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inflation factor. Accommodation costs were derived by multiplying the covered days on the claim/encounter times the accommodation cost per diems from the cost report.

e. Costed claims/encounters were then assigned to tiers using the logic specified above. For claims assigned to more than one tier, ancillary costs were allocated to the tiers in the same proportion as the accommodation costs.

f. All costs were reduced by an audit adjustment factor equal to four percent since cost reports were not audited.

2) **Inflation Factor**: For rates effective on and after October 1, 1999, AHCCCS shall inflate the operating component of the tiered per diem rates to the mid-point of the prospective rate year, using the DRI inflation factor. For rates effective October 1, 2010, to September 30, 2011, and from October 1, 2011 to September 30, 2012, no inflation factor will be applied.

Length of Stay (LOS) Adjustment: For rates effective October 1, 1999 through September 30, 2000, the operating component of the Maternity and Nursery tiers shall be adjusted to reflect changes in LOS as required by the federal mandate that allows women at least 48 hours of inpatient care for a normal vaginal delivery, and at least 96 hours of inpatient care for a cesarean section delivery, effective for dates of service on and after January 1, 1998. There shall be no LOS updates for any tiers for rates effective on or after October 1, 2000.

B. Direct Medical Education Component

Direct medical education includes nursing school education, intern and resident salaries, fringes and program costs and paramedical education.

1) For the service period July 1, 2010 through June 30, 2011, the Administration shall distribute up to $15,122,881 as described in this paragraph to the following hospitals: Maricopa Medical Center, Phoenix Children's Hospital, and University Medical Center. In addition to the above amount, this pool also includes the payment amounts listed on page 9(g)(i) for other teaching hospitals. For dates of service on and after October 1, 1997 (FFY98), GME payment dollars will be separated from the tiered per diem rates to create an AHCCCS GME pool. For FFY98 and each year thereafter, the value of the GME pool will be based on the total GME payments made for claims and encounters in FFY96, inflated by the DRI inflation factor. On an annual basis GME pool funds will be distributed to each hospital with an approved GME program based on the percentage of the total FFY96 GME pool that each hospital's FFY96 GME payment represented. In

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5 (10/1/97-9/30/98)	50%	50%
6 (10/1/98) and after	40%	60%

3) **Capital Payment by Tier**: Capital payments effective before September 30, 2000, shall be indexed to each tier by a relative weight factor, which is calculated by dividing each of the hospital's tiered operating rates by the weighted average of all the tiered operating rates for that hospital. For rates effective on and after October 1, 2000, this weighting of capital rates by tier will be frozen at the level in effect on September 30, 2000.

4) **Annual Update**: On an annual basis, AHCCCS shall adjust the capital component by the DRI inflation factor. For rates effective October 1, 2010, to September 30, 2011, and from October 1, 2011 to September 30, 2012, no inflation factor will be applied.

H. Discounts and Penalties

AHCCCS shall subject all inpatient hospital admissions on and after March 1, 1993 to quick-pay discounts and slow-pay penalties in accordance with Arizona Revised Statute (A.R.S.) Title 36, Chapter 29, Article 1.

For dates of service or admissions on or after October 1, 1999, a quick pay discount of 1% is applied to claims paid within 30 days of the clean claim date.

Effective with dates of service or admissions on or after March 1, 1993, if a hospital's bill is paid after 30 days but within 60 days of the clean claim date, AHCCCS shall pay 100% of the rate. If a hospital's bill is paid any time after 60 days of the clean claim date, AHCCCS shall pay 100% of the rate plus a fee of 1% per month for each month or portion of a month following the 60th day of receipt of the bill until the date of payment.

IV. PAYMENT TO NEW HOSPITALS AND OUT-OF-STATE HOSPITALS, AND FOR NEW PROGRAMS

A. New Hospitals

New hospitals are assigned the statewide (or peer group) average operating cost and the statewide average capital amount for each tier, as appropriate. Capital reimbursement for new hospitals is indexed according to statewide relative weights per tier. A new hospital's statewide operating and capital components shall be updated annually by the DRI inflation factor. For rates effective October 1, 2010, to September 30, 2011, and from October 1, 2011 to September 30, 2012, no inflation factor will be applied.

