SPECIAL TERMS AND CONDITIONS
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

MEDICAID SECTION 1115 DEMONSTRATION

NUMBER: 11-W-00275/9
21-W-00064/9

TITLE: Arizona Health Care Cost Containment System -- AHCCCS, A Statewide Approach of Cost Effective Health Care Financing

AWARDEE: Arizona Health Care Cost Containment System

I. PREFACE

The following are the special terms and conditions (STCs) for Arizona's section 1115(a) Medicaid demonstration extension (hereinafter "demonstration"). The parties to this agreement are the state of Arizona and the Centers for Medicare & Medicaid Services (CMS). This demonstration is approved for a 5-year period, from October 22, 2011, through September 30, 2016. The STCs set forth below and the lists of waivers and expenditure authorities are incorporated in their entirety into the letter approving the demonstration. The STCs are effective as of October 22, 2011, unless otherwise specified.

The STCs have been arranged into the following subject areas:

I. Preface;
II. Program Overview and Historical Context;
III. General Program Requirements;
IV. Eligibility;
V. Demonstration Programs;
VI. Funding Pools Under the Demonstration;
VII. Delivery Systems;
VIII. Evaluation;
IX. General Reporting Requirements;
X. General Financial Requirements under Title XIX;
XI. General Financial Requirements under Title XXI;
XII. Monitoring Budget Neutrality; and
XIII. Schedule of State Deliverables during the Demonstration.

II. PROGRAM OVERVIEW AND HISTORICAL CONTEXT

Until 1982, Arizona was the only state that did not have a Medicaid program under title XIX of

the Social Security Act. In October 1982, Arizona implemented the AHCCCS in the state's first section 1115 demonstration project. AHCCCS initially covered only acute care services, however, by 1989, the program was expanded to include the Arizona Long Term Care System (ALTCS), the state's capitated long term care (LTC) program for the elderly and physically disabled (EPD) and the developmentally disabled (DD) populations. In 2000, the state also expanded coverage to adults without dependent children with family income up to and including 100 percent of the Federal poverty level (FPL) as well as established the Medical Expense Deduction (MED) program for adults with income in excess of 100 percent of the FPL who have qualifying healthcare costs that reduce their income at or below 40 percent of the FPL. On March 31, 2011, Arizona requested to terminate its initial section 1115 demonstration in order to eliminate the MED program and implement an enrollment freeze on the adults without dependent children population. On April 30, 2011, and July 1, 2011, CMS approved the state's required phase-out plans for the MED program and the adults without dependent children population, respectively.

The new demonstration provides health care services through a prepaid, capitated managed care delivery model that operates statewide for both Medicaid state plan groups as well as demonstration expansion groups. The goal of the demonstration is to test health care delivery systems to provide organized and coordinated health care for both acute and long term care that include pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and management of health services. The demonstration will also test the extent to which health outcomes in the overall population are improved by expanding coverage to additional needy groups.

The demonstration affects coverage for certain specified mandatory state plan eligibles by requiring enrollment in coordinated, cost effective, health care delivery systems. In this way, the demonstration will test the use of managed care entities to provide cost effective care coordination, including two pilot projects that will test the effect of integrating behavioral and physical health services for two populations– individuals residing in Maricopa county and Greater Arizona with serious mental illness and children participating in the Children's Rehabilitative Services program. In addition, the demonstration will provide for payments to IHS and tribal 638 facilities to address the fiscal burden of uncompensated care for certain services not covered under the state plan and provided in or by such facilities. This authority will enable the state to evaluate how this approach impacts the financial viability of IHS and 638 facilities and ensures the continued availability of a robust health care delivery network for current and future Medicaid beneficiaries.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy (e.g. CHIPRA).** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b) If mandated changes in the Federal law require state legislation, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit title XIX and XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the state Plan is required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the

change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

a) Demonstration of Public Notice 42 CFR Section 431.408 and Tribal Consultation: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 and documentation that the tribal consultation requirements outlined in paragraph 14 have been met;

b) Demonstration Amendment Summary and Objectives: The state must provide a detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming title XIX and/or title XXI state plan amendment, if necessary;

c) Waiver and Expenditure Authority: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested for the amendment;

d) A data analysis worksheet, which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by eligibility group) the impact of the amendment;

e) An up-to-date CHIP allotment neutrality worksheet, if necessary; and

f) If applicable, a description of how the evaluation design will be modified to incorporate the amendment process.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of paragraph 9 of this section.

    a. Compliance with Transparency Requirements at 42 CFR §431.412.

    b. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR

§431.412 and the public notice and tribal consultation requirements outlined in STC 14.

9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

   a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

      The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

   b) Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

   c) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed at 42 CFR section 435.916.

   d) Exemption from Public Notice Procedures 42.CFR Section 431.416(g): CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR section 431.416(g).

   e) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs

associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

    In states with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    In states with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)).

The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **FFP.** Federal funds are not available for expenditures for this demonstration until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY

16. **Eligibility.** The demonstration affects all of the mandatory Medicaid eligibility groups set forth in Arizona's approved state plan, 14 optional groups set forth in the state plan, and 1 expansion group made eligible under this demonstration. Mandatory and optional state plan groups described below are subject to all applicable Medicaid laws and regulations except as expressly waived. Any Medicaid state plan amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income (MAGI) standard January 1, 2014, will apply to this demonstration. Expansion populations are defined as those groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration and are subject to Medicaid and CHIP laws or regulations except as specified in the STCs and waiver and expenditure authorities for this demonstration. These cited documents generally provide that all requirements of Medicaid and CHIP laws and regulations do apply, except to the extent waived or specified as not applicable. The criteria for Arizona eligibility groups are as follows (Table 1):

Table 1 – State Plan and Expansion Populations Affected by the Demonstration

Description	Program	Social Security Act Cite	42CFR Cite
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS **Families and Children**			
1931 (Title IV A program that was in place in July 1996) including: • pregnant women with no other eligible children (coverage for third trimester) • persons 18 years of age, if a full-time student • family with unemployed parent	AACP	1902(a)(10)(A)(i)(I)	435.110
Twelve months continued coverage (transitional medical assistance) 1931 ineligible due to increase in income from employment or work hours or loss of "income disregard."	AACP	1902(a)(52) 1902(e)(l) 1925(a)(b)(c)	435.112
1931 Extension-Extension of MA when child or spousal support collection results in 1931 ineligibility. (4 months continued coverage)	AACP	408(a)(11)(B) 1902 (a) (10) (A) (i) (I) 1931 (c)	435.115
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS **Pregnant Women, Children, and Newborns**			
Qualified pregnant women who: • would be AFDC eligible if child were born and • meet AFDC income & resource criteria	AACP	1902(a)(10)(A)(i)III 1905(n)	435.116

Description	Program	Social Security Act Cite	42CFR Cite
"S.O.B.R.A. WOMEN & INFANTS" Pregnant women & infants under age 1 with incomes less than or equal to 133% FPL. (optional group extends coverage up to 140% FPL for infants under age 1)	AACP ALTCS	1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	
"S.O.B.R.A. CHILDREN" Children age 1+ but not yet 6 with incomes at or below 133% FPL.	AACP ALTCS	1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)	
"S.O.B.R.A. CHILDREN" Children age 6+ but not yet 19, born after 9-30-83, with income less than or equal to 133% FPL.	AACP ALTCS	1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)	
"DEEMED CATEGORICAL NEWBORNS" Children born to a woman who was eligible and received Medicaid on the date of the child's birth. Children living with their mothers are eligible for 1 year as long as mothers are eligible or would be eligible if pregnant.*	AACP	1902(e)(4)	435.117
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS **Qualified Family Members**			
Qualified members of family with unemployed principal wage earner (persons who would be eligible if state did not limit number of months AFDC-UP cash was available).	AACP	1902(a)(10)(A)(i) 1905(m)(l)	435.119
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS **Aged, Blind, and Disabled**			
All SSI cash recipients: aged, blind or disabled persons	AACP ALTCS	1902(a)(10)(A)(i)(II)	435.120
Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or state supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87	AACP	1902(a)(10)(A)(i)(II) 1905(q)	435.120
"DAC" Disabled adult child (age 18+) who lost SSI by becoming OASDI eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits.	AACP	1634(c)	
SSI cash or state supplement ineligible for reasons prohibited by Title XIX.	AACP ALTCS		435.122
SSA Beneficiaries who lost SSI or state supplement cash benefits due to cost of living adjustment (COLA) increase in Title II benefits	AACP		435.135
Disabled widow/widower who lost SSI or state supplement due to 1984 increase in OASDI caused by elimination of reduction factor in PL 98-21. (person must apply for this by 7/88)	AACP	1634(b)	435.137
Disabled widow/widower (age 60-64 and ineligible for Medicare Part A) who lost SSI or state supplement due to early receipt of Social Security benefits.	AACP	1634(d)	435.138
"DC Children" Children under the age of 18 who were receiving SSI Cash on 8/26/96 and would continue to be eligible for SSI Cash if their disability met the childhood definition of disability that was in effect prior to 8/26/96.	AACP	1902(a)(10)(A)(i)(II)	
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS **Adoption Assistance and Foster Care Children**			

Description	Program	Social Security Act Cite	42CFR Cite
Children in adoption subsidy/foster care Title IV-E programs	AACP ALTCS	473(b)(l) 1902(a)(10)(A)(i)(I)	435.145
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS **Special Groups**			
"POSTPARTUM" Title XIX eligible women who apply on or before pregnancy ends, (continuous coverage through the month in which the 60th day postpartum period ends)	AACP	1902(e)(5) 1902(e)(6)	435.170
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS **New Adult Group**			
Individuals age 19 through 64 with incomes at or below 133% FPL	AACP	1902(a)(10)(A)(i)(VIII)	435.119
STATE PLAN OPTIONAL TITLE XIX COVERAGE GROUPS			
Description	**Program**	**Social Security Act Cite**	**42CFR Cite**
"210 GROUP" Persons who meet AFDC, SSI or state supplement income & resource criteria.	AACP ALTCS Case Management	1902(a)(10)(A)(ii)(I)	435.210
"211 GROUP" Persons who would be eligible for cash assistance except for their institutional status.	ALTCS	1902(a)(10)(A)(ii)(IV)	435.211
"GUARANTEED ENROLLMENT" Continuous coverage for persons enrolled in AHCCCS Health Plans who lose categorical eligibility prior to 6 months from enrollment. (5 full months plus month of enrollment)	AACP	1902(e)(2)	435.212
"S.O.B.R.A. Infants" infants with incomes between the 133% FPL mandatory group maximum and a 140% FPL optional state maximum.	AACP ALTCS	1902(a)(10)(A)(ii)(IX)	
Pregnant women, including postpartum, who maintain eligibility without regard to changes in income.	AACP	1902(e)(6)	
"HCBS GROUP" Persons receiving HCBS under a waiver with incomes < or equal to 300% of the Federal benefit rate (FBR).	ALTCS	1902(a)(10)(A)(ii)(VI)	435.217
"State Adoption Subsidy" Children who receive a state adoption subsidy payment.	AACP	1902(a)(10)(ii)(VIII)	435.227
"236 GROUP" Persons in medical institutions for 30 consecutive days who meet state-set income level of < or equal to 300% of FBR.	ALTCS	1902(a)(10)(A)(ii)(V)	435.236
"Freedom to Work" Basic Coverage Group – individuals aged 16-64 with a disability who would be eligible, except for earnings, for SSI up to and including 250% of FPL.	AACP ALTCS	1902(a)(10)(A)(ii)(XV)	
"Freedom to Work" Medical Improvement Group – employed individuals aged 16-64 with a medically improved disability up to and including 250% of FPL.	AACP ALTCS	1902(a)(10)(A)(ii)(XVI)	
Women under 65 who need treatment for breast or cervical cancer, and not otherwise eligible for Medicaid.	AACP	1902(a)(10)(A)(ii)(XVIII)	
Children who have aged out of foster care at 18 up to age 21	AACP	1902(a)(10)(A)(ii)(XVII)	
1931 Expansion-Income Greater than 36% FPL and less than or equal to 100% FPL.	AACP		
SSI-MAO Expansion (Optional 210 Group)- aged, blind, or disabled individuals with income greater than 100% FBR and less than or equal to 100% FPL.	AACP	Arizona State Plan	

*Arizona's 1115 demonstration provides the authority to waive some of the provisions.

V. DEMONSTRATION PROGRAMS

17. **Arizona Acute Care Program (AACP)**. The AACP is a statewide, managed care system, which delivers acute care services through prepaid, capitated Managed Care Organizations (MCOs) that AHCCCS calls "Health Plans." Most Health Plan contracts are awarded by Geographic Service Area (GSA), which is a specific county or defined grouping of counties designated by AHCCCS within which a Contractor provides, directly or through subcontract, covered health care to members enrolled with that Contractor. AACP enrollees receive most Medicaid-covered services through the Health Plans, but receive, on a "carve out" basis, behavioral health services through a separate PIHP contract. The one exception to the behavioral health carve out is for AACP members with a Serious Mental Illness (SMI) residing in Maricopa County and Greater Arizona (these two regions cover the entire state) who receive their acute care and behavioral health services through a geographically designated Regional Behavioral Health Authority (RBHA). The RBHA remains a subcontractor of the Arizona Department of Health Services/Division of Behavioral Health, which serves as the state's director contractor/MCO for behavioral health and integrated health for persons with SMI. In addition, AACP members with a CRS condition receive all of their care – acute care and treatment for CRS and behavioral health care conditions – through a separate MCO contract.

    a) **AACP Eligibility –** Those Groups identified in Table 1.

    b) **Enrollment -** The Arizona DES processes applications and determines acute care Medicaid eligibility for children, pregnant women, families and non-disabled adults under the age of 65 years. The Social Security Administration (SSA) determines eligibility for the Supplemental Security Income (SSI) cash-related groups, and AHCCCS determines eligibility for the SSI- related aged and disabled groups, Medicare Savings Programs, women diagnosed with breast or cervical cancer, and Freedom to Work recipients. Individuals determined eligible must then select and enroll in a Health Plan, or they will be auto-assigned by the AHCCCS administration.

    c) **Benefits** – With the exception of the new adult group, benefits for AACP and the expansion population authorized by the 1115 demonstration will consist of all acute care benefits covered under the Medicaid state plan, unless otherwise noted within these STCs. The new adult group will receive benefits for AACP through the state's approved alternative benefit plan (ABP) state plan amendment (SPA).

        i. **Notice -** The state must include the CMS Central Office when submitting a SPA to the CMS Regional Office that would impact the expansion population authorized by the 1115 demonstration inclusive of:
            a. The proposed date of implementation;
            b. The date the state plans to submit the SPA; and
            c. Revised budget neutrality projections.

ii. **Demonstration Amendment.** CMS reserves the right to require the state to submit an amendment if it is determined that it is warranted.

iii. Behavioral health services are outlined in Table 2 and subject to limitations set forth in the existing state plan.

Table 2 – AACP Behavioral Management

Benefit	**Title XIX**		**Title XXI**
Age	< 21 yrs	≥ 21 yrs	< 19 yrs
Behavioral Management	X	X	X
Case Management	X	X	X
Emergency Behavioral Health Care	X	X	X
Evaluation	X	X	X
Therapeutic Residential Support (in home, excluding room and board)	X	X	X
Inpatient Services			
Inpatient Hospital	X	X	X
Inpatient Psychiatric Facilities	X	X	X
Lab & X – Ray	X	X	X
Medications (Psychotropic)	X	X	X
Medication Adjustment & Monitoring	X	X	X
Methadone / IAAM	X	X	X
Partial Care	X	X	X
Professional Services			
Individual	X	X	X
Group & Family	X	X	X
Psychosocial Rehabilitation	X	X	X
Respite (with limits)	X	X	X
Screening	X	X	X
Transportation – Emergency	X	X	X
Transportation – Non Emergency	X	X	X

d) **AACP Cost Sharing** – Cost sharing shall be imposed as specified in the Medicaid state plan for all populations.

18. **Children in Foster Care** – Services for Arizona's children in foster care are provided through an MCO contract between AHCCCS and the Arizona DES/CMDP. CMDP operates in the same manner as other AACP Health Plans, but children in foster care who receive acute care services will be enrolled in CMDP instead of other Health Plans. Children in foster care who are eligible for or receive ALTCS will be enrolled or remain with the Program Contractor. Case Management services provided and reimbursed through this contractual relationship must be provided consistent with Federal policy, regulations and law. Children in foster care who are also eligible for CRS receive treatment for their CRS and behavioral health care conditions through the separate MCO contract for the CRS program. CRS eligible foster children will receive services for all conditions other than behavioral health or CRS related conditions through CMDP.

a) **FFP**. FFP will not be available for:

i. Duplicate payments made to public agencies or private entities under other program authorities for case management services or other Medicaid services for the same purpose; or

ii. Activities integral to the administration of the foster care program excluding any health care related activities.

