name -Type name of State official who signed block 12.

Block 14 -Title -Type title of State official who signed block 12.

Block 15 - Date Submitted - Enter the date you mail plan material to RO.

Block 16 - Return To -Type the name and address of State official to whom this form should be returned.

Block 17–23 (FOR REGIONAL OFFICE USE ONLY).

Block 17 - Date Received - Enter the date plan material is received in RO. See ROM section 6003.2.

Block 18 - Date Approved - Enter the date RO approved the plan material.

Block 19 - Effective Date of Approved Material - Enter the date the plan material becomes effective. If more than one effective date, list each provision and its effective date in Block 23 or attach a sheet.

Block 20 - Signature of Regional Official -Approving RO official signs this block.

Block 21 -Typed Name -Type approving official's name.

Block 22 -Title -Type approving official's title.

Block 23 - Remarks - Use this block to reference pen and ink changes, a partial approval, more than one effective date, etc. If additional space is needed, use bond paper.

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 number for this information collection is 0938-0193. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21224-1850.

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.

~~Under the ALTCS program, the fee-for-service rates established under this plan are used to reimburse facilities for services provided to Native American members with an on-reservation status (including prior period coverage). Under the acute care program, these fee-for-service rates are used to reimburse the acute care program's limited coverage of nursing facility services for Native American members.~~

Other than services provided by nursing facilities owned or operated by the Indian Health or tribes under PL 93-638, nursing facility services provided to American Indian members who reside on reservation are reimbursed at the fee-for-service rates established under this plan. Nursing facility services provided to American Indians by facilities owned or operated by the Indian Health or tribes under PL 93-638 are reimbursed 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.