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VII. Temporary Rate Reduction

Notwithstanding the methods and rates as otherwise described in this attachment, for claims with dates of service between April 1, 2011 and September 30, 2011, payments in the following categories will be reduced by 5% of the payments that would otherwise have been made under the methodology in effect as of October 1, 2010 as described in this attachment:

- Tiered per diem payments including tiered per diem payments to new hospitals,
- Cost to Charge ratios used to qualify and pay inpatient outliers.
- Payments to out-of-state hospitals

The following payments described in this attachment will not be subject to this 5% rate reduction:

- Transplant services,
- Specialty services,
- Direct Medical Education payments,
- Indirect Medical Education payments,
- Payments for services provided by the Indian Health Service or Tribal 638 Health facilities
- Payments to freestanding psychiatric hospitals

For claims with dates of admission effective from October 1, 2011 to September 30, 2012, the following payments will be at the payment rates in effect as of September 30, 2011, reduced by 5%:

- Tiered per diem payments including tiered per diem payments to new hospitals,
- Cost to Charge ratios used to qualify and pay inpatient outliers. For more information about Cost to Charge ratios, refer to page 6 of this Attachment.
- Payments to out-of-state hospitals
- Payments to freestanding psychiatric hospitals

The following payments described in this attachment will not be subject to this 5% rate reduction:

- Transplant services,
- Specialty services,
- Direct Medical Education payments,
- Indirect Medical Education payments,
- Payments for services provided by the Indian Health Service or Tribal 638 Health facilities

OS Notification

State/Title/Plan Number: Arizona State Plan Amendment 11-009A

Type of Action: SPA Approval

Effective Date of SPA: October 1, 2011

Required Date for State Notification: December 28, 2011

Fiscal Impact: $(4,918,600) federal for federal fiscal year 2012 (FFS only)

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0
or
Eligibility Simplification:

Provider Payment Increase or Decrease: Decrease

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail:

This State plan amendment (SPA) proposes a five percent reduction to inpatient hospital reimbursement rates, for services between October 1, 2011 and September 30, 2012. With this amendment, inpatient hospital services would be reimbursed at 95% of the rates that were in effect as of September 30, 2011. There are certain hospital payments exempt from the reduction, including payments for services provided by the Indian Health Services (IHS) or Tribal 638 health facilities, payments for transplant and specialty services, and medical education supplemental payments. Note that this is a reduction on top of a five percent reduction that was already in effect as of April 1, 2011. And inpatient hospital rates in Arizona have been frozen since October 1, 2008. Additionally, it is likely that these reduced rates will remain in effect past September 30, 2012 unless Arizona legislature takes additional action to impose further cuts or to restore the rates. State plan amendments would need to be submitted for the next rate period to address the continuation of the reduction beyond September 30, 2012.

This amendment is one of a number of pending Arizona SPAs proposing reduction to Medicaid payments:

AZ 11-009A – Inpatient Hospital 5% Rate Reduction
AZ 11-009B – Outpatient Hospital 5% Rate Reduction
AZ 11-009C – All Non-Institutional Providers 5% Rate Reduction
AZ 11-009D – NF 5% Rate Reduction
AZ 11-011 – Inpatient Hospital Outlier Payment Reduction

Separate from the above payment reduction SPAs, Arizona has a pending SPA to implement a 25-day per year hard cap on inpatient hospital days for all adults as well as a pending waiver request to exempt all American Indian/Alaska Native populations from benefit and eligibility reductions. Furthermore, since 2010, CMS has approved a number of benefit and cost-sharing changes in Arizona. Effective October 1, 2010, Arizona

eliminated most optional benefits for adults (though the State restored hospice and certain transplants earlier this year) and began assessing copayments for prescription drugs and outpatient office visits on Transitional Medical Assistance adults with household income exceeding 100% FPL; nominal copayments for all other non-exempt Medicaid beneficiaries for outpatient office visits and prescription drugs; and nominal copayments on pregnant women for services unrelated to the pregnancy. Under the new statewide 1115 waiver effective October 22, 2011, the waiver-only eligible childless adult population will pay mandatory copayments for prescriptions, office visits, non-emergency use of the emergency room, and, for residents of Maricopa and Pima Counties only, copayments for taxi services.

