State/Territory: Arizona

Standards for the Coverage of Organ Transplant Services

Medically necessary transplant services are available to AHCCCS members as described in the AHCCCS Medical Policy Manual, meeting nationally recognized criteria for non-experimental, non-investigational organ or tissue transplants. All medically necessary, non experimental transplants are covered for EPSDT members. For persons age 21 and older, AHCCCS coverage of transplants is limited to the following:

- Heart
- Liver
- Kidney
- Simultaneous Pancreas/Kidney
- Autologous and Allogenic related and unrelated Hematopoietic Cell
- Cornea
- Bone
- Lung
- Pancreas after Kidney

AHCCCS does not cover the following transplants for persons age 21 years and older:

- Pancreas only transplants
- Partial pancreas transplants, including islet cell transplants
- Intestine transplants (Visceral)
- Any other transplant not listed in the covered transplants above.

All AHCCCS members are eligible to receive the medically necessary transplants and related services described in the AHCCCS Medical Policy Manual with the following exceptions:

- Title XIX SOBRA Family Planning Program members; and
- Federal Emergency Services Program (FESP) members.

AHCCCS has established specific prior authorization medical criteria for coverage of transplant and related services as specified in the AHCCCS Medical Policy Manual. The Manual, including all supplements and updates to the Manual are available to the public on the agency's web site:
http://www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx?ID=policymanuals

State: ARIZONA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

- **Organ Transplantation**

AHCCCS shall negotiate contracts with hospitals qualified to perform covered organ and hematopoietic cell transplantation services. Reimbursement is based on a fixed price per type of transplant, by component, which may include stop-loss provisions. Component reimbursement is based on provider cost reports. At no time will payment for the entire case exceed a hospital's billed charges. The follow-up time period lasts until the transplant team releases the member, not to exceed 60 days post-transplant.

- **Specialty Services**

AHCCCS may negotiate contracts for specialized hospital services, including but not limited to: subacute, neonatalogy, neurology, cardiology and burn care. Rates are determined based on provider cost information and at no time will contracted rates exceed billed charges

State: ARIZONA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

- **Federally Qualified Health Centers (FQHCs)**

AHCCCS will utilize the following payment methodology from January 1, 2001, forward.

1) AHCCCS will establish a baseline Prospective Payment System effective January 1, 2001. The calculation will conform to section 1902(a)(15)(c) of the Social Security Act. AHCCCS will use the center/clinic's fiscal year that ends during calendar year 1999 and 2000 for the base rate calculations. Each FQHC/RHC may elect to have rates adjusted by either the BIPA 2000 methodology, or the Alternative Payment Methodology. If the FQHC/RHC elects the BIPA methodology, the Medicare Economic Index (MEI) at the beginning of each federal fiscal year (October 1st) will be used to update rates on a prospective basis. If the FQHC/RHC elects the Alternative Payment Methodology, the Physician Service Index (PSI) subcomponent of the Medical Care component of the Consumer Price Index at the beginning of each federal fiscal year (October 1st) will be used to update rates on a prospective basis. Under either methodology, the baseline rates for 1999 and 2000 will be calculated based on the provider's cost data for the center/clinic's fiscal year that end during calendar year 1999 or 2000. Costs included in the base rate calculation will include all Medicaid covered services provided by the center/clinic. The calculated 1999 and 2000 base rates will be averaged by calculating a simple average of the costs per encounter for 1999 and 2000. The calculation is as follows:

$$\frac{\text{Total Medicaid costs 1999} + \text{Total Medicaid costs 2000}}{\text{Total visits 1999} + \text{Total visits 2000}} = \text{Average Cost Per Visit}$$

These base rates will then be indexed forward utilizing the MEI from the midpoint of the cost report period being utilized, to the midpoint of the initial rate period (January 1, 2001 through September 30, 2001). Annually thereafter, the MEI for those FQHCs/RHCs selecting the BIPA methodology, or the PSI for those FQHCs/RHCs selecting the Alternative Payment Methodology, will be applied to the inflated based rates at the beginning of the federal fiscal year (October 1st). AHCCCS and the FQHCs/RHCs have agreed to supplement payments to the FQHCs/RHCs payments once the PPS baseline is established, if necessary.

2) For a center/clinic that becomes a FQHC or RHC after FY 2000, AHCCCS will calculate the initial rate using data from an established FQHC or RHC in the same or adjacent area with a similar caseload. Absent an existing FQHC or RHC with a similar caseload, the center/clinic rate will be based on projected costs subject to tests of reasonableness. Costs would be subjected to reasonable cost definitions as outlined in Section 1833(a)(3) of the Act. If a center/clinic has inadequate cost data for one of the base periods, that