19. **Children Rehabilitative Services (CRS)**. AHCCCS contracts on a sole-source, capitated basis for the CRS program. Acute Care enrolled children with qualifying conditions receive their CRS specialty care, behavioral health care and acute care through the CRS contractor. Children enrolled in ALTCS DES/DDD who also have a CRS condition will receive care for their CRS and behavioral health conditions through the CRS contractor. Children with a CRS condition who are enrolled in CMDP will receive treatment for their CRS and behavioral health care conditions through the CRS contractor.

    a) **Transition of Care.** When individuals transition to the CRS contractor from an AACP health plan, children in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a CRS non-participating provider shall be allowed to continue receiving treatment from the non-participating provider through the duration of their prescribed treatment.

    b) **Choice of Primary Care Physician (PCP).** The CRS contractor is required to assure that members have a choice of PCPs. Specifically, beneficiaries will have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). In addition, the CRS contractor will offer contracts to primary and specialist physicians who have established relationships with beneficiaries including specialists who may also serve as PCPs to encourage continuity of provider. For children who have an established relationship with a PCP that does not participate in the CRS contractor's provider network, the CRS contractor will provide, at a minimum, a 90-day transition period in which the child may continue to seek care from their established PCP while the child and child's parents and/or guardian, the CRS contractor, and/or case manager finds an alternative PCP within the CRS contractor's provider network.

    c) **Readiness Review of Health Plan.** The state will submit to CMS for review a copy of its readiness review report of the health plan selected to provide the integrated services to the CRS population to ensure the selected health plan's provider network, both in terms of primary and specialty care providers, is adequate and would not result in access to care issues for the affected population.

20. **Individuals with Serious Mental Illness (SMI) in Maricopa County.** Individuals who are AACP members residing in Maricopa County and who are diagnosed with a serious mental illness will receive their acute care services and behavioral health services through a separate MCO called a RBHA. RBHAs serve as subcontractors of ADHS/DBHS.

a) **Transition Period.** When individuals transition to the RBHA for their physical health from an AACP health plan, members in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider shall be allowed to continue receiving treatment from the non-participating/non-contracted provider through the duration of their prescribed treatment.

b) **Choice of Primary Care Physician (PCP).** The RBHA is required to assure that members have a choice of PCPs. Specifically, beneficiaries will have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). In addition, the RBHA, through the Regional Behavioral Health Authorities (RBHA), will offer contracts to primary and specialist physicians who have established relationships with beneficiaries including specialists who may also serve as PCPs to encourage continuity of provider. For individuals who have an established relationship with a PCP that does not participate in the /RBHA's provider network, the RBHA will provide, at a minimum, a 6-month transition period in which the individual may continue to seek care from their established PCP while the individual, the RBHA and/or case manager finds an alternative PCP within the /RBHA's provider network.

c) **Readiness Review of Health Plan.** The state will submit to CMS for review a copy of its readiness review report of the health plan selected to provide the integrated services to the SMI population to ensure the selected health plan's provider network, both in terms of primary and specialty care providers, is adequate and would not result in access to care issues for the affected population.

d) **Opt out for Cause**. Beginning October 1, 2015, individuals with SMI in Maricopa County will have the option to opt-out of the RBHA for acute care services and be transferred to the acute care plan under the following conditions only:
    i. Either the beneficiary, beneficiary's guardian, or beneficiary's physician successfully dispute the beneficiary's diagnosis as SMI;
    ii. Network limitations and restrictions;
    iii. Physician or provider course of care recommendation
    iv. The member established that due to the enrollment and affiliation with the RBHA as a person with a SMI, and in contrast to persons enrolled with an acute care provider, there is demonstrable evidence to establish actual harm or the potential for discriminatory or disparate treatment in:
        a. The access to, continuity or availability of acute care covered services;
        b. Exercising client choice;
        c. Privacy rights;
        d. Quality of services provided; or

e. Client rights under Arizona Administrative Code, Title 9, Chapter 21.

e) Under paragraph 20 subparagraph (d)(iv), a beneficiary must either demonstrate that the discriminatory or disparate treatment has already occurred, or establish the plausible potential of such treatment. It is insufficient for a member to establish actual harm or the potential for discriminatory or disparate treatment solely on the basis that they are enrolled in the RBHA.

f) A transfer requested under paragraph 20 subparagraph (d)(iv) will be clearly documented in the enrollee handbook and any other relevant enrollee notices, and will be processed as follows:

1) <u>The RBHA will take the following actions</u>:
   i. Responsibility for reducing to writing the member's assertions of the actual or perceived disparate treatment of individuals as a result of their enrollment in the integrated plan.
   ii. Responsibility for completing ADHS transfer of a RBHA member to an approved Acute Care Contractor Form.
   iii. Confirmation and documentation that the member is enrolled in SMI RBHA program.
   iv. Providing documentation of efforts to investigate and resolve member's concern.
   v. Inclusion of any evidence provided by the member of actual or reasonable likelihood of discriminatory or disparate treatment.
   vi. Recommendation of approval or denial of request, and forward completed packet to ADHS for approval or denial within 7 days of request.

2) <u>ADHS will take the following actions:</u>
   i. Review completed request packets received from the RBHA.
   ii. Approve or deny request in writing within 10 calendar days of request.
   iii. Provide notice that includes the reasons for the denial and appeal/hearing rights to the member for requests which are denied.

3) <u>AHCCCS will take the following actions:</u>
   i. If a hearing is requested, the request for hearing will be forwarded to the AHCCCS Administration which will then schedule the matter for hearing with OAH;
   ii. The AHCCCS Administration will issue a Director's Decision within 30 calendar days of receipt of the ALJ Decision.

g) The state will track the Opt-out for Cause requests detailed in paragraph 20, subparagraph (d) including the number of each type of request; the county of each request; and the final result of the request. This information shall be provided to CMS in the quarterly reports.

21. **Individuals with SMI in Greater Arizona.** Individuals who are AACP members residing in Greater Arizona (all counties with the exception of Maricopa County) and who are diagnosed with a serious mental illness will receive their acute care services and behavioral health services through a separate MCO known as a RBHA. This separate RBHA may differ depending on whether the individual resides in the north or south geographic service area (GSA) for the state.

    a) **Implementation Plan:** The state will submit to CMS, by June 1, 2015, a schedule indicating its planned start date for mandatory enrollment for integrated care for its SMI population in Greater Arizona. The state is prohibited from beginning mandatory enrollment in Greater Arizona until CMS approves the implementation plan. The state may revise the implementation plan as needed, and must promptly notify CMS of any changes. The approved implementation plan will be included as an attachment to these STCs. The plan will include:
        i. Identification of triggers that would prevent the state from proceeding with implementation;
        ii. Identification of risks with the implementation;
        iii. A mitigation strategy for the identified risks;
        iv. A fail-safe or back-up plan in the event that the mitigation strategy fails;
        v. Identification of circumstances that would stop the state proceeding with the implementation; and
        vi. The role of stakeholder feedback in implementation.

    b) **Transition plan.** The state must conduct an assessment of the plan transition needs for Greater Arizona and will explain its policies other than those discussed in (d) and (e) below, to promote beneficiary continuity and continuation of care, particularly for beneficiaries who will no longer have access to his or her physician.

    c) **Notice information.** The state must provide notice at least 60 days in advance of the change in delivery system to individuals in Greater Arizona in simple and understandable terms and in a manner that is accessible to persons who are limited English proficient and individuals living with disabilities.

    d) **Transition Period.** When individuals transition to the MCO for their physical health from an AACP health plan, members in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider shall be allowed to continue receiving treatment from the non-participating/non-contracted provider through the duration of their prescribed treatment.

    e) **Choice of Primary Care Physician (PCP).** The MCO is required to assure that members have a choice of PCPs. Specifically, beneficiaries will have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). In addition, the MCO, through the Regional Behavioral Health Authorities (RBHA), will offer contracts to primary and specialist physicians who have established relationships with beneficiaries including

specialists who may also serve as PCPs to encourage continuity of provider. For individuals who have an established relationship with a PCP that does not participate in the MCO/RBHA's provider network, the MCO will provide, at a minimum, a 12-month transition period in which the individual may continue to seek care from their established PCP while the individual, the MCO, RBHA and/or case manager finds an alternative PCP within the MCO/RBHA's provider network.

f) **Readiness Review of Health Plan.** The state must assess plan readiness in Greater Arizona in accordance with the requirements of 42 CFR 438. Readiness reviews will include, but are not limited to, documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations. The state will also notify CMS of its intent to conduct a readiness review 30 days in advance of the review and provide CMS the opportunity to observe the readiness review. The state will submit to CMS for review by September 1, 2015, a copy of its readiness review report of the health plan(s) selected to provide the integrated services to the SMI population to ensure the selected health plan's provider network, both in terms of primary and specialty care providers, is adequate and would not result in access to care issues for the affected population.

g) **Care Coordination for Integrated SMI Program.** The State shall submit to CMS their procedures for ensuring that the integrated RBHAs have sufficient resources and training available to provide the full range of care coordination for individuals with disabilities, multiple and chronic conditions, and individuals who are aging. Care coordination capacity should reflect demonstrated knowledge and capacity to address the unique needs (medical, support and communication) of individuals in the SMI population. The needs may be identified through a risk assessment process. Care shall be coordinated across all settings including services outside the provider network.

h) **Compliance with Managed Care requirements**. Prior to implementation of the Greater Arizona SMI program, the state must submit a report to CMS on its compliance with subparagraphs (a) through (g) above, along with the most recent version of the implementation plan mentioned in (a). The state may not initiate expansion unless CMS has received this report at least 30 days in advance of the implementation date.

i) **Opt out for Cause**. Individuals with SMI in Greater Arizona will have the option to opt-out of the RBHA for acute care services and be transferred to the acute care plan under the following conditions only:
    i. Either the beneficiary, beneficiary's guardian, or beneficiary's physician successfully dispute the beneficiary's diagnosis as SMI;
    ii. Network limitations and restrictions;
    iii. Physician or provider course of care recommendation
    iv. The member established that due to the enrollment and affiliation with the RBHA as a person with a SMI, and in contrast to persons enrolled with an

acute care provider, there is demonstrable evidence to establish actual harm or the potential for discriminatory or disparate treatment in:

f. The access to, continuity or availability of acute care covered services;
g. Exercising client choice;
h. Privacy rights;
i. Quality of services provided; or
j. Client rights under Arizona Administrative Code, Title 9, Chapter 21.

j) Under paragraph 21 subparagraph (i)(iv), a beneficiary must either demonstrate that the discriminatory or disparate treatment has already occurred, or establish the plausible potential of such treatment. It is insufficient for a member to establish actual harm or the potential for discriminatory or disparate treatment solely on the basis that they are enrolled in the RBHA.

k) A transfer requested under paragraph 21 subparagraph (i)(iv) will be clearly documented in the enrollee handbook and any other relevant enrollee notices, and will be processed as follows:

1) <u>The RBHA will take the following actions</u>:

vii. Responsibility for reducing to writing the member's assertions of the actual or perceived disparate treatment of individuals as a result of their enrollment in the integrated plan.
viii. Responsibility for completing ADHS transfer of a RBHA member to an approved Acute Care Contractor Form
ix. Confirmation and documentation that the member is enrolled in SMI RBHA program
x. Providing documentation of efforts to investigate and resolve member's concern
xi. Inclusion of any evidence provided by the member of actual or reasonable likelihood of discriminatory or disparate treatment.
xii. Recommendation of approval or denial of request, and forward completed packet to ADHS for approval or denial within 7 days of request.

2) <u>ADHS will take the following actions:</u>

iv. Review completed request packets received from the RBHA;
v. Approve or deny request in writing within 10 calendar days of request.
vi. Provide notice that includes the reasons for the denial and appeal/hearing rights to the member for requests which are denied.

3) <u>AHCCCS will take the following actions:</u>

iii. If a hearing is requested, the request for hearing will be forwarded to the AHCCCS Administration which will then schedule the matter for hearing with OAH;

The AHCCCS Administration will issue a Director's Decision within 30 calendar days of receipt of the ALJ Decision.

l) The state will track the Opt-out for Cause requests detailed in paragraph 21, subparagraph (i) including the number of each type of request; the county of each request; and the final result of the request. This information shall be provided to CMS in the quarterly reports.

22. **Arizona Long Term Care System (ALTCS).** The ALTCS program is for individuals who are age 65 and over, blind, disabled, or who need ongoing services at a nursing facility or ICF/MR level of care. ALTCS enrollees do not have to reside in a nursing home and may live in their own homes or an alternative residential setting and receive needed in-home services. The ALTCS package also includes all medical care covered under AACP inclusive of doctor's office visits, hospitalization, prescriptions, lab work, behavioral health services, and rehabilitative services. Rehabilitative services may only be eligible for FFP if these services reduce disability or restore the program enrollee to the best possible level of functionality.

The ALTCS is administered through a statewide, managed care system which delivers acute, long-term care, home-and-community based, CRS and behavioral health care services through capitated MCOs that AHCCCS calls "Program Contractors." The one exception is ALTCS DES/DDD enrollees eligible under the CRS program receive specialty care for treatment of their CRS and behavioral health conditions through a separate MCO contract. Those enrollees will receive services for all conditions other than behavioral health or CRS related conditions through ALTCS DES/DDD.

With one exception, ALTCS contracts are awarded in the same geographic service areas as AACP are awarded. The exception is for the ALTCS contract with the Arizona DES/DDD to provide coverage on a statewide basis of the full ALTCS benefit package to all eligible individuals with developmental disabilities. Under state law, A.R.S. 36-2940, AHCCCS is required to enter into an intergovernmental agreement (IGA) with DES/DDD to serve as the managed care organization for individuals with developmental disabilities. The DES/DDD ALTCS contract is an at-risk MCO contract that complies with 42 C.F.R. Part 438 and as such is reviewed and approved by CMS. Payments to DES/DDD under the ALTCS contract shall not include any payments other than payments that meet the requirements of 42 C.F.R. 438.6(c) including the requirement that all payments and risk-sharing mechanisms in the contract are actuarially sound. State law, A.R.S. 36-2953, requires DES/DDD to maintain a separate fund to account for all revenues and expenditures under the ALTCS contract and limits use of the fund for the administration of the ALTCS contract. ALTCS enrollees in Maricopa and Pima Counties have a choice of Program Contractors, but ALTCS enrollees in the rest of the state enroll in the Program Contractor for their GSA.

a) **ALTCS Eligibility Groups -** Individuals as defined in Table 1 requiring health care services at a nursing facility or ICF/MR level of care.

b) **ALTCS Financial Eligibility -** Individuals must be financially eligible for ALTCS with income equal to or less than 300 percent of the Federal Benefit Rate (FBR), as used by SSA to determine eligibility for SSI.

   i. The state may disregard income in excess of the FBR for persons with AHCCCS approved income-only trusts.

   ii. The resource (cash, bank accounts, stocks, bonds, etc.) limit is $2,000 for a single individual. Resources, such as a person's home, vehicle, and irrevocable burial plan are not counted toward the resource limit.

   iii. When the applicant has a spouse who resides in the community, the spouse can retain one-half of the couple's resources, up to the Federal maximum as specified in section 1924(f)(2) of the Act. Resources, such as a person's home, vehicle, and irrevocable burial plan are not counted toward the resource limit.

   iv. The total gross income for a married couple is combined and divided by 2. The resulting income may not exceed 300 percent of the single FBR. If the resulting income exceeds 300 percent of the single FBR, the income of the applicant only (name on check) is compared to 300 percent of the single FBR.

c) **Pre-Admission Screening (PAS) -** Once financial eligibility has been established, a PAS will be conducted by a registered nurse or social worker to determine if the individual is at immediate risk of institutionalization in either a nursing facility or an ICF/MR. The PAS must be used to determine if the applicant is eligible for ALTCS based on functional, medical, nursing, and social needs of the individual.

d) **Written Plan of Care -** An individual written plan of care will be developed by qualified providers for ALTCS enrollees under this demonstration. This plan of care will describe the medical and other services to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the review of AHCCCS.

   i. **FFP -** will not be claimed for demonstration services furnished prior to the development of the plan of care. FFP will not be claimed for demonstration services which are not included in the individual written plan of care.

e) **ALTCS Safeguards** – AHCCCS will take the following necessary safeguards to protect the health and welfare of persons receiving HCBS services under the ALTCS program. Those safeguards include:

   i. Adequate standards for all types of providers that furnish services under the ALTCS program;

ii. Assurance that the standards of any state licensure or certification requirements are met for services or for individuals furnishing services that are provided under the ALTCS program. The state assures that these requirements will be met on the date that the services are furnished; and

iii. Assurance that all facilities covered by section 1616 (e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable state standards that meet the requirement of 45 CFR Part 1397 for board and care facilities.

iv. A formal quality control system which monitors the health and welfare of members served in the ALTCS program.