Arizona is a State that operates its Medicaid program primarily through managed care under an 1115 waiver. Over 95% of Medicaid services are furnished under managed care. The only services that are furnished under fee-for-service (FFS) in Arizona are for: 1) American Indians who elect not to receive services through managed care; 2) individuals who qualify for Medicaid for emergency services only (i.e., non-qualified aliens); and 3) individuals who qualify for Medicaid for a temporary period (such as those whc became eligible but passed away prior to being enrolled in managed care). We are evaluating this State plan amendment from the FFS perspective, and not from a managed care perspective, to determine compliance with all federal requirements, including Section 1902(a)(30)(A) of the Social Security Act, which is a requirement on the State plan regarding sufficient payment and access to care. While we acknowledge that these State plan rates do have an effect on how a managed care plan will set rates for its network providers and therefore an effect on the capitation rates the State pays its managed care plans, the State plan itself does not govern Arizona's managed care delivery system, and access for managed care services are ensured through managed care adequacy standards and are not governed by Section 1902(a)(30)(A).

For the FFS members, services can be obtained from almost any registered Medicaid provider. Almost all providers who contract with a health plan to provide Medicaid managed care services are registered Medicaid providers who must provide services to FFS members. (Developmental disability service providers are an exception since Arizona's developmental disability program is solely operated as a managed care program under the 1115 waiver, so these provider are managed care-only providers. Other than the developmental disability service providers, there are 113 (out of a total of about 54,000 registered providers) who are registered only to provide managed care services through contracts with managed care plans.) Furthermore, American Indians who elect to not be in managed care have access to IHS/638 facilities as well as all other registered Medicaid providers. For American Indians, approximately 83% of hospital services are received at IHS/638 facilities; these facilities are not subject to the proposed reductions.

To address compliance with Section 1902(a)(30)(A) access to care requirements, Arizona submitted data related to its network of registered providers over the last five quarters. While there were fluctuation throughout the five quarters, the number of registered hospital providers (1234) as of June 30, 2011 (after the last rate reduction) is relatively the same as that (1220) of June 30, 2010 (prior to the last rate freeze and the rate reduction). This number includes registered providers who are located out-of-State. Of this number, 108 are in-State hospitals, including eleven IHS/638 hospitals. It should be noted that all but two licensed hospitals in Arizona are registered with the State; the two are a cancer hospital and a psychiatric/substance abuse hospital, both of which have never been registered. Again, a registered hospital must provide service to FFS members, unless it is registered only to provide managed care services. Ten out-of-State hospitals and no in-State hospitals fall into this category.

While we are not evaluating access for managed care services, because the managed care provider network is basically the same provider network that is available to all FFS members, it is valuable to consider the provider network information gathered by the State as part of its health plan monitoring efforts. The State has robust tools in place to monitor health plan compliance with network adequacy requirements and track member complaints and provider dropouts, and any health plan that fails to maintain adequate networks is subject to corrective action plans and sanctions. As part of the enhanced monitoring tools, the State tracks provider dropouts on a quarterly basis. Arizona documented that over the last year no hospital providers have dropped out of network due to rate freezes and reductions. The monitoring tools also require reporting of material changes in network and gaps in

minimum network requirements, and no access to care issue has surfaced. Furthermore, all health plans have reported that all network hospitals have signed their contracts for rate year 2012 with no dropouts due to rates. This also means that the same registered hospitals (other than the 10 out-of-State hospitals which are registered for only managed care services) are available to the FFS members.

