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

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, 2012, no inflation factor will be applied.

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.

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

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, 2012, 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.

OS Notification

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

Type of Action: SPA Approval

Effective Date of SPA: October 1, 2011

Required Date for State Notification: December 28, 2011

Fiscal Impact: $(1.15M) 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 nursing facility reimbursement rates, for services between October 1, 2011 and September 30, 2012. With this amendment, nursing facility services would be reimbursed at 95% of the rates that were in effect as of September 30, 2011. Payments for services provided by Indian Health Services (IHS) or Tribal 638 facilities are exempt from the reduction. Note that nursing facility rates in Arizona have been frozen since 2009. 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 who 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 5% of nursing facility services is received at a IHS/638 facility. Note again that IHS facilities are exempt from the proposed reduction.

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. The number of registered nursing facility providers (146) as of June 30, 2011 (after the last rate reduction) is relatively the same as that (143) of June 30, 2010 (prior to the last rate freeze and the rate reduction). In fact, the number has remained relatively unchanged throughout the last five quarters. Of all registered nursing facilities, only one is registered to provide only managed care services; this means all other registered nursing facilities must provide services to FFS members.

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 nursing facility 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 issues has surfaced.

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 the emergency-only enrollment number decreased by 23% (likely due to changes in economy and immigrant laws). For the American Indian utilizing members, there is a decrease in nursing facility services of

.5%. (The emergency-only utilizing member data is non-applicable for nursing facility services.) The decrease in American Indian nursing facility utilization of 0.5% is somewhat inconsistent with the increase in enrollment of 3%. This may be attributable to incomplete claims for the quarter of June 30, 2011, which was generated in September of 2011; 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 there is any indicator of access problem for nursing facility services for American Indians.

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 12 tribal consultations in calendar year 2010 and 10 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.

Finally, Arizona has stated that it did not receive any comment during the Public Comment period for this nursing facility SPA. However, during the legislative hearings for the Senate Bill behind Arizona's proposed Medicaid payment reductions, testimonies were taken from the public, and all were in opposition to the bill. CMS has not directly received any objections or complaints related to this SPA. We did receive numerous correspondences from Hooper, Lundy & Bookman, a law firm representing the Arizona Hospital and Healthcare Association, requesting disapproval of the inpatient and outpatient hospital payment reduction SPAs. We are addressing those issues under the hospital SPAs.

We have considered all factors and concluded that there is reasonable support that there is sufficient access to nursing facility 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.

CMS Contacts: Mark Wong, NIRT, 415-744-3561
Janet Freeze, DRSF, 410-786-5917
Christopher Thompson, DRSF, 410-786-4044
Venesa Day, DRSF, 410-786-8281
Tim Weidler, NIRT, 816-426-6429
Kristin Fan, FMG, 410-786-4581
Dianne Heffron , FMG, 410-786-3247