1) Monitoring will ensure that all provider standards and health and welfare assurances are continually met, and that plans of care are periodically reviewed to ensure that the services furnished are reasonably consistent with the identified needs of the individuals.

2) The state further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

f) **ALTCS Benefits and Services**

i. **ALTCS Acute Care -** Enrollees receive the same acute services as defined in paragraph 17(c).

ii. **ALTCS Behavioral Health Care -** Enrollees receive behavioral health care services as defined in paragraph 17(c)(iii).

iii. **Home and Community-Based Services (HCBS) -** ALTCS will provide a comprehensive HCBS package to eligible enrollees in the enrollee's home or in an ALTCS approved Alternative Residential Setting.

1) **Alternative Residential Settings** include:

a. Adult foster care.
Assisted living homes, assisted living centers, adult developmental homes, child developmental homes and group homes, hospices, group homes for traumatic brain injured members, and rural substance abuse transitional agencies.

b. Behavioral Health Facilities that are licensed to provide behavioral health services in a structured setting with 24-hour supervision. ALTCS covers services, except room and board, that are provided to ALTCS members who have a behavioral

health disorder and are residing in one of the following behavioral health facilities:

i. Level II behavioral health facility – Licensed by ADHS. An HCBS alternative residential behavioral health treatment setting for individuals who do not require the intensity of services or onsite medical services found in a Level I facility.

ii. Level III behavioral health facility - Licensed by ADHS. An HCBS alternative residential behavioral health treatment setting with 24-hour supervision and supportive, protective oversight. These services are excluded for individuals involuntarily living in the secure custody of law enforcement, judicial, or penal systems.

2) **HCBS Services** – Services provided to ALTCS enrollees receiving HCBS are enumerated in Table 4.

Table 4 – ALTCS HCBS

Service	Title XIX	
	EPD	DD
Acute Hospital Admission	X	X
Adult Day Health Services	X	N/A
Attendant Care	X	X
Behavioral Health Services	X	X
Community Transition Services*	X	X
DME / Medical Supplies	X	X
Emergency Alert	X	X
Habilitation	X	X
Home Delivered Meals	X	n/a
Home Health Agency Services	X	X
Home Modifications	X	X
Home Maker Services	X	X
Hospice Services (HCBS & Institutional)	X	X
ICF / MR	n/a	X
Medical Care Acute Services	X	X
Nursing Facility Services	X	X
Personal Care	X	X
Respite Care (in home)	X	X
Respite Care (Institutional)	X	X
Therapies	X	X
Transportation	X	X

*As Defined in State Medicaid Director Letter #02-008 (see Attachment C)

3) **HCBS Expenditures**- Expenditures for individual members are limited to an amount that does not exceed the cost of providing care to the eligible individual in an institutional setting. Exceptions are

permitted including when the need for additional services is due to a change in condition that is not expected to last more than 6 months.

iv. **Spouses As Paid Care Givers**. AHCCCS may implement a voluntary program for spouses as paid caregivers. The program will provide reimbursement to spouses who elect to provide needed in-home care for eligible ALTCS enrollees. Spouses providing care to eligible enrollees will be employed by an ALTCS network contractor, or registered with AHCCCS as an ALTCS independent provider when providing services to an ALTCS FFS Native American or developmentally disabled member. In order for the state to receive FFP from CMS for Paid Caregiver Spouses of Medicaid beneficiaries, the personal care service or support must meet the following criteria and monitoring provisions.

1) Services provided by the Spouse as Paid Caregiver must meet the definition of a "service/support" for personal care or similar services that are rendered by a Paid Caregiver when such services are deemed extraordinary care.
    a. Personal care or similar services – Is defined as assistance with the Activities of Daily Living (ADLs), or Instrumental Activities of Daily Living (IADLs), whether furnished in the home or the community, including personal assistance, attendant care, and closely related services such as home health aide, homemaker, chore, and companion services which may include improving and maintaining mobility and physical functioning, promoting health and personal safety, preparation with meals and snacks, accessing and using transportation, and participating in community experiences and activities.
    b. Extraordinary care - Is defined as care that exceeds the range of activities that a spouse would ordinarily perform in the household on behalf of the recipient spouse, if he/she did not have a disability or chronic illness, and which are necessary to assure the health and welfare of the beneficiary, and avoid institutionalization.

2) The Spouse as Paid Caregiver must be a service/support that is specified in a plan of care prepared on behalf of the enrollee.

3) The enrollee who selects the Spouse as Paid Caregiver is not eligible to receive like services from another attendant caregiver.

4) The enrollee will remain eligible to receive other HCBS such as skilled/professional type services, home modifications, respite care, and other services that are not within the scope of the

personal/attendant care services prescribed in the provider's plan of care.

5) The Services must be provided by a Spouse as Paid Caregiver who meets specified provider qualifications and training standards prepared by the state for a Paid Caregiver.

6) The Spouse as Paid Caregiver must be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the state Medicaid Agency (SMA) for the payment of personal care/attendant services; and

7) The Spouse as Paid Caregiver will comply with the following conditions.
    a. A Spouse as Paid Caregiver may not be paid for more than 40 hours of services in a 7-day period;
    b. The Spouse as Paid Caregiver must maintain and submit time sheets and other required documentation for hours worked/paid;
    c. The Spouse as Paid Caregiver may only submit claims for services that have been authorized by the Program Contractor or ALTCS FFS case manager;
    d. The ALTCS enrollee must be offered a choice of providers, other than his/her spouse. The enrollee's choice of a Paid Caregiver Spouse as provider must be recorded in his/her plan of care, at least annually.

8) AHCCCS and its Program Contractors must comply with the following monitoring requirements:
    a. Require Program Contractors and FFS case managers to make an on-site case management visit at least every 90 days to reassess a beneficiary's need for services, including the health, safety, and welfare status of the beneficiary serviced by the Spouse as Paid Caregiver;
    b. Require Program Contractors to provide quarterly financial statements that include separate authorized hours and expenditure information for Paid Caregiver Spouses; and
    c. Require AHCCCS to perform quarterly financial analysis that includes authorized hours and expenditure information for ALTCS FFS Spouses as Paid Caregivers.

v. **Institutional Care** ALTCS will provide institutional care in facilities appropriate to their needs that hold state licenses and Medicaid provider agreements indicating compliance with Medicaid requirements.

g) **Cost Sharing.**

i. Monthly Premiums for ALTCS. The AHCCCS may implement a monthly premium on ALTCS eligible households with an adjusted gross income at or above 400 percent of the FPL that have children under the age of 18 years with developmental disabilities enrolled in ALTCS.

ii. The total of all monthly premiums will be 2 percent of the annual adjusted gross income for households with income between 400 percent and 500 percent of the FPL, and 4 percent for households with income at and above 500 percent the FPL. There will be no distinction between institutional or non-institutional placements.

iii. AHCCCS will compute the premium amount using annual adjusted gross income from the parent's most recent Federal income tax return.
   1) Premiums will be billed monthly on the 1st and due on the 15th.
   2) AHCCCS will establish a grievance and appeal process allowing families to dispute the initial amount of the premium based on annual income or family size, increases in premiums and discontinuances for failure to pay the monthly premiums or deductibles.
      a. Premiums will continue to be billed and incurred during an eligibility appeal period and failure to pay the premium during the appeal period could mean a loss of eligibility.
      b. If the appeal is based on an increase in the premium amount, the premium increase will not be imposed until after an appeal decision.

h) **Other ALTCS Requirements**

i. The state of Arizona will continue to provide access to ALTCS services to American Indians on the reservation as it does to other citizens of the state.

ii. The state will not deny acute care Medicaid eligibility for any potentially disabled individual based on using PAS criteria in lieu of the SSI-disability determination. Prior to rendering a final decision of ineligibility for acute care services based on disability, the state will use the SSI criteria as required under section 1902(a)(10) as interpreted through Federal regulations at sections 435.120 and 435.601.

iii. In the absence of a limit, AHCCCS will report annually on current placements and ongoing activities for expanding HCB services and settings. The report will be due by March 31 of each year.

iv. The DES/DDD will comply with all contractual and reporting requirements as specified in the contract between AHCCCS and DES/DDD and in any subsequent amendments. DES/DDD will be sanctioned as specified in the

contract if DES/DDD fails to comply with the stated contractual and reporting requirements.

23. **ALTCS Transitional Program**. AHCCCS will complete a second scoring of the PAS for members who are enrolled in ALTCS, but fail to be at "immediate risk of institutionalization" based on the PAS conducted at the time of the re-determination.

    If determined eligible for the ALTCS Transitional Program, AHCCCS will transfer the member to the ALTCS Transitional Program which limits institutional services to 90-days per admission and provides the member with medically necessary acute care services, HCBS, behavioral health services and case management services as prescribed in paragraph 21.

24. **Medicare Part B Premiums.** The state of Arizona will continue to pay the Medicare Part B premiums on behalf of individuals enrolled in ALTCS with income up to 300 percent of the FBR who are also eligible for Medicare, but do not qualify as a QMB, SLMB or QI; eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO); eligible for continued coverage under 42 CFR 435.1003; or are in the guaranteed enrollment period described in 42 CFR 435.212 and the state was paying their Part B premium before eligibility terminated. Once the state has received the Medicare Part B premium invoice, it will automatically make an electronic payment on behalf of the beneficiary.

VI. Funding Pools and Payments under the Demonstration.

25. **Safety Net Care Pool (SNCP).** Payments from this pool will assist Phoenix Children's Hospital (PCH), which has high levels of uncompensated care related to medical assistance provided to Medicaid eligibles or to individuals who have no source of third party coverage. For PCH, for each demonstration year (DY), the annual SNCP will be distributed to PCH based on its uncompensated care (based on prior period data). Payments to PCH for each DY will be subject to a limit computed in accordance with Attachment E, based on PCH's uncompensated care costs incurred up to December 31, 2015. The total computable amount for the SNCP for PCH is $137 million per DY for eligible uncompensated care costs of PCH. Specifically, the SNCP for PCH is $102,750,000 in DY 3: 1/1/14-9/30/14; $137 million for DY 4: 10/1/14 – 9/30/15; and $34,250,000 in DY 5: 10/1/15-12/31-15. Any unspent cap amount cannot be transferred to the following DY in order to increase the annual cap amount.

    a) **SNCP Payments.** Funds may be used to assist PCH with high levels of uncompensated care related to medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals incurred by PCH. Expenditures must be claimed in accordance with CMS-approved claiming protocols in Attachment E. For any provider receiving SNCP payments, the total Medicaid payments, Disproportionate Share Hospital (DSH) payments, SNCP payments, and any other payments for medical services furnished to Medicaid eligible and uninsured individuals cannot

exceed the actual cost of providing services to Medicaid eligibles and the uninsured as defined in the claiming protocol. SNCP payments will be made directly from the state to the eligible providers as defined in subparagraph (d), who incurred uncompensated care costs.

b) **Prohibited Use of SNCP Funds.** SNCP funds cannot be used to pay for costs associated with non-emergency services provided to non-qualified aliens. The state must develop a methodology as part of the claiming protocol to exclude such costs from eligible uncompensated care costs.

c) **Uncompensated Care Cost Limit** The aggregate amount of SNCP payments made to PCH will not exceed the SNCP amount of $137 million per DY. The annual SNCP payment distributed to each individual provider will not exceed its uncompensated care costs for providing section 1905(a) medical services to Medicaid eligible and uninsured individuals for the period.

The uncompensated care cost limit is computed and SNCP payments are made on a DY basis. To the extent that a provider's cost reporting period does not coincide with the DY, the cost protocol will provide for an allocation of uncompensated care costs to the DY.

Any SNCP payments made in excess of the individual provider's uncompensated care cost limit for a demonstration period will be recouped from the provider, and the federal share of the overpayment will be returned to CMS.

d) **Eligible Providers.** Phoenix Children's Hospital beginning January 1, 2014 through December 31, 2015.

e) **DSH and SNCP.** All applicable inpatient hospital and outpatient hospital SNCP payments received by a hospital provider must be included as offsetting revenue in the state's annual DSH audit reports. Hospitals cannot receive total payments, including DSH and SNCP payments, related to inpatient and outpatient hospital services furnished to Medicaid eligible and uninsured individuals that exceed the hospital's total eligible inpatient hospital and outpatient hospital uncompensated care costs.

f) **Intergovernmental Transfers (IGTs).** The non-federal share of the SNCP payments for PCH will be funded by contributions from eligible governmental entities through IGTs. The state will submit to CMS for review and approval all IGT agreements to ensure compliance with Section 1903(w)(6)(A) of the Act and Part X of these STCs. Such agreements should specify the source and use of the IGT money. The agreements shall ensure that the IGT is not derived from an impermissible source, including recycled Medicaid payments, Federal money precluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. The agreements shall also ensure that providers will retain the SNCP payments.

g) **Annual Reporting Requirements for SNCP Payments**. The state will submit to

CMS an annual report specifically related to the amount of payments made from the SNCP per DY. The reporting requirements are as follows:

Within ninety (90) days after the end of each DY, the state shall provide the following information to CMS:

1) Actual SNCP payments to each provider for each DY, including the interim payments and any overpayments resulting from the recomputations of the uncompensated care cost limits in accordance with the protocol in Attachment E;

2) The uncompensated care cost limit computed for each provider for each DY, including the projected uncompensated care costs used for interim payment purposes, the uncompensated care costs based on the as-filed cost reports, and the uncompensated care costs based on the finalized cost reports.

h) **Transition Plan**. The state shall submit a transition plan describing movement towards long term payment reforms and solutions for PCH and away from current payments received through the SNCP. The transition plan should be submitted to CMS by September 1, 2015 and should address the following:

1) The types of payment reforms currently implemented in the state that affects PCH;
2) The estimated total amount of payments for each type of reform that are paid to PCH; and
3) Other payment reforms and solutions that may be implemented by the state and the effects of such reforms on PCH financing that do not rely on SNCP funding.

26. **Payments to IHS and 638 Facilities.** The state is authorized through September 30, 2016 under the expenditure authorities of this demonstration to make payments to IHS and tribal 638 facilities that take in to account their uncompensated costs in furnishing specified types of care furnished by IHS and tribal 638 facilities to Medicaid-eligible individuals. Facilities must use the methodology discussed in Attachment F.

VII. DELIVERY SYSTEMS

27. **Contracts.** All contracts and modifications of existing contracts between the state and MCOs must be prior approved by CMS. The state will provide CMS with a minimum of 45 days to review changes.

VIII. EVALUATION

28. **State Must Separately Evaluate Components of the Demonstration.** As outlined in subparagraphs (a) - (g) the outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the state met the demonstration

goal, with recommendations for future efforts regarding all components. The evaluation must outline and address evaluation questions for all of the following components:

a) **Evaluation Design Plan.** At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those outlined in subparagraphs (c) and (d), as well as those that focus specifically on the target populations within the Acute Care, ALTCS, SMI, ESI program and the Family Planning Extension Program within the demonstration. The draft design plan must also include a separate section discussing the AACP cost sharing, the missed appointment fee evaluation requirements, the uncompensated care payments to IHS and 638 facilities and the CRS and SMI integration programs as described further in subparagraphs (c) - (f). The draft design shall discuss the outcome measures that must be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes (Attachment B – Evaluation Design Guidelines). The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration are isolated from other initiatives occurring in the state.