Arizona also submitted FFS enrollment and utilization data during our SPA review. The data is submitted for the quarters ending June 30, 2010 and June 30, 2011. The American Indian enrollment number increased by 3%, while there is actually a decrease in inpatient hospital services of 16%. It is not completely clear as to why the American Indian inpatient hospital utilization decreased. Partially it can be attributed to incomplete claims data for the quarter of June 30, 2011, which was generated in September of 2011 based on date of service; Arizona approximates that 32% of claims are submitted after 90 days of the service date. Nonetheless, the State has regular stakeholder meetings with the tribal organizations to discuss any programmatic changes with a material impact on American Indians, and no access issues have arisen from those discussions. Furthermore, the State tracks hearing requests from tribal members, and there were three in 2010 and none in 2011. Given that the provider network has remained stable and no tribal member access issues have been identified otherwise, we do not believe the decrease in American Indian inpatient hospital utilization on its own is an indicator of access problem, but it is worth monitoring.

With this and other pending reduction SPAs, Arizona will regularly monitor both provider availability and American Indian FFS member enrollment and utilization, using relevant metrics, to ensure that there will be no access problems as these new rate reductions take effect. This activity will supplement Arizona's existing managed care monitoring tools, which will also be relevant in assessing the provider networks available to FFS members. As previously discussed, Arizona has robust managed care network monitoring tools in place to ensure that each managed care plan maintains an adequate network in accordance with established network standards. The State requires the plans to report on compliance of network standards through regular quarterly and annual reports. The State also requires that the plans timely report material changes in network and gaps in minimum network requirements. The monitoring tools have also been enhanced since 2010 to specifically report and track provider dropouts and member complaints regarding access. Any health plan that fails to maintain adequate networks is subject to corrective action plans and sanctions. Tribal consultation will continue to play an essential role in the State's monitoring of access for the American Indians. Arizona has an approved Tribal Consultation Policy for SPAs and waivers in its State plan. CMS considers Arizona's Tribal Consultation Policy a national model because it includes both standard and expedited processes for consultation. More importantly, the State consults on a wide range of policy changes, thereby affording the Tribes and Indian health providers the opportunity to comment, even if the potential impact is minimal. The tribal consultation includes all tribal stakeholders, including Tribes, Indian Health Service Area Offices, Tribal Health Programs operated under PL 93-638, Urban Indian Health Programs, Advisory Council on Indian Health Care, and Inter Tribal Council of Arizona, Inc. There were twelve tribal consultations in calendar year 2010 and ten so far in 2011. Additionally, the State meets quarterly with IHS Areas Directors and holds regular meetings with IHS/638 providers. These monitoring activities will allow the State to identify access problems as they arise for FFS members and take corrective actions. An example of corrective actions is arranging for and transporting a FFS member located in geographically isolated areas to access care at specialty providers available in other areas. Expanding the use of telemedicine is another means of enhancing access for members who are in geographically isolated areas.

In addition to the analysis on access for the American Indians, we also reviewed the utilization data submitted for FFS emergency services. Emergency-only enrollment number decreased by 23% between June of 2010 and June of 2011, likely due to changes in economy and immigration laws. For the same period, the number of emergency-only utilizing members decreased by 24%, which, in spite of the incomplete utilization data for June of 2011, is consistent with the decrease in enrollment. With the utilization trending consistent with the enrollment numbers and the availability of a relatively stable provider network, we do not observe any access problems for this FFS population.

It is worth noting that in addition to its ongoing efforts to monitor provider network adequacy, the State prior to

these rate reductions engaged Milliman, Inc. in 2010 and again in 2011 to study the effects of the rate reductions on Medicaid access to care in Arizona. However, this study primarily focused on the relationship between cost and payment rates and concluded that, despite that the Medicaid cost-to-payment ratio for Arizona hospitals will be at 70-72% after the rate reductions, Arizona hospitals would likely not drop out of Medicaid participation for various reasons. In arriving at that conclusion, Milliman considered Medicaid coverage of the hospitals' fixed costs and also room for hospital cost efficiency. However, CMS current policy regarding how we evaluate a State's compliance of Section 1902(a)(30)(A) is based on looking at access outcomes. Our conclusions therefore do not hinge on the cost analysis performed by Milliman.