   The state must submit a revised draft evaluation design plan by April 1, 2015, in order to include the evaluation requirements outlined in subparagraph (e) – (g).

b) **ESI Evaluation**. Arizona must conduct an evaluation of the ESI demonstration that was in effect through December 31, 2013. The state shall report on its progress in the quarterly and annual reports. AHCCCS will monitor the private insurance market as it relates to the ESI program (e.g., changes in employer contribution levels, trends in sources of insurance, etc.). AHCCCS will also continue to monitor substitution of coverage (i.e., participants dropping private coverage to enroll in the demonstration).

c) **AACP Cost Sharing Evaluation.** Arizona must conduct an independent evaluation of the AACP cost sharing requirements required for adults without dependent children with income up to 100 percent of the FPL that was in effect through December 31, 2013. These copayments included services for prescription drugs, non-emergency use of the emergency room, physician office visits, and non-emergency medical transportation for taxi rides only. The evaluation must test the following specific hypotheses related to the mandatory copayments assessed on the adults without dependent children population:

   i. How will utilization of needed preventive, primary care, and treatment services be affected;
   ii. To what extent will the imposition of the pharmacy co-payments and copayments related to non-emergent use of emergency rooms ensure appropriate utilization of emergency room care and appropriate

utilization of cost and clinically effective generic and brand name drugs; and

iii. Will the mandatory co-payments affect state and federal expenditures (per enrollee) in the short and long term; and

iv. Will there be an impact on physician participation, or physician willingness to accept appointments from the adults without dependent children population.

Methods by which the state can evaluate these hypotheses include evaluating the relative utilization of, and access to, services provided to the adults without dependent children population compared to a similar population of parents (who are not subject to the copayment requirements), as well as, comparing selected access, utilization and quality indicators, across the pre-copayment adults without dependent children population with those of the post-co-payment adults without dependent children population, as well as across the adults without dependent children populations. Measures could include examining the impact of the copayments on rates of emergency department utilization, rates of inpatient readmission, and selected evidence-based measures indicating management of chronic conditions (such as diabetes and asthma).

In addition, the state will evaluate how the NEMT copayment on adults without dependent children residing in Maricopa and Pima counties has affected access compared to the same population residing in all other counties.

Finally, the state shall report on the evaluation's progress in the state's quarterly and annual reports.

d) **Permissible Provider Fee for Missed Appointments Evaluation.** The state must submit an independent evaluation of the missed appointment fee on the TANF parents and adults without dependent children residing in all counties except for Maricopa and Pima counties that was in effect from October 22, 2011 through January 1, 2013. In addition to the other hypotheses that the state has developed to test this fee, the state must evaluate the following to determine the fee's impact on:

i. Reducing the number of missed appointments;

ii. Beneficiaries seeking more care from walk-in clinics, urgent care centers, and/or emergency rooms, and any resulting impact on costs;

iii. Denial of service as a result of the fee;

iv. Subgroups within the adults without dependent children population, i.e., were there variations by income level, age, gender, etc.;

v. Program integrity;

vi. Compliance with the provisions for missed appointment fees;

vii. Administrative feasibility and cost to the provider; and

viii. The rate of missed appointment fees assessed by provider type and

region of the state.

e) **Uncompensated Care Payments to IHS and 638 Facilities.** Arizona must conduct an independent evaluation of the uncompensated care payments provided to IHS and 638 facilities as described in paragraph 26 and Attachment F. The evaluation must test the following specific hypotheses related to the uncompensated care payments:

i. What is the effect on service utilization as a result of the uncompensated care payments broken down by type of service as well as the population served?
ii. Are the affected facilities able to maintain and/or increase their current staffing levels?

Methods by which the state can evaluate these hypotheses include evaluating staffing levels as well as the relative utilization of, and access to, services provided to adults pre-uncompensated care payment period to services with those of the post-uncompensated care payment period. Measures could include examining selected evidence-based measures indicating management of chronic conditions (such as diabetes and asthma).

f) **Integration of Physical and Behavioral Health Services for the CRS and SMI populations.** Arizona must contract with an independent evaluator in order to conduct an evaluation of the integration of physical and behavioral health services for the CRS and SMI populations as described in paragraphs 19 and 20. The evaluation will focus on two components – integration of care and health outcomes. As part of the state's revised evaluation design plan, as specified in subparagraph (a), the state must use baseline data from October 1, 2012 through March 31, 2014, and must begin the evaluation of the integration projects by April1, 2014.

i. Integration of Care. This component of the evaluation must test the following hypotheses as they relate to both populations affected by the integration projects:

1) Did this care model provide the same or an improved level of physical and behavioral health care quality as non-integrated care model? Health care quality includes improved access, utilization, health care outcomes and patient experience.

2) Did this care model improve how physical and behavioral health is integrated for the target population in a way that is different than the care they would have received if they had remained in the traditional care model?

The baseline period, as reflected in the revised evaluation design, must include information detailing the characteristics of the fragmented delivery system that is being replaced with the integrated system of care, such as the prevalence of multiple care plans, the number of primary care provider not connected with case managers, the number of duplicated tests and/or treatment, and the number of

beneficiaries making and keeping appointments post discharge.

ii. Health Outcomes. This component of the evaluation will be broken down by each target population.

1) CRS Population. The evaluation must test the following specific hypotheses related to the integration of services for the CRS population:

a. What is the effect on health outcomes as a result of the integration of services, including but not limited to improving:

i. Emergency department visit rates with a primary diagnosis of asthma;

ii. Hospital readmissions rates with a primary diagnosis of asthma diabetes, congestive heart failure and behavioral health as well as all-cause hospital readmissions rates.

b. How will the integration of services affect access to care and the utilization of needed preventive, primary care, and treatment services, such as immunization rates?

c. For foster children enrolled in the CRS integrated plan, how will the integration of services improve the appropriateness of prescribing patterns and utilization of psychotropic prescription drugs?

2) SMI Population. The evaluation must test the following specific hypotheses related to the integration of services for the SMI population in Maricopa county and Greater Arizona:

a. Did the integration project improve care coordination for the target population (as measured by patient experience improved access to specialty care, appropriate medications, etc.)?

b. Does the integration of services result in an increase in access to and utilization of primary and specialty care?

c. What is the effect on health outcomes as a result of the integration of services, including but not limited to improving chronic disease management, diabetes and cardiovascular conditions such as congestive heart failure?

d. How is this model providing more appropriate care for this population as measured by: inpatient utilization for asthma, congestive heart failure and COPD conditions; hospital readmissions with a primary diagnosis of asthma, diabetes, congestive heart failure and behavioral health as well as all-cause hospital readmissions; and emergency room visits with a primary diagnosis of asthma and diabetes, broken down by diagnosis?

Measures by which the state can evaluate these hypotheses include, but are not limited to, primary care and preventive services utilization (as applicable), emergency room utilization, inpatient hospital utilization and rate of readmissions, screenings and testing associated with diabetes, cardiovascular disease, and HIV/AIDS. In addition to the above measures, the state must use data from beneficiary satisfaction surveys and grievance and appeals data to assist in the evaluation. The state must also incorporate home health quality measures and CMS Behavioral Health Performance Measure Set in its evaluation. As the demonstration progresses, the state may include additional measures and data sources working in coordination with CMS, such as body mass index assessments and integration of electronic health records as penetration increases.

g) **Safety Net Care Pool (SNCP) for Phoenix Children's Hospital**. Arizona must conduct an independent evaluation of the use of the SNCP for Phoenix Children's Hospital beginning January 1, 2014 described in paragraph 25. The hypothesis test for the evaluation must focus on the effect of the Affordable Care Act coverage expansion on the existing SNCP payments and how this affects future needs for both the uninsured and Medicaid shortfall scenarios. The evaluation must contain the following:

i. A detailed analysis of the SNCP payments for PCH pre- and post- the extension period beginning January 1, 2014.

ii. A comparison of SNCP payments that are attributable to each of the following:

1) Uninsured children; and

2) Children who are Medicaid beneficiaries.

iii. An analysis of factors that contributed to the necessity of SNCP payments to PCH including, but not limited to:

1) Provider and diagnosis payment rates in the state; and

2) The number of uninsured and Medicaid eligible children in the state.

iv. A comparison of evidence based proposals with strategies regarding PCH payment rate reform to reduce or eliminate Medicaid shortfall for PCH that will address the shortfall amounts in the future

v. An analysis of the findings and conclusions drawn from the factors that contributed to the necessity of SNCP payments overall as well as specifically for Medicaid shortfall.

29. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft design, within 60 days of receipt. The state must submit a final design within 60-days of receipt of CMS comments and implement the evaluation design. The evaluation design may be revised during the demonstration approval period as needed or required by the STCs.

30. **Interim Evaluation Report.** The state must submit an interim evaluation report to CMS as part of any future request to extend the demonstration, or by March 31, 2016, if no

extension request has been submitted. The interim evaluation report will discuss evaluation progress and present findings to date as required under paragraph 28.

31. **Final Evaluation Report.** The state must submit to CMS a draft of the evaluation final report within 60 days prior to the expiration of the demonstration. The state must take into consideration CMS' comments for incorporation into the final report. The final evaluation report is due to CMS no later than 60 days after receipt of CMS' comments.

32. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration, the state must fully cooperate with Federal evaluators' and their contractors' efforts to conduct an independent, federally funded evaluation of the demonstration program.

IX. GENERAL REPORTING REQUIREMENTS

33. **General Financial Requirements.** The state shall comply with all general financial requirements under title XIX and title XXI.

34. **Reporting Requirements Relating to Budget and Allotment Neutrality.** The state shall comply with all reporting requirements for monitoring budget and allotment neutrality set forth in this Agreement.

35. **Budget Neutrality Information.** For each quarter, the state will correctly report expenditures and member months that are subject to budget neutrality. Where data are incorrect and upon the request of CMS, the state must submit corrected budget neutrality data.

36. **Monthly Calls.** CMS shall schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, employer-sponsored insurance progress, family planning issues, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

37. **Quarterly Reports.** The state shall submit progress reports in a format agreed upon by CMS and the state no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports shall include, but not be limited to (Attachment A – Quarterly Report Guidelines):

a) A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, health plan financial performance that is relevant to the demonstration, the benefit package, and other operational issues, including the transition of SMI and CRS individuals;

b) Action plans for addressing any policy and administrative issues identified;

c) The quarterly reports must also include at least enrollment data, member month data, and budget neutrality monitoring tables;

d) The number of IHS and 638 facilities receiving uncompensated care payments, broken down by the methodology selected in which the uncompensated care payment is calculated (effective through December 31, 2013), as well as a discussion on how the payments are affecting the financial viability of the facilities, using metrics that the state will develop in consultation with IHS and tribal programs, and the impact on service utilization broken down by type of service and by populations served.

e) The number of complaints and grievances filed on behalf of beneficiaries participating in the SMI and CRS integration projects, broken down by access to care, health plan and provider satisfaction.

f) Data on for cause opt-out reasons for the SMI integration project as described in paragraphs 21 and 22.

g) The number of individuals enrolled in the Family Planning Extension Program at the end of the quarter through December 31, 2013, as well as the number of participants served during the prior quarter (participants include all individuals who obtain one or more covered family planning or family planning-related services through the demonstration);

h) Notification of any changes in enrollment and/or participation to the Family Planning Extension Program through December 31, 2013 that fluctuate 10 percent or more in relation to the previous quarter within the same demonstration Year (DY) and the same quarter in the previous DY; and

h) Any issues which arise in conjunction with the Employer Sponsored Insurance (ESI) portion of the program through December 31, 2013, including but not limited to enrollment, quality of care, grievances, and other operational issues; and evaluation activities.

38. **Annual Report.** The state shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, the status of the collection and verification of encounter data and policy and

administrative difficulties in the operation of the Acute Care, ALTCS, ESI (through December 31, 2013), KidsCare II (through January 31, 2014), Family Planning (through December 31, 2013), IHS and 638 facilities uncompensated care payments, and SNCP/DSHP components of the demonstration. The state shall submit the draft annual report no later than 120-days after the end of each operational year. Within 30-days of receipt of comments from CMS, a final annual report shall be submitted.

For the Family Planning Extension Program, the annual report must include the following:

a) The number of actual births that occur to Family Planning Extension Program participants (participants include all individuals who obtain one or more covered medical family planning services through the Family Planning Extension Program each year);

b) Total number of individuals enrolled at the end of the demonstration year;

c) Total number of participants enrolled at the end of the demonstration year; and

d) The average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1 (the services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)

39. **Transition Plan**. On or before July 1, 2012, the state is required to submit a draft, and incrementally revise a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the demonstration. This plan will address how the state plans to coordinate the transition of these individuals, including children enrolled in the KidsCare II program, to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in subparagraphs (a)-(f) outlined below. In addition, the Plan will include a schedule of implementation activities that the state will use to operationalize the Transition Plan.

a) Seamless Transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the state plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the state must:

i. Determine eligibility under all January 1, 2014, eligibility groups for which the state is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the

FPL.

ii. Identify demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.

iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

iv. Conduct an analysis that identifies populations in the demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the state identifies that may be necessary to continue coverage for these individuals.

v. Develop a MAGI conversion for program eligibility.

b) Cost-sharing Transition: The Plan must include the state's process to come into compliance with all applicable Federal cost-sharing requirements, including the section 1916(f) requirements that apply to the adults without dependent children population when it becomes a mandatory state plan population on January 1, 2014.

c) Access to Care and Provider Payments and System Development or Remediation: The state should assure adequate provider supply for the state plan and demonstration populations affected by the demonstration on December 31, 2013. Additionally, the Transition Plan for the demonstration is expected to expedite the state's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation.

d) Pilot Programs: Progress towards developing and testing, when feasible, pilot programs that support Affordable Care Act activities, such as the state's Medicare-Medicaid integration project to allow for more efficient and effective management of dually eligible ALTCS EPD beneficiaries.

e) Progress Updates: After submitting the initial Transition Plan for CMS approval, the state must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

f) Implementation:

i. By October 1, 2013, the state must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the state plan, the state will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the state must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

40. **Final Report.** The state shall submit a final report pursuant to the requirements of section 1115 of the Act.

41. **Contractor Reviews**. The state will forward summaries of the financial and operational reviews that:

a) The Arizona Department of Health Services/ Behavioral Health Services (ADHS/BHS) completes on the Regional Behavioral Health Authorities (RBHAs).

b) The Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) performs on its subcontracting MCOs.

c) The state will also forward summaries of the financial and operational reviews that AHCCCS completes on the Children's Rehabilitative Services Program (CRS) contractor; and the Comprehensive Medical and Dental Program (CMDP) at the Arizona DES.

42. **Contractor Quality**. AHCCCS will require the same level of quality reporting for DES/DDD, DES/CMDP and ADHS/BHS as for Health Plans and Program Contractors, subject to the same time lines and penalties.

43. **Contractor Disclosure of Ownership**. Before contracting with any provider of service, the state will obtain from the provider full disclosure of ownership and control and related party transactions, as specified in sections 1124 and 1902(a)(38) of the Act. No FFP will be available for providers that fail to provide this information.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

44. **Quarterly Expenditure Reports.** Effective with the quarter beginning October 1, 2011, the state shall provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in this Agreement.

45. **Reporting Expenditures in the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality cap:

a) **Tracking Expenditures.** In order to track expenditures under this demonstration,

Arizona shall report demonstration expenditures through the Medicaid and state Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the state Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.C through 10.F, as instructed in the state Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below.

b) **Use of Forms**. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality cap. The state must complete separate forms for the following categories:

   i. AFDC/SOBRA
   ii. SSI
   iii. Expansion State Adults
   iv. MED
   v. ALTCS-DD
   vi. ALTCS-EPD
   vii. Uncompensated Care Payments to IHS and 638 Facilities
   viii. SNCP/DSHP
   ix. DSH and Critical Access Hospital Payments (CAHP)**
   x. New Adult Group

   **Critical Access Hospital Payments as defined in Attachment D

c) **Expenditures Subject to the Budget Neutrality Cap**. For purposes of section X, the term “expenditures subject to the budget neutrality cap” shall include all Medicaid expenditures except those as described below, on behalf of the individuals who are enrolled in this demonstration. Expenditures excluded from this demonstration and the budget neutrality cap are Direct Services Claiming program expenditures for Medicaid in the public schools, Breast and Cervical Cancer Treatment program expenditures, Freedom to Work program expenditures, and all administrative expenditures.

d) **Premium and Cost Sharing Adjustment**. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration shall be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that the demonstration is properly credited with premium collections, premium collections (both total

computable and Federal share) should also be reported on the CMS-64 Narrative. The state should include these section 1115 premium collections as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

e) **Administrative Costs.** Administrative costs shall not be included in the budget neutrality limit. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

f) **Claiming Period**. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

g) **Pharmacy Rebates.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration. The proposed methodology must determine, in a way that reasonably reflects actual rebate-eligible pharmacy utilization, the amounts of rebate that are attributable to pharmacy utilization under the demonstration *vs.* outside the demonstration, and appropriate subtotals by EG and DY. The methodology (and any subsequent changes to the methodology) must be approved in advance by the CMS Regional Office prior to use. Rebate amounts assigned to the demonstration must be reported on the appropriate Forms CMS-64.9 or 64.9P Waiver, and not on any other CMS-64.9 form (to avoid double-counting). In the absence of an approved methodology, all pharmacy rebates must be reported on Forms CMS-64.9 or 64.9P Base.

46. **Reporting of Member Months.** The following describes the reporting of member months in the demonstration.

a) Member months subject to the budget neutrality cap include:

i. For the purpose of calculating the budget neutrality expenditure cap described in this Agreement, the state shall provide to CMS on a quarterly basis the actual number of eligible member months for:

1) Eligibility Group 1:AFDC / SOBRA
2) Eligibility Group 2: SSI
3) Eligibility Group 3: Expansion State Adults
4) Eligibility Group 4 ALTCS-DD
5) Eligibility Group 5: ALTCS–EPD
6) Eligibility Group 6: New Adult Group

ii. This information shall be provided to CMS 30 days after the end of each quarter as part of the CMS-64 submission, either under the narrative section of the MBES/CBES or as a stand-alone report.

iii. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member months.

iv. For the purposes of this demonstration, the term “demonstration eligibles” refers to all individuals covered by Arizona Medicaid with the exception of individuals in the Freedom to Work and Breast and Cervical Cancer Treatment programs

b) Demonstration Member Months subject to reporting on the CMS 64-Narrative includes the MED Group – described in paragraph 16 as:

i. MED - Individuals who applied for the MED program (under Expenditure Authority 20 of demonstration project #11-W-00032/9 and #21-W-00009/9) prior to May 1, 2011 and were determined eligible for that population for a 6-month guaranteed eligibility period after that date, until the end of that 6-month period.

47. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the state’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

48. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in this Agreement.

a) Administrative costs, including those associated with the administration of the demonstration;

b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c) Net expenditures and prior period adjustments made with dates of service during the operation of the demonstration.

d) CMS shall provide FFP for family planning and family planning-related services and supplies at the applicable Federal matching rates described in STC 24(a)(i) and (ii), subject to the limits and processes described below:

i. For family planning services, reimbursable codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service;
ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, described in STC 24(a)(i), should be entered in Column (D) of the Forms CMS-64.9 Waiver.
iii. Allowable family planning-related expenditures eligible for reimbursement at the FMAP rate, as described in STC 24(a)(ii), should be entered in Column (B) on the Forms CMS-64.9 Waiver.
iv. FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. The match rate for the subsequent treatment would be paid at the applicable Federal matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.
v. Pursuant to 42 CFR 433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

49. **Medicare Part D Drugs.** No FFP is available for this demonstration for Medicare Part D drugs.

50. **Sources of Non-Federal Share**. The state certifies that the source of the non-Federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the non-Federal share for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with Title XIX of the Social Security Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a) CMS shall review the sources of the non-Federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b) The state shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendments that impact the financial status of the program.

c) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid or demonstration payments. This confirmation of Medicaid and demonstration payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid or the demonstration and in which there is no connection to Medicaid or demonstration payments) are not considered returning and/or redirecting a Medicaid or demonstration payment.

51. **Certification of Public Expenditures.** The state must certify that the following conditions for non-Federal share of demonstration expenditures are met:

a) Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-Federal share of funds under the demonstration.

b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

i. To the extent that Arizona institutes the use of CPEs, the requirements of this term and condition fully apply. The state is subject to any policy guidance or regulation released by CMS regarding the use of CPEs.

ii. The disproportionate share hospital (DSH) payment methodology for Arizona State Hospital (ASH) and the Maricopa Medical Center will be cost reimbursement and will utilize CPEs as the funding system. The methodology and the cost identification/reconciliation process, as approved by CMS, are included as an amendment to the DSH methodology in Attachment C.

c) To the extent the state utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the state the amount of such tax revenue (state or local) appropriated to the non-governmental

provider used to satisfy demonstration expenditures. The non-governmental provider that incurred the cost must also provide cost documentation to support the state's claim for Federal match.

d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

52. **Applicability of Fee for Service Upper Payment Limits.** If expenditures (excluding expenditures for members enrolled with the Indian Health Service for inpatient hospital and long-term-care facility services, other institutional and non-institutional services (including drugs) provided to AHCCCS fee-for-service beneficiaries equal or exceed 5 percent of the state's total Medical Assistance expenditures, the expenditure authority will be terminated and the state shall submit a demonstration amendment that includes a plan to comply with the administrative requirements of section 1902(a)(30)(A). The state shall submit documentation to CMS on an annual basis that shows the percentage AHCCCS fee-for-service beneficiary expenditures as compared to total Medical Assistance expenditures.

53. **Fraud and Abuse Recoveries**: The state must improve fraud and abuse recoveries by:

a) Submitting for CMS review an action plan by April 1, 2012, to enhance Medicaid fraud and abuse recoveries by the end of the demonstration period ending September 30, 2016.

b) Submitting to CMS an annual report of the state's implementation of its action plan as required in paragraph 38.

c) Demonstrating by September 30, 2016, that its level of recoveries is equal to, or greater than, the level anticipated in the action report approved by CMS.

XI. <u>GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI</u>

54. **Quarterly CHIP Expenditure Reports.** The state shall provide quarterly expenditure

reports using the Form CMS-21 to report total expenditures for services provided to all demonstration populations receiving title XXI funds under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP only for allowable demonstration title XXI expenditures that do not exceed the state's available title XXI funding.

55. **Tracking CHIP Expenditures.** In order to track title XXI expenditures under this demonstration, the state will report demonstration expenditures, excluding KidsCare II, through the MBES/CBES, following routine CMS-21 reporting instructions. Title XXI demonstration expenditures will be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver identified by the demonstration project number assigned by CMS (including project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). Expenditures for the KidsCare II program will be reported on the CMS-21 with the state plan population in the MBES/CBES._Separate KidsCare II reporting will be provided in the CMS-21 Narrative using a proportion of KidsCare II to the total KidsCare population based on date of payments.

a) **CHIP Claiming.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.

b) **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. Arizona must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the state shall provide updated estimates of expenditures for the demonstration population. CMS will make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

c) **Sources of CHIP Non-Federal Share.** The state will certify state/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law. All sources of non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-Federal share of funding

56. **Limit on Title XXI Funding**. Arizona will be subject to a limit on the amount of Federal title XXI funding that the state may receive for demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including currently available reallocated funds. Should the state expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the demonstration until the next allotment becomes available.

57. **Compliance with Federal Rules.** All Federal rules shall continue to apply during the period of the demonstration if title XXI Federal funds are not available and the state decides to continue the program.

XII. MONITORING BUDGET NEUTRALITY

58. **Monitoring Demonstration Funding Flows.** The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

    a) Each year, AHCCCS will monitor and ensure that for each contract year, the DES/DDD and the ADHS/BHS have provided the appropriate state match necessary to draw down the FMAP for title XIX services provided, respectively, to ALTCS eligible persons and to AHCCCS eligible persons enrolled with ADHS/BHS. Specifically, AHCCCS and DES/DDD entered into an Intergovernmental Agreement, effective July 1, 1998, whereby DES/DDD transfers to AHCCCS the total amount appropriated for the state match for title XIX ALTCS expenditures. Likewise, AHCCCS and ADHS/BHS entered into an Intergovernmental Agreement, effective July 1, 1999, whereby ADHS/BHS transfers to AHCCCS the total amount appropriated for the state match for title XIX expenditures. AHCCCS deposits the monies transferred into an Intergovernmental Fund from which AHCCCS has sole disbursement authority.

    b) AHCCCS will report on a comparison of revenues and costs associated with the DES Interagency Agreement, including how any excess revenues are spent. AHCCCS will also report this information for ADHS/BHS. Both reports will be due by January 15 of each year for the state fiscal year ending the previous June 30.

59. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of Federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

60. **Risk.** The state shall be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality agreement, but not for the number of demonstration eligibles in each of the groups. By providing FFP for all demonstration eligibles, the state shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs for demonstration eligibles under this agreement, CMS assures that Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

61. **Demonstration Populations and Programs Subject to the Budget Neutrality Cap.** The following demonstration populations are subject to the budget neutrality cap and are incorporated into the following eligibility groups:

    a) Eligibility Group 1: AFDC / SOBRA

    b) Eligibility Group 2: SSI

    c) Eligibility Group 3: Expansion State Adults

    d) Eligibility Group 4: ALTCS-DD

    e) Eligibility Group 5: ALTCS–EPD

    f) Program Group 1: DSH

    g) Program Group 2: Uncompensated Care Payments to IHS and Tribal Facilities

    h) Program Group 3: SNCP/DSHP

    i) Program Group 4: KidsCare II

62. **Budget Neutrality Expenditure Cap:** The following describes the method for calculating the budget neutrality expenditure cap for the demonstration:

    a) For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each eligibility group described in paragraph 61 as follows:

        i. An annual eligibility group expenditure cap must be calculated as a product of the number of eligible member months reported by the state under paragraph 46 for each eligibility group, times the appropriate estimated per member per month (PM/PM) costs from the table in subparagraph (iii) below.

        ii. The PM/PM costs in subparagraph (iii) below are net of premiums paid by demonstration eligibles.

iii. The PM/PM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility groups subject to the budget neutrality agreement under this demonstration are specified below. In addition, the PM/PM cost for each eligibility group in DY 1 has been increased by the appropriate growth rate included in the President's Federal fiscal year 2012 budget for DYs 2, 3, 4 and 5, as outlined below. The Expansion State Adults population is structured as a "pass-through" or a "hypothetical state plan population" beginning in DY 1. Therefore, the state may not derive savings from these populations.

Eligibility Group	Trend Rate	DY 1 FFY 2012	DY 2 FFY 2013	DY 3 FFY 2014	DY 4 FFY 2015	DY 5 FFY 2016
AFDC / SOBRA	5.2%	$585.28	$615.71	$647.73	$681.41	$716.85
SSI	6.0%	$885.41	$938.53	$994.84	$1054.53	$1117.81
Expansion State Adults	0.0%	$707.33	$707.58	$707.58	$0	$0
ALTCS - EPD	5.2%	$4737.37	$4983.71	$5242.86	$5515.49	$5802.30
ALTCS - DD	6.0%	$4922.38	$5217.72	$5530.78	$5862.63	$6214.39

iv. The annual budget neutrality expenditure cap for the demonstration as a whole is the sum of DSH allotment, the uncompensated care payments to IHS and tribal facilities, expenditures for the SNCP/DSHP and KidsCare II program plus the annual expenditure caps for each eligibility group calculated in subparagraph (a)(i) above.

b) The overall budget neutrality expenditure cap for the 5-year demonstration period is the sum of the annual budget neutrality expenditure caps calculated in subparagraph (a) (iv) above for each of the 5 years. The Federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration populations and expenditures described in paragraph 48 during the demonstration period.

c) Apply the effective FMAP, or enhanced 90 percent match for family planning services, that is determined from the MBES/CBES Schedule C report.

63. **Monitoring of New Adult Group Spending and Opportunity to Adjust Projections.** For each DY, a separate annual budget limit for the new adult group will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in paragraph 46. The trend rates and per capita cost estimates for the new adult group are listed in the table below.

MEG	TREND	DY 3 – PMPM	DY 4 – PMPM	DY 5 – PMPM
New Adult Group	4.7%	$578.54	$605.73	$634.20

a. If the State's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the new adult group PMPM limit described above may underestimate the actual costs of medical assistance for the new adult group, the State has the opportunity to submit an adjustment to the PMPM limit, along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to paragraph 7. In order to ensure timely adjustments to the PMPM limit for a demonstration year, the revised projection must be submitted to CMS by no later than the end of the third quarter of the demonstration year for which the adjustment would take effect.

b. The budget limit for the new adult group is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.

c. The State will not be allowed to obtain budget neutrality "savings" from this population.

d. If total FFP reported by the state for the new adult group should exceed the federal share of FFP for the budget limit for the new adult group by more than 3 percent following each demonstration year, the state must submit a corrective action plan to CMS for approval.

64. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state exceeds the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the DYs, the state must submit a corrective action plan to CMS for approval.

Cumulative Demonstration Years	Cumulative Expenditure Cap Definition	Percentage
Year 1	Budget neutrality expenditure cap plus Year 1 Budget Cap	1.0 %
Year 2	Combined budget neutrality expenditure caps plus Year 1 through 2 Budget Cap	0.75 %
Year 3	Combined budget neutrality expenditure caps plus Year 1 through 3 Budget Cap	0.5 %
Year 4	Combined budget neutrality expenditure caps plus Year 1 through 4 Budget Cap	0.25 %
Year 5	Combined budget neutrality expenditure caps plus Year 1 through 5 Budget Cap	0.0 %

65. **Exceeding Budget Neutrality.** If, at the end of this demonstration period the overall budget neutrality expenditure cap has been exceeded, the excess Federal funds must be returned to

CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

The state is held to all reporting requirements outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date	**Deliverable**
September 30, 2015	Complete Demonstration Extension Application (1115) and interim evaluation report
March 31, 2016	Submit Interim Evaluation Report - Paragraph 30
August 1, 2016	Final Evaluation Report – Paragraph 31; Final Report - Paragraph 40. End of Demonstration Period.
Monthly Deliverables	Monthly call – Paragraph 36
Quarterly Deliverables	Requirements for Quarterly Reports – Paragraph 37
	Quarterly Budget Neutrality Reports – Paragraph 35
	Expenditure Reports CMS 64 and CMS 21 - Paragraph 44 and Paragraph 54
	Member Months Report – Paragraph 46
Annual Deliverables	Requirement for Annual Report – Paragraph 38
	Requirement for annual HCBS Report on March 31st – Paragraph 22 (h)(iii)
	Comparison of Costs for the DES Interagency Agreement, including how any excess revenues are spent, and for ADHS/BHS. Both reports will be due by January 15 – Paragraph 58 (b)

Attachment A - Quarterly Report Guidelines

As written in STC paragraph 37, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 30 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include the budget neutrality monitoring workbook. An electronic copy of the report narrative and the Microsoft Excel budget neutrality monitoring workbook is provided.

NARRATIVE REPORT FORMAT:

TITLE

Title Line One – Arizona Health Care Cost Containment System -- AHCCCS, A statewide Approach of Cost Effective Health Care Financing

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 5 (5/01/04 - 4/30/05)
Federal Fiscal Quarter: 4/2004 (7/04 - 9/04)

INTRODUCTION:

Information describing the goal of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

ENROLLMENT INFORMATION:

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

Note: Enrollment counts should be person counts, not participant months.

Population Groups (as hard coded in the CMS 64)	**Current Enrollees** (to date)	**No. Voluntary Disenrolled in current Quarter**	**No. Involuntary Disenrolled in current Quarter**
Population 1 – AFDC / SOBRA			
Population 2 - SSI			
Population 3 – ALTCS DD			
Etcetera			

Voluntary Disenrollments:
Cumulative Number of Voluntary Disenrollments Within Current Demonstration Year:
Reasons for Voluntary Disenrollments:

Involuntary Disenrollments:
Cumulative Number of Involuntary Disenrollments Within Current Demonstration Year:
Reasons for Involuntary Disenrollments:

Outreach/Innovative Activities:

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:

Identify all significant program developments/issues/problems that have occurred in the current quarter.

Financial/Budget Neutrality Developments/Issues:

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state's actions to address these issues.

Consumer Issues:

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken, or to be taken, to prevent other occurrences.

Quality Assurance/Monitoring Activity:

Identify any quality assurance/monitoring activity in current quarter.

Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

The state may also add additional program headings as applicable.

Date Submitted to CMS:

Attachment B – Evaluation Guidelines

Section 1115 demonstrations are valued for information on health services, health services delivery, health care delivery for uninsured populations, and other innovations that would not otherwise be part of Medicaid programs. CMS encourages states with demonstration programs to conduct or arrange for evaluations of the design, implementation, and/or outcomes of their demonstrations. The CMS also conducts evaluation activities.

The CMS believes that all parties to demonstrations; states, Federal Government, and individuals benefit from state conducted self-evaluations that include process and case-study evaluations—these would include, but are not limited to: 1) studies that document the design, development, implementation, and operational features of the demonstration, and 2) studies that document participant and applicant experiences that are gathered through surveys, quality assurance activities, grievances and appeals, and in-depth investigations of groups of participants and applicants and/or providers (focus groups, interviews, other). These are generally studies of short-term experiences and they provide value for quality assurance and quality improvements programs (QA/QI) that are part of quality assurance activities and/or demonstration refinements and enhancements.

Benefit also derives from studies of intermediate and longer-term investigations of the impact of the demonstration on health outcomes, self-assessments of health status, and/or quality of life. Studies such as these contribute to state and Federal formation and refinements of policies, statutes, and regulations.

States are encouraged to conduct short-term studies that are useful for QA/QI that contribute to operating quality demonstration programs. Should states have resources available after conducting these studies, they are encouraged to conduct outcome studies.

The following are criteria and content areas to be considered for inclusion in Evaluation Design Reports.

- Evaluation Plan Development - Describe how plan was or will be developed and maintained:
    - Use of experts through technical contracts or advisory bodies;
    - Use of techniques for determining interest and concerns of stakeholders (funding entities, administrators, providers, clients);
    - Selection of existing indicators or development of innovative indicators;
    - Types of studies to be included, such as Process Evaluations, Case-Studies and Outcome investigations;
    - Types of data collection and tools that will be used – for instance, participant and provider surveys and focus groups; collection of health service utilization; employment data; or, participant purchases of other sources of health care coverage; and, whether the data collection instruments will be existing or newly developed tools;
    - Incorporation of results through QA/QI activities into improving health service delivery; and

- Plans for implementation and consideration of ongoing refinement to the evaluation plan.

- Study Questions – Discuss:
  - Hypothesis or research questions to be investigated;
  - Goals, such as:
    - Increase Access
    - Cost Effectiveness
    - Improve Care Coordination
    - Increase Family Satisfaction and Stability
  - Outcome Measures, Indicators, and Data Sources

- Control Group and/or Sample Selection Discussion:
  - The type of research design(s) to be included -
    - Pre/Post Methodology
    - Quasi-Experimental
    - Experimental
  - Plans for Base-line Measures and Documentation – time period, outcome measures, indicators, and data sources that were used or will be used

- Data Collection Methods – Discuss the use of data sources such as:
  - Enrollment and outreach records;
  - Medicaid claims data;
  - Vital statistics data;
  - Provide record reviews;
  - School record reviews; and
  - Existing or custom surveys

- Relationship of Evaluation to Quality Assessment and Quality Improvement Activities– Discuss:
  - How evaluation activities and findings are shared with program designers, administrators, providers, outreach workers, etc., in order to refine or redesign operations;
  - How findings will be incorporated into outreach, enrollment and education activities;
  - How findings will be incorporated into provider relations such as provider standards, retention, recruitment, and education; and
  - How findings will be incorporated into grievance and appeal proceedings.

- Discuss additional points as merited by interest of the state and/or relevance to nuances of the demonstration intervention.

ATTACHMENT C
AHCCCS DISPROPORTIONATE SHARE HOSPITAL PROGRAM
DSH 102

Congress established the Medicaid Disproportionate Share Hospital (DSH) program in 1981 to provide financial support to hospitals that serve a significant number of low-income patients with special needs.

This document sets forth the criteria by which Arizona defines DSH hospitals and the methodology through which DSH payments are calculated and distributed. The document is divided into the following major topics:

- Hospital eligibility requirements
- Data on a State Plan Year Basis
- Timing of eligibility determination
- Medicaid Inpatient Utilization Rate (MIUR) calculation (Overall and Group 1 eligibility)
- Low Income Utilization Rate (LIUR) calculation (Group 2 eligibility)
- Governmentally-operated hospitals (Group 4 eligibility)
- Obstetrician Requirements
- Payment
- Aggregate Limits
- Reconciliations
- Certified Public Expenditures (CPEs)
- Grievances and appeals
- Other provisions

Eligibility Requirements

In order to be considered a DSH hospital in Arizona, a hospital must be located in the state of Arizona, must submit the information required by AHCCCS by the specified due date, must satisfy one (1) of the conditions in Column A, AND must satisfy one (1) of the conditions in Column B, AND must satisfy the condition in Column C.

COLUMN A	COLUMN B	COLUMN C
1. The hospital has a Medicaid Inpatient Utilization Rate (MIUR) which is at least one standard deviation above the mean MIUR for all hospitals receiving a Medicaid payment in the state (“Group 1”)	1. The hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid patients 2. The hospital is outside a Metropolitan Statistical	The hospital has an MIUR of at least 1 percent

1.A. The hospital meets all of the requirements of 1 above (Group 1) and is a privately owned or privately operated hospital licensed by the state of Arizona ("Group 1A") 2. The hospital has a Low Income Utilization Rate (LIUR) that exceeds 25% ("Group 2") 2.A. The hospital meets all of the requirements of 2 above (Group 2) and is a privately owned or privately operated hospital licensed by the state of Arizona ("Group 2A") 3. The hospital is a governmentally-operated hospital ("Group 4")	Area and has at least two (2) physicians with staff privileges to perform non-emergency obstetric procedures 3. The patients of the hospital are predominantly under 18 years of age 4. The hospital was in existence on December 22, 1987 but did not offer non-emergency obstetric services as of that date	

Notice that within Column A, there are six group numbers assigned. Group 1 and Group 2 contain those hospitals that are "deemed" to be DSH hospitals under federal Medicaid law. Group 1A, Group 2A, and Group 4 contain additional hospitals that the state has designated to be DSH hospitals within its federal authority to do so. The criteria listed in Columns B and C are federal eligibility requirements which apply regardless of whether or not the hospital is deemed or designated as a DSH hospital.

- In Group 4, the term "governmentally-operated hospital" refers to a hospital provider which under federal law is able to participate in the financing of the non-federal portion of medical assistance expenditures. A governmentally-operated hospital is differentiated herein from "non-governmental", "non-public", "private", "privately operated" or "privately owned" hospitals as well as IHS or tribal or 638 hospitals and facilities as well as other federally owned or operated facilities.

Medicare Certification

In addition to the eligibility requirements outlined above, in order to receive payment under Medicaid, hospitals must meet the requirements for participation as a hospital in Medicare (except in the case of medical supervision of nurse-midwife services). Therefore, for purposes of DSH, the facility must be Medicare-certified during the state plan rate year for which the initial

DSH payment is made.

If a facility is Medicare-certified for the full state plan rate year for which the initial DSH payment is made, but subsequently loses that certification, the facility remains eligible to receive the payment (together with any payment adjustments). If a hospital is only Medicare-certified for part of the state plan rate year for which the initial DSH payment is made, the eligibility and the payment will be calculated based on the period for which the hospital was Medicare-certified.

Data on a State Plan Year Basis

DSH payments are made based on the State Plan Rate Year. The State Plan Rate Year (or State Plan Year or SPY) is equivalent to the Federal Fiscal Year and runs from October 1 to September 30 of each year. The calculations to determine eligibility for, and the amount of, DSH payments, will be made on the basis of the State Plan Year. This requirement will impact the information collected and submitted by all hospitals that do not have a fiscal year and/or CMS 2552 Report year that runs from 10/1 to 9/30.

In order to make the necessary calculations to determine eligibility and payments on a State Plan Year basis, hospitals that do not have a fiscal/CMS Report year that runs from 10/1 to 9/30 will have to submit cost reports and other data elements for each of the fiscal/CMS Report years that encompass the State Plan Year. For example, for SPY 2008 (10/1/07 to 9/30/08), for a hospital that has a CMS 2552 Report year that runs from 7/1 to 6/30, the hospital will have to submit the CMS 2552 Report and other data elements for the fiscal/CMS Report year that ends on 6/30/08 and the same information for the fiscal/CMS Report year that ends 6/30/09.[1]

As discussed later in this Attachment, AHCCCS will extract all Title XIX (Medicaid) claims and encounters from the PMMIS system on the basis of each hospital's CMS 2552 Report year and these data will serve as the basis for all Medicaid days, charges and payments. Similarly, AHCCCS will collect and distribute to hospitals all Medicaid supplemental payments (e.g. GME, Critical Access Hospitals (CAH), Rural Inpatient Payments) and Non-Title XIX payments (for Children Rehabilitative Services, the Comprehensive Medical and Dental Program, Behavioral Health Services and Payments for Trauma and Emergency Departments) on the basis of each hospital's CMS 2552 Report year.

All data compiled by the hospitals (e.g. total, uninsured and charity days; charges and payments; and state and local subsidy payment information not provided by AHCCCS) will be compiled on a CMS 2552 Report year basis.

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[1] Note however that the use of the 2008 and 2009 reports and information referred to in this paragraph is for the determination of *final* DSH payments. For the initial 2008 DSH payments, reports and information for 2006 and 2007 will be submitted. For a discussion of initial payments, final payments and data sources, see the discussions that follow.

Except in the case where a hospital's fiscal year is identical to the State Plan Year – the calculations to determine eligibility for, and the amount of, DSH payments, will be performed separately for each hospital's fiscal year and these results will be prorated based on the distribution of months from each of the two years that encompass the SPY. For example, for SPY 2008 (10/1/07 to 9/30/08), for a hospital that has a CMS 2552 Report year that runs from 7/1 to 6/30, the proration of the results of the calculations will be derived by summing:

1. 9/12th of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/08, and
2. 3/12th of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/09.

Timing of Eligibility Determination

The eligibility determination calculations will be performed annually for all hospitals located in the state of Arizona that are registered as providers with AHCCCS. Eligibility calculations will be performed only with and for hospitals that have submitted the information required by this document and/or as otherwise requested by AHCCCS. In order to be considered "submitted", the information must be received by AHCCCS by the due date specified in a request for information communicated to the Chief Financial Officer of the hospital. The calculations will be performed with the information submitted by, or available to AHCCCS on the due date specified as the deadline for the submission of information.

The eligibility determination will be made in at least two steps:

1. The first step of the eligibility process will occur in the state plan rate year of the initial DSH payment. To determine initial eligibility, AHCCCS will:
    a. Extract from the PMMIS system all inpatient and outpatient hospital claims and encounters by date of service for each registered hospital for that hospital's fiscal years that encompass the state plan rate year two years prior to the state plan year of the initial DSH payment.
    b. Based on the extracted claims and encounters data and data provided by the hospitals, determine for each hospital whether or not that hospital has a Medicaid Inpatient Utilization Rate (MIUR) of at least 1%. For hospitals that qualify under this criteria, determine if the hospital:
        i. Meets the criteria for Group 1
        ii. Meets the criteria for Group 1A
        iii. Meets the criteria for Group 2
        iv. Meets the criteria for Group 2A
        v. Meets the criteria for Group 4
    c. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above.

2. The second step of the eligibility process will occur in the state plan rate year two years after the state plan rate year of the initial DSH payment. To determine final eligibility, AHCCCS will:
    a. Extract from the PMMIS system all inpatient and outpatient hospital claims and encounters by date of service for each registered hospital for that hospital's fiscal years that encompass the state plan rate year of the initial DSH payment.
    b. Based on the extracted claims and encounters data and data provided by the hospitals determine for each hospital whether or not that hospital has a MIUR of at least 1%. For hospitals that qualify under this criteria, determine if the hospital:
        i. Meets the criteria for Group 1
        ii. Meets the criteria for Group 1A
        iii. Meets the criteria for Group 2
        iv. Meets the criteria for Group 2A
        v. Meets the criteria for Group 4
    c. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above.

3. AHCCCS may redetermine any hospital's eligibility for any DSH payment should the agency become aware of any information that may prove that the hospital was not eligible for a DSH payment.

MIUR Calculation (Overall Eligibility Criteria and Group 1 and Group 1A Eligibility)

A hospital's Medicaid Inpatient Utilization Rate (MIUR) will determine the hospital's overall eligibility for DSH (Column C above) as well as the hospital's eligibility for Group 1 and Group 1A. A hospital's MIUR is calculated using the following equation:

$$\boxed{MIUR = \frac{Total\ Medicaid\ Inpatient\ Days}{Total\ Number\ of\ Inpatient\ Days}}$$

The calculation will be performed based on the state plan rate year. In order to find each hospital's MIUR for the state plan year, AHCCCS will calculate a MIUR separately for each hospital fiscal/CMS Report year that encompasses the relevant State Plan Year and then prorate the results from the two hospital fiscal/CMS Report years as described in the discussion above entitled "Data on a State Plan Year Basis".

If a hospital has a MIUR of at least 1%, and the obstetrical criteria of Column B above are satisfied, it will meet the overall eligibility criteria. If a hospital has a MIUR which is at least one standard deviation above the mean MIUR for all Arizona hospitals receiving a Medicaid payment in that State Plan Year, it will meet the eligibility for Group 1. If a hospital meets the eligibility criteria for Group 1 and is a privately owned or privately operated hospital licensed by the state of Arizona, it will meet the eligibility for Group 1A. NOTE that meeting overall eligibility criteria does not ensure that a hospital will meet the eligibility criteria for any Group.

In performing the calculations:

1. "Inpatient Days" includes:
    a. Fee-for-service and managed care days, and
    b. Each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward, and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

2. "Medicaid Inpatient Days" includes:
    a. All adjudicated inpatient days for categorically eligible Title XIX clients including days paid by Medicare except as noted below
    b. All adjudicated inpatient days for demonstration eligible Title XIX clients – that is clients that are eligible for Title XIX including days paid by Medicare and days funded by Title XXI except as noted below

3. "Medicaid Inpatient Days" does not include:
    a. Inpatient days in which a categorically or demonstration eligible Title XIX client was in an Institution for Mental Disease (IMD) and the client was between 21 and 65 years of age

Data Sources for MIUR Calculations

1. For "Medicaid Inpatient Days" the PMMIS claims and encounters
    a. For the initial determination of a hospital's MIUR, extracted based on date of service for the hospital's fiscal/CMS Report years that encompass the state plan rate year that ends two years prior to the state plan rate year of the initial DSH payment.
    b. For the second determination of a hospital's MIUR, extracted based on date of service for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

2. For "Total Number of Inpatient Days" the CMS 2552-96
    a. For the initial determination of a hospital's MIUR, the cost report (or reports) for the hospital that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet S-3, Lines 1 and 6 through 11, Column 6 plus Line 14, Column 6 for hospital subprovider days. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.
    b. For the second determination of a hospital's MIUR, the cost report(s) for the hospital that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet S-3, Lines 1 and 6 through 11, Column 6 plus Line 14, Column 6 for hospital subprovider days. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the

issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

Calculation of the mean MIUR and the Standard Deviation

In calculating the mean MIUR, the MIUR calculated for the state plan year for all Arizona hospitals that have received a Medicaid payment will be used. The mean MIUR – the average of the individual MIURs – will be calculated based on all the individual state plan year MIURs greater than zero (i.e. including the MIURs that are less than 1%). The standard deviation will be calculated based on the same list of individual hospital MIURs.

LIUR Calculation (Group 2 Eligibility)

A hospital's Low Income Utilization Rate (LIUR) will determine the hospital's eligibility for Group 2. A hospital's LIUR is calculated by summing the following two equations:

$$LIUR = \frac{Total\ Medicaid\ Patient\ Services\ Charges + Total\ State\ and\ Local\ Cash\ Subsidies\ for\ Patient\ Services}{Total\ Charges\ for\ Patient\ Services}$$

$$+$$

$$\frac{Total\ Inpatient\ Charges\ Attributable\ to\ Charity\ Care - Cash\ Subsidies\ Portion\ Attributable\ to\ Inpatient}{Total\ Inpatient\ Charges}$$

The calculation will be performed based on the state plan rate year. In order to find each hospital's LIUR for the state plan year, AHCCCS will calculate a LIUR separately for each hospital fiscal/CMS Report year that encompasses the relevant State Plan Year and then prorate the results from the two hospital fiscal/CMS Report years as described in the discussion above entitled "Data on a State Plan Year Basis".

If a hospital has a LIUR that exceeds 25% it will meet the eligibility for Group 2. If a hospital meets the eligibility criteria for Group 2 and is a privately owned or privately operated hospital licensed by the state of Arizona, it will meet the eligibility for Group 2A.

In performing the calculations:

1. "Total Medicaid Patient Services Charges" includes Title XIX charges for inpatient and outpatient services (both fee-for-service and managed care)

2. "Total Medicaid Patient Services Charges" does not include DSH payments or payments made for GME, Critical Access Hospitals, Rural Inpatient Payments or any other TXIX supplemental payments authorized by the Legislature as these amounts are effectively included in charges

3. "Total State and Local Cash Subsidies for Patient Services" includes payments made with state-only or local-only funds and includes, but is not limited to
    a. Payments made for:
        i. Non-Title XIX and Non-Title XXI enrollees in the DES Comprehensive Medical and Dental Program
        ii. Non-Title XIX and Non-Title XXI enrollees in the DHS Children's Rehabilitative Services program
        iii. Non-Title XIX and Non-Title XXI enrollees in the DHS Behavioral Health Services Program (note that these payments are typically made through Regional Behavioral Health Authorities)
        iv. The support of trauma centers and emergency departments
    b. Payments made by:
        i. An appropriation of state-only funds
        ii. The Arizona State Hospital
        iii. Local governments including (but not limited to):
            (1) Tax levies dedicated to support a governmentally-operated hospital
            (2) Tax levies from a hospital district organized pursuant to A.R.S. § 48-1901 et seq.
            (3) Subsidies for the general support of a hospital

4. "Total State and Local Cash Subsidies for Patient Services" does not include payments for or by:
    a. Inpatient or outpatient services for employees of state or local governments
    b. Governmentally-operated AHCCCS health plans or program contractors
    c. Tax reductions or abatements

5. "Total Charges for Patient Services" includes total gross patient revenue for hospital services (including hospital subprovider charges).

6. "Total Inpatient Charges Attributable to Charity Care" includes the amount of inpatient services – stated as charges – that is provided free to individuals who cannot afford health care due to inadequate resources as determined by the hospital's charity care policy and do not otherwise qualify for government subsidized insurance. In order to qualify as charity care, payment may neither be received nor expected.

7. "Total Inpatient Charges Attributable to Charity Care" does not include bad debt expense or contract allowances and discounts offered to third party payors or self pay patients that do not qualify for charity care pursuant to the hospital's charity care policy.

8. "Cash Subsidies Portion Attributable to Inpatient" means that portion of "Total state and Local Cash Subsidies for Patient Services" that is attributable to inpatient services.

9. "Total Inpatient Charges" includes total inpatient and hospital subprovider charges without any deductions for contract allowances or discounts offered to third party payors or self pay patients.

Data Sources for LIUR Calculations

1. For "Total Medicaid Patient Services Charges":
    a. For the initial determination of a hospital's LIUR:
        i. The PMMIS claims and encounters extracted based on date of service for each registered hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
    b. For the second determination of a hospital's LIUR:
        i. The PMMIS claims and encounters extracted based on date of service for each registered hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

2. For the portion of "Total State and Local Cash Subsidies for Patient Services" and "Cash Subsidies Portion Attributable to Inpatient" attributed to Non-Title XIX and Non-Title XXI payments for the CMDP, CRS or Behavioral Health programs and for the payments in support of trauma centers and emergency departments:
    a. For the initial determination of a hospital's LIUR:
        i. AHCCCS will provide to hospitals the amounts of such payments made during the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment based on data from its financial records or from the financial records of the state agencies making the payments.
    b. For the second determination of a hospital's LIUR:
        i. AHCCCS will provide to hospitals the amounts of such payments made during the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment based on data from its financial records or from the financial records of the state agencies making the payments.
    c. In the case of CRS payments, if AHCCCS does not provide a breakdown of inpatient and outpatient payments, the hospital shall allocate the CRS payments between outpatient and inpatient based on the percentage of total inpatient charges to total charges for patient services

3. For all other "Total State and Local Cash Subsidies for Patient Services" and "Cash Subsidies Portion Attributable to Inpatient":
    a. For the initial determination of a hospital's LIUR:
        i. The hospital financial records for the payments received during the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
    b. For the second determination of a hospital's LIUR:
        i. The hospital financial records for the payments received during the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

c. In the case of "Cash Subsidies Portion Attributable to Inpatient", if the hospital receives subsidies for the general operation of the hospital, allocation between outpatient and inpatient should be based on the percentage of total inpatient charges to total charges from patient services.

4. For "Total Inpatient Charges Attributable to Charity Care":
    a. For the initial determination of a hospital's LIUR:
        i. The hospital claims and financial records for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the year of the initial DSH payment.
    b. For the second determination of a hospital's LIUR:
        i. The hospital claims and financial records for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment.

5. For "Total Inpatient Charges":
    a. For the initial determination of a hospital's LIUR, the cost report (or reports) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 6 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.
    b. For the second determination of a hospital's LIUR, the cost report(s) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 6 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

6. For "Total Charges for Patient Services":
    a. For the initial determination of a hospital's LIUR, the cost report (or reports) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year two years prior to the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 8 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68.

If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

b. For the second determination of a hospital's LIUR, the cost report(s) for the hospital for the hospital's fiscal/CMS Report years that encompass the state plan rate year of the initial DSH payment. The specific figure to be used is found on Worksheet C Part 1, Column 8 Line 101 less Lines 34 to 36, less Lines 63.5 to 63.99, and less Lines 64 to 68. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101. The CMS 2552-96 form(s) to be used is the "finalized" or "settled" version (i.e., the CMS 2552-96 that has been settled by the hospital's Medicare fiscal intermediary with the issuance of a Notice of Program Reimbursement). If the finalized version of the CMS 2552-96 is not available, the filed (or latest filed) report shall be used.

Group 4 Eligibility Determination – Governmentally-operated Hospitals

Because the state has designated all governmentally-operated hospitals (represented in Group 4) as DSH hospitals, no eligibility calculations are required.

Obstetrician Requirements

In order to ensure that hospitals receiving DSH payments meet requirements related to obstetricians, all hospitals that are determined to have a MIUR of at least 1% must file a completed certification statement indicating their compliance with the requirements. Any hospital that fails to return the certification statement by the date specified by AHCCCS will not be eligible to receive DSH payments for the state plan rate year of the initial DSH payment.

For the determination of a hospital's compliance with the obstetrician requirement, the certification will be based on the state plan rate year of the initial DSH payment from the start of the state plan rate year to the date of certification.

The certification statement shall incorporate the following language:

> I certify that the hospital indicated below currently has and has had since the beginning of the current state plan year at least two (2) obstetricians with staff privileges who have agreed to provide obstetric services to individuals eligible for Medicaid, OR
>
> I certify that the hospital indicated below is located in a rural area and currently has and has had since the beginning of the current state plan year at least two (2) qualified physicians with staff privileges who have agreed to provide non-emergency obstetric

services to individuals eligible for Medicaid, OR

I certify that the hospital indicated below did not offer non-emergency obstetric services to the general population as of December 22, 1987, or that the inpatients of the hospital are predominantly individuals under 18 years of age.

Payment

Pools and Changing Payment Levels

The DSH program in Arizona is funded through a six pool system. Each of the pools correlates to one of the hospital eligibility Groups. Therefore, there are five non-governmental hospital pools and one governmental hospital pool. The non-governmental hospital pool amounts are set by AHCCCS as authorized by the Arizona Legislature; the governmental pool amount is established by the Arizona Legislature. The amounts of funding for the pools for the current state plan year are contained in Exhibit 3.

If a non-governmental hospital qualifies for pool 1A it will be removed from pool 1. Similarly, if a non-governmental hospital qualifies for pool 2A it will be removed from pool 2. The non-governmental hospitals in pool 1 and pool 2 will be considered as a group and if a non-governmental hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment. The non-governmental hospitals in pool 1A and 2A will be considered as a group, and if a non-governmental hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment. The payment amount to each non-governmental hospital will be determined based on the maximization process performed during the state plan rate year of the initial DSH payment. The maximization process will be performed separately for 1) the non-governmental hospitals that qualify for pools 1 and 2, and; 2) the non-governmental hospitals that qualify for pools 1A and 2A.

There are five instances where the initial DSH payment to one or more non-governmental hospitals may change:

1. A hospital is found on the second eligibility determination (or any subsequent eligibility check) to not be eligible for a DSH payment in the state plan rate year of the initial DSH payment. In this instance, the amount of payment to the hospital will be recouped and the recouped amount will be distributed proportionately based on the initial DSH payments to the eligible hospitals remaining in the pool in which the ineligible hospital was placed in the state plan rate year of the initial DSH payment, up to each hospital's OBRA limit (see discussion below).

2. A hospital is found to have exceeded its finalized OBRA limit (see discussions below). In this instance, the amount of payment to the hospital in excess of its finalized OBRA limit will be recouped, and the recouped amount will be distributed proportionately based on the initial DSH payments to the eligible hospitals remaining in the pool in which the

hospital was placed in the state plan rate year of the initial DSH payment, up to each hospital's finalized OBRA limit.

3. In the event of a recoupment of an initial DSH payment and as a result of the process of distributing the recoupment to the pool to which the recouped payment was originally made, the distribution would result in all the hospitals in the pool receiving a total DSH payment in excess of their finalized OBRA limit, the amount of recoupment will be proportionately allocated among the remaining non-governmental hospital pools based on the initial DSH payments and distributed proportionately based on the initial DSH payments to the hospitals in the remaining pools up to each hospital's finalized OBRA limit.

4. In the event that litigation (either by court order or settlement), or a CMS audit, financial review, or proposed disallowance requires AHCCCS to issue DSH payment amounts to one or more hospitals in a pool in excess of the initial DSH payment amount, AHCCCS will proportionately recoup funds based on the initial DSH payments from the remaining hospitals in the pool or pools effected to satisfy the requirement. This process will be followed to ensure that the annual federal DSH allotment is not exceeded.

5. In the event that a hospital qualifies for a DSH payment in the second (or any subsequent) eligibility determination that did not qualify in the initial eligibility determination, that hospital will receive the minimum payment under the DSH program which is $5,000.

The payment amount to each governmentally-operated hospital will be determined during the state plan rate year of the initial DSH payment. The payment amount will only change if the total DSH payment to a hospital in the pool would be in excess of its finalized OBRA limit (see discussion below). To the extent that the excess amount recouped from a governmentally-operated hospital can be distributed to other hospitals in the pool without exceeding the interim or finalized OBRA limits of the remaining governmentally-operated hospitals, the excess amount will be distributed to the other governmentally-operated hospitals.

<u>Determination of Payment Amounts</u>

The amount that each non-governmental hospital receives as an initial DSH payment from the pool for which it qualifies is determined by a weighting method that considers both the amounts/points over the Group threshold and the volume of services. The volume of services is either measured by Title XIX days or net inpatient revenue, depending upon the group being considered.

Hospitals that only qualify for Group 1 or Group 2

There are ten steps to determining the DSH payment amount for non-governmental hospitals that only qualify for Group 1 or Group 2 (and not Group 1A or 2A). After determining the initial DSH payment amount through the ten step process, there is a final adjustment that may be made depending on the result of the hospital's OBRA limit.

1. Determine Points Exceeding Threshold.
   Each of the Groups 1 and 2 has thresholds established for qualification of the hospital. For Group 1 it is one standard deviation above the mean MIUR; for Group 2 it is greater than 25% LIUR. Step 1 merely determines the difference between each hospital's "score" for the Group measure and that Group's threshold.

2. Convert Points Exceeding Threshold into a Value.
   Each of the Groups 1 and 2 are measuring a value: for Group 1 the value is Medicaid days; for Group 2 it is revenue. Step 2 multiplies the Points Exceeding Threshold by the value of the associated Group.

3. Determine Relative Weight of Each Hospital in Each Group.
   The relative weight of each hospital in each Group is determined by dividing each hospital's value for a Group determined in Step 2 by the total of all hospital values for that Group.

4. Initial Allocation of Dollars to Each Hospital in Each Group.
   The amount of funds available to each of the Groups 1 and 2 is determined by AHCCCS as authorized by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3. The initial allocation to each hospital in each group is determined by multiplying each hospital's relative weight in a Group (determined in Step 3) by the amount of funds available for that Group.

5. Maximize Allocation of Dollars Between Group 1 and Group 2.
   This step selects the greater of the allocation to each hospital between Group 1 and Group 2.

6. Recalculating the Relative Weights of Each Hospital in Group 1 and Group 2.
   Since Step 5 eliminated hospitals from both Group 1 and Group 2, it is necessary to redetermine the weight for each remaining hospital. This is accomplished by dividing the value of each hospital remaining in Group 1 and Group 2 after Step 5 by the total of the remaining hospitals.

7. Second Allocation of Dollars Within Group 1 and Group 2.
   The second allocation to each hospital remaining in Group 1 and Group 2 is determined by multiplying each hospital's recalculated relative weight pursuant to Step 6 by the amount of funds available for that Group.

8. Identifying Minimum Payment.
   It is policy that the minimum payment made to any hospital qualifying for DSH is $5,000. This step identifies any amount thus far determined for any hospital that is less than $5,000.

9. Ensuring Minimum Payment.
   This step replaces any amount thus far determined for any hospital that is less than $5,000 with a $5,000 amount.

10. Determining Penultimate Payment Amount.
    With the replacement of values with the $5,000 minimum amounts, it is necessary to recalculate and redistribute the values within any Group where the minimum payment amount was imposed in order to ensure that the total funding for a Group is not exceeded. Step 10 accomplishes this.

After determining the penultimate initial DSH payment amount for each non-governmental hospital that only qualifies for Group 1 or Group 2 (and not Group 1A or 2A) a check of the determined amount is made against the hospital's initial OBRA limit. The description of that limit follows in a subsequent section. If the initial DSH payment amount exceeds the initial OBRA limit, the initial DSH amount is set to the OBRA limit and the excess amount is distributed to the remaining hospitals in the group, with a recheck of the initial DSH amounts against the OBRA limit. This process is repeated until all amounts are distributed or all hospitals in the group are at their OBRA limit.

Hospitals that qualify for Group 1A or Group 2A

There are thirteen steps to determining the DSH payment amount for non-governmental hospitals that qualify for Group 1A or 2A. After determining the initial DSH payment amount through the thirteen step process, there is a final adjustment that may be made depending on the result of the hospital's OBRA limit.

1. Determine Points Exceeding Threshold.
   Each of the Groups 1A or 2A has thresholds established for qualification of the hospital. For Group 1A it is one standard deviation above the mean MIUR; for Group 2A it is greater than 25% LIUR. Step 1 merely determines the difference between each hospital's "score" for the Group measure and that Group's threshold.

2. Convert Points Exceeding Threshold into a Value.
   Each of the Groups 1A and 2A are measuring a value: for Group 1A the value is Medicaid days; for Group 2A it is revenue; Step 2 multiplies the Points Exceeding Threshold by the value of the associated Group.

3. Determine Relative Weight of Each Hospital in Each Group.
   The relative weight of each hospital in each Group is determined by dividing each hospital's value for a Group determined in Step 2 by the total of all hospital values for that Group.

4. Initial Allocation of Dollars to Each Hospital in Each Group.
   The amount of funds available to each of the Groups 1A and 2A is determined by AHCCCS as authorized by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3. The initial allocation to each hospital in each group is determined by multiplying each hospital's relative weight in a Group (determined in Step 3) by the amount of funds available for that Group.

5. Maximize Allocation of Dollars Between Group 1A and Group 2A.
   This step selects the greater of the allocation to each hospital between Group 1A and Group 2A.

6. Recalculating the Relative Weights of Each Hospital in Group 1A and Group 2A.
   Since Step 5 eliminated hospitals from both Group 1A and Group 2A, it is necessary to redetermine the weight for each remaining hospital. This is accomplished by dividing the value of each hospital remaining in Group 1A and Group 2A after Step 5 by the total of the remaining hospitals.

7. Second Allocation of Dollars Within Group 1A and Group 2A.
   The second allocation to each hospital remaining in Group 1A and Group 2A is determined by multiplying each hospital's recalculated relative weight pursuant to Step 6 by the amount of funds available for that Group.

8. Identifying Minimum Payment.
   It is policy that the minimum payment made to any hospital qualifying for DSH is $5,000. This step identifies any amount thus far determined for any hospital that is less than $5,000.

9. Ensuring Minimum Payment.
   This step replaces any amount thus far determined for any hospital that is less than $5,000 with a $5,000 amount.

10. Determining Penultimate Payment Amount.
    With the replacement of values with the $5,000 minimum amounts, it is necessary to recalculate and redistribute the values within any Group where the minimum payment amount was imposed in order to ensure that the total funding for a Group is not exceeded.

After determining the penultimate initial DSH payment amount for each non-governmental hospital that qualifies for Group 1A or 2A a check of the determined amount is made against the hospital's initial OBRA limit. The description of that limit follows in the next section. If the initial DSH payment amount exceeds the initial OBRA limit, the initial DSH amount is set to the OBRA limit and the excess amount is distributed to the remaining hospitals in the group, with a recheck of the initial DSH amounts against the OBRA limit. This process is repeated until all amounts are distributed or all hospitals in the group are at their OBRA limit.