Finally, we have received numerous correspondences from Hooper, Lundy & Bookman, a law firm representing the Arizona Hospital and Healthcare Association. These correspondences argue that State plan amendments submitted by Arizona affecting hospital payments, including this amendment on inpatient hospital payment reductions, should be disapproved by CMS due to non-compliance with federal requirements, in particular Section 1902(a)(30)(A). We have carefully considered the major concerns raised by the attorney:

- *The Ninth Circuit court has ruled that payment rates must bear a reasonable relationship to cost and that payment rates should be high enough to cover a hospital's cost of providing quality care. Arizona has failed to demonstrate that the reduced rates are reasonable in relationship to cost of providing quality care.* CMS, based on guidance from our OGC, has determined that we can evaluate compliance based on the agency's interpretation of Section 1902(a)(30)(A), even when reviewing amendments pertaining to Ninth Circuit States. CMS has taken the approach of evaluating access outcomes.

- *State plan amendment language as submitted by the State lacks clarity.* CMS and the State, during the State plan amendment review process, have the opportunity to work on State plan language. We have done so, and the State plan amendment that we are recommending for approval contains clear, comprehensive language on the rate reductions.

- *Numerous hospitals, particularly those in rural remote areas, are at risk of closure or elimination of particular services. There is no support that the State has made an effort to monitor regionalized access problems.* The attorney has submitted hospital survey results and declarations from various rural hospitals. While these situations are of concern to CMS, we have to weigh the survey information and declarations against the fact that there has been no diminished hospital participation in Medicaid in Arizona. The State has shown through its quarterly monitoring that no hospitals have dropped out of managed care network due to rate issues, and that all hospitals have signed contracts with their health plans for the 2011-2012 rate year. Managed care network standards ensure that there is adequate hospital coverage in all geographic service areas. While we acknowledge that these are managed care standards, the same hospitals would be available to the FFS members. The lack of specialty services or the closure of certain primary care clinics in remote areas, for both Medicaid and the general population, is a concern but does not in itself equate to unequal access or non-compliance with Section 1902(a)(30)(A). The State has stated that there are avenues to ensure Medicaid FFS recipients receive needed care, including transporting the patient to another available provider and expanding the use of telemedicine where applicable.

- *The Milliman study is flawed, and its conclusion is not adequately supported.* The attorney submitted reports from other firms debating the merits of the Milliman study. In our evaluation of compliance with Section 1902(a)(30)(A), CMS is focusing on access outcomes. Therefore, we do not feel the need to address whether the Milliman cost analysis was based on valid data and assumptions.

- *The State's managed care monitoring is lacking, and any evaluation would only be backward-looking.* We believe there is sufficient and reasonable support that there isn't currently an access problem for Medicaid FFS members in Arizona. We are asking Arizona to monitor access for the FFS members by evaluating relevant metrics on a continuous basis. We believe the managed care network monitoring tools in place are also valuable in ensuring adequate provider networks for FFS members, since the same providers must also

provide services to FFS members.

- *State plan amendments have an impact beyond FFS. Limiting the analysis to only FFS does not fully account for the magnitude of the impact to hospitals.* We acknowledge that the Arizona health plans may, and do, base payments to their network providers on State plan rates. However, Arizona's managed care delivery system is not governed by the State plan, and our review of these State plan amendments does not cover managed care services. Access for managed care services in Arizona are covered by separately established managed care network standards outside of State plan requirements.

We have considered all factors and concluded that there is reasonable support that there is sufficient access to inpatient hospital care in Arizona per Section 1902(a)(30)(A). We will request that the State continue its monitoring of the FFS utilization and provider availability and take action to address any problem that arises as a result of the rate reductions.

Finally, public process and tribal consultation requirements were met, and the State has adequately responded to standard funding questions.

Other Considerations: We do not recommend the Secretary contact the Governor.

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