Hospitals that qualify for Group 4

To determine the initial DSH payment amount for each governmentally-operated hospital, the relative allocation percentage for each hospital is computed based on the lesser of the hospital's CPE and the amount of funding specified by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3.

OBRA Limits

The DSH payment ultimately received by qualifying non-governmental hospitals is the *lesser* of the amount calculated pursuant to the above-described methodologies or the hospital's OBRA limit. The DSH payment ultimately received by governmentally-operated hospitals is the *lesser* of the amount funded and specified by the Legislature or the hospital's finalized OBRA limit. All DSH payments are subject to the federal DSH allotment.

The OBRA limit is calculated using the following equation:

$$\boxed{\begin{array}{l}\textit{Uncompensated Care Costs Incurred Serving Medicaid Recipients} + \\ \textit{Uncompensated Care Costs Incurred Serving the Uninsured}\end{array}}$$

Pursuant to the above equation, the OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to individuals with no source of third party coverage for the inpatient and outpatient hospital services they received (uninsured costs).

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for each hospital up to three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment for all eligible hospitals based on the cost report(s) and days and charges and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment
2. For governmentally-operated hospitals, the OBRA limit will be recalculated when the cost report for the state plan rate year of the initial DSH payment is filed
3. The final calculation of each hospital's OBRA limit will be performed when the cost report for the state plan rate year of the initial DSH payment is finalized

The steps to computing the OBRA limit are[2]:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). Each hospital must complete the cost report to determine per diems (for inpatient routine services) and ratios of cost to charges (RCC) (for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in

[2] Note: The following discussion applies to hospitals that do not have a per diem ancillary allocation methodology approved by Medicare. For the steps to calculate the OBRA limit for governmental hospitals that do have such approval, see Exhibit 2 to this Attachment C. Non-governmental hospitals that have such approval should contact AHCCCS for further information.

the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.

2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and charges and other program data collected by each hospital from its claims and financial records, other systems, and the cost report.

The sum of each hospital's Medicaid shortfall (whether positive or negative) and uninsured costs (whether positive or negative) is that hospital's OBRA limit.

The Medicaid Shortfall

The data used to calculate the Medicaid shortfall is extracted from the cost report(s) as well as from the AHCCCS PMMIS system and other AHCCCS financial reporting systems. The Medicaid shortfall will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the above discussion entitled "Data on a State Plan Year Basis".

The information from AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
3. The Medicaid inpatient and outpatient hospital FFS charges for ancillary cost centers (for governmentally-operated hospitals this will be accumulated separately for each ancillary cost center on the cost report)
4. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital FFS services
5. The amounts of Medicaid payments made by AHCCCS for inpatient and outpatient hospital FFS services
6. The Medicaid inpatient and outpatient hospital managed care charges for ancillary cost centers (for governmentally-operated hospitals this will be accumulated separately for each ancillary cost center on the cost report)
7. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services for health plans and program contractors
8. The amounts of Medicaid payments made by health plans and program contractors for inpatient and outpatient hospital services for health plans and program contractors
9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan rate year under review (e.g. GME, CAH, etc.)

For each hospital, the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report will be applied to the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services. The per diem amounts will be calculated by dividing:

- The individual amounts on Worksheet B Part 1 Column 25 Lines (and where applicable Subscript Lines) 25 to 33
- By
- The corresponding day totals on Lines (and where applicable Subscript Lines) 5 through 11 and Line 14 (for inpatient hospital subproviders) from Worksheet S-3 Part I Column 6.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary RCCs will be calculated by dividing:

1. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet B Part 1 Column 25
2. By
3. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet C Part 1 Column 8

Costs will be offset by the payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services as well as payments made by AHCCCS including FFS payments, payments by health plans and program contractors, and supplemental payments (such as GME, Rural Hospital Payments and CAH) made during the hospital's fiscal/CMS Report years that encompass the state plan rate year.

Uninsured Costs

Each hospital will collect uninsured days and charges and program data for the hospital's fiscal/CMS Report years that encompass the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient and outpatient days and charges and program data for medical services that would otherwise be eligible for Medicaid should be included in the DSH calculation. Inpatient and outpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days, charges and program information provided to the state are subject to the same audit standards and procedures as the data included in the cost report.

When providing uninsured days, charges and program information hospitals should be guided by

the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

When submitting uninsured days, charges and program information hospitals should accompany the submission with:

- A listing of all payor types that are included in the uninsured data compilation, and
- A CD or DVD that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted to the financial records of the hospital

The uninsured costs will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting uninsured costs for each fiscal/CMS Report year will be prorated to derive the state plan year uninsured costs according to the above discussion entitled “Data on a State Plan Year Basis”.

The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for governmentally-operated hospitals this will be accumulated for each inpatient routine service cost center on the cost report)
2. The uninsured inpatient and outpatient hospital ancillary charges (for governmentally-operated hospitals this will be accumulated for each ancillary cost center on the cost report)
3. The amounts of payments received during the hospital’s fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services. The information collected shall:

a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,
b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

For each hospital the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report (as determined for Medicaid) will be applied to the data collected by the hospital to determine the uninsured costs.

Costs will be offset by the payments received during the state plan year from or on behalf of patients and payments received during the hospital's fiscal/CMS Report years that encompass the state plan year from third parties related to all uninsured inpatient and outpatient hospital services. Payments made by state or local government are not considered a source of third party payment.

The OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit.

Group 5 Eligibility Determination

Any Arizona hospital that qualifies for funding in Groups 1 and 2 (Group 1, 1A, 2, or 2A) is eligible for funding through Group 5. Group 5 is created to enable DSH-eligible hospitals to get qualifying DSH payments matched via voluntary intergovernmental agreements (IGAs). Per State Medicaid Director Letter #10-010, the state will require the appropriate documentation that the funding has been voluntarily provided. Group 5 DSH payments are on top of the Groups 1 and 2 DSH payments, but no individual hospital will receive aggregate DSH payments that exceed its OBRA limit.

Funding for any hospital in Group 5 must be arranged via a voluntary intergovernmental agreement with a political subdivision, tribal government or public university, using public funds not derived from impermissible sources, such as impermissible provider-related donations or impermissible health care-related taxes, as a match to draw down DSH payments. Political subdivisions, tribal governments and public universities will notify AHCCCS of the hospitals designated to receive funds and of the amount of matching funds that are available through their IGAs.
For hospitals that qualify for Group 5, a "LOM" score will be calculated by multiplying the hospital's LIUR times the hospital's full OBRA limit, times the hospital's MIUR.

Example:
Hospital A
OBRA = $54,734,467, MIUR = 0.3542, LIUR = 0.2946
Group 5 LOM score for Hospital A = $54,734,467 x 0.3542 x 0.2946 = $5,711,394

For the first round of distributions, each hospital's percentage of the total group LOM score will be calculated using the hospital's LOM score as the numerator and the total of all eligible hospitals' LOM scores as the denominator. The total amount of DSH available as a result of the IGAs (Group 5 DSH

funds) will be multiplied by each hospital's LOM percentage of this first round. If any allocation from this round is higher than a hospital's OBRA limit (remaining after Group 1 and 2 DSH distributions) or higher than the matching funds (in total computable) for that hospital, the lower of those two limits will be recorded as the allocation for round one.

For subsequent rounds, only the hospitals that have not hit their OBRA limit or matching fund limit will be considered in that round. The LOM score for only those hospitals will be totaled. Each hospital's percentage of the total LOM score for that round will be calculated. The total amount of Group 5 DSH funds remaining for that round will be multiplied by each hospital's LOM percentage for that round. If any allocation from any round is higher than a hospital's remaining OBRA limit or higher than the remaining total computable matching funds for that hospital, the lower of those two limits will be recorded as the allocation for that round.

Distribution rounds will continue until all Group 5 DSH funds are distributed, or all Group 5 qualifying hospitals have received the maximum distribution identified in the IGAs or reached their individual OBRA limits, whichever comes first. All excess IGA funds not used for Group 5 DSH distributions, due to application of the above limits, will be returned to the originating political subdivisions, tribal governments or public universities and will not be retained by AHCCCS for other uses.

The Group 5 DSH distribution for any hospital will consist of that hospital's total of allocations from all rounds.

Aggregate Limits

IMD Limit

Federal law provides that aggregate DSH payments to Institutions for Mental Diseases (IMDs) in Arizona is confined to the *lesser* of $28,474,900 or the amount equal to the product of Arizona's current year total computable DSH allotment and 23.27%. Therefore, DSH payment to IMDs will be reduced proportionately to the extent necessary to ensure that the aggregate IMD limit is not exceeded.

"Institutions for Mental Diseases" includes hospitals that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

Overall Total Limit

The federal government shares in the cost of Medicaid DSH expenditures based on the Federal Medical Assistance Percentage (FMAP) for each state. However, for each fiscal year, the amount of federal funds available to states for DSH payment is fixed. As such, the total amount of DSH payments for a state plan rate year will not exceed the federal allotment divided by the FMAP.

Reconciliation

The initial DSH payment issued to a hospital by AHCCCS is considered "interim" and is subject to different reconciliation methodologies depending upon whether the hospital is non-governmental or governmentally-operated. The payments to hospitals are generally made as a single lump sum payment that is made once the calculations of the payment amounts are completed. The purpose of the interim DSH payment is to provide reimbursement that approximates the Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care costs eligible for Federal Financial Participation (FFP).

The reasons for a change in the initial (or interim) DSH payment for both non-governmental and governmentally-operated hospitals are outlined above under "Pools and Changing Payment Levels".

If it is determined that the total amount of payments made to non-governmental hospitals under the methodology outlined in the "Pools and Changing Payment Levels" exceeds the amount of all finalized non-governmental hospital OBRA limits, the amount in excess will be recouped by AHCCCS and any associated federal funding claimed will be properly credited to the federal government.

If it is determined that the total amount of payments made to governmentally-operated hospitals under the methodology outlined in the "Pools and Changing Payment Levels" exceeds the amount of either:

1. All governmentally-operated hospital OBRA limits calculated based on the "finalized" cost report, or
2. The total amount of certified public expenditures of governmentally-operated hospitals, then
3. The amount in excess will be recouped by AHCCCS and any associated federal funding claimed will be properly credited to the federal government.

Certified Public Expenditures

Expenditures by governmentally-operated hospitals shall be used by AHCCCS in claiming FFP for DSH payments to the extent that the amount of funds expended are certified by the appropriate officials at the governmentally-operated hospital.

The method for determining a governmentally-operated hospital's allowable uncompensated care costs eligible for DSH reimbursement when such costs are funded through the certified public expenditure (CPE) process will be the same as the method for calculating and reconciling the OBRA limit for governmentally-operated hospitals set forth above.

However, because governmentally-operated hospitals are certifying expenditures for the state plan year of the initial DSH payment and final expenditures may not be known at the time of initial certification of public expenditures, governmentally owned hospitals may certify an amount of expenditures for the initial DSH payment based on an estimate of the OBRA limit for the state plan year of the initial DSH payment.

In certifying estimates of public expenditure for the initial DSH payment, the governmentally operated hospital will first calculate its expenditures based on the methodology for calculating the OBRA limit for the state plan year two years before the state plan year of the initial payment (as specified in the protocols in Exhibit 1 or Exhibit 2) and then provide for adjustments to such OBRA limit. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS.

In order to use CPE, the certifying governmentally-operated hospital must follow the protocol in Exhibit 1 or Exhibit 2 and provide a certification as to the amount of allowable uncompensated care costs eligible for DSH reimbursement. If CPE is used, the amount of expenditures used to determine the FFP will not exceed the amount of the CPE.

The payment of FFP to governmentally-operated hospitals is subject to legislative appropriation.

Grievances and Appeals

The state considers a hospital's DSH eligibility and DSH payment amount to be appealable issues. A DSH eligibility list along with the initial DSH payment amounts that eligible hospitals have been calculated to receive will be distributed. Hospitals will be permitted thirty (30) days from distribution to appeal their DSH eligibility and payment amounts. Because the total amount of DSH funds is fixed, the successful appeal of one DSH hospital will reduce DSH payment amounts to all other providers. Once the final reconciliation process is completed, no additional DSH payment will be issued.

Other Provisions

Ownership

DSH payment will only be issued to the entity which is currently registered with AHCCCS as a participating hospital provider. Therefore, it is expected that facilities will consider this information when negotiating ownership changes.

Exceptions (Revised May 29, 2009)

An exception to the use of the Medicare Cost Report (Form CMS 2552-96) as a data source shall apply to:

I. **Hospitals that:**

- Serve patients that are predominantly under 18 years of age, and
- Are licensed for fewer than 50 beds, and
- Do not file a comprehensive Form CMS 2552-96 (Medicare Cost Report), and
- Receive an acceptance letter from the CMS fiscal intermediary for the portion of the CMS 2552-96 (Medicare Cost Report) that the hospital does file with the fiscal intermediary, and
- Receive written permission from AHCCCS to invoke the provisions of this exception.

Such hospitals may extract data from their financial records in lieu of extracting data from the Form CMS 2552-96 (Medicare Cost Report) as provided in this Attachment C.

The method of extracting and compiling the data from the hospital's financial records shall conform to the instructions for the Form CMS 2552-96. All other non-Medicare Cost Report data and documentation as described in this Attachment C shall be required from such hospitals.

II. Indian Health Service (IHS) Hospitals and tribally-operated 638 hospitals who do not file a full Form CMS 2552-96 Medicare Cost Report but rather file an abbreviated Medicare cost report in accordance with Medicare Provider Reimbursement Manual, Part I, Section 2208.1.E (Method E cost report).

Such IHS Hospitals and tribally-operated 638 hospitals can submit a Private Facility Information Sheet (PFIS) to AHCCCS using data from the IHS Method E report that is filed with CMS as well as supporting hospital financial reports, as necessary.

The method of extracting and compiling the data from the hospital's financial records shall conform to the instructions for the Form CMS 2552-96. All other non-Medicare Cost Report data and documentation as described on the PFIS cover sheet will be required by such hospitals.

EXHIBIT 1 to ATTACHMENT C

AHCCCS
Disproportionate Share Hospital Payment Methodology
Calculation of OBRA Limits for
Governmentally-Operated Hospitals for the Purpose of
Certified Public Expenditures

Each governmentally-operated hospital certifying its expenditures for Disproportionate Share Hospital (DSH) payments shall compute and report its OBRA limit as prescribed by this Exhibit. The governmentally-operated hospital's OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to individuals with no source of third party coverage for the inpatient and outpatient hospital services they received (uninsured costs).

The steps to computing the governmentally-operated hospital's OBRA limit are[3]:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). Each hospital must complete the cost report to determine per diems (for inpatient routine services) and ratios of cost to charges (RCC) (for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.
2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and charges and other program data collected by the hospital from its claims and financial records, other systems, and the cost report.
4. Finally, the governmentally-operated hospital will compile and summarize the calculations on The OBRA Limit and CPE Schedule. In compiling and summarizing the OBRA calculations, the governmentally-operated hospital may make adjustments to the calculated OBRA limit to estimate the OBRA limit for a future state plan year. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior to the state plan year of the initial payment, but will be reflected in

[3] Note: The following discussion applies to hospitals that do not have a per diem ancillary allocation methodology approved by Medicare. For the steps to calculate the OBRA limit for governmental hospitals that do have such approval, see Exhibit 2 to this Attachment C.

the final information for the state plan year of the initial payment. All adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS. The Schedule will be submitted to AHCCCS, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan rate year(s) under review.

The Medicaid Shortfall

AHCCCS will provide each governmentally-operated hospital with a report from the PMMIS system and other agency financial reporting systems to assist each governmentally-operated hospital in completing required schedules. The information to be provided by AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for each inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for each inpatient routine service cost center on the cost report)
3. The Medicaid inpatient and outpatient hospital FFS charges (separately for each ancillary cost center on the cost report). Inpatient and outpatient Medicaid charges will not include charges reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services.
4. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital FFS services
5. The amounts of Medicaid payments made by AHCCCS for inpatient and outpatient hospital FFS services
6. The Medicaid inpatient and outpatient hospital managed care charges (for each ancillary cost center on the cost report). Inpatient and outpatient Medicaid charges will not include charges reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services.
7. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services for health plans and program contractors
8. The amounts of Medicaid payments made by health plans and program contractors for inpatient and outpatient hospital services for health plans and program contractors
9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan rate year under review (e.g. GME, CAH, etc.)

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report and the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services. The Medicaid shortfall will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the discussion entitled “Data on a State Plan Year Basis”.

The per diem amounts will be calculated by dividing:

- The individual amounts on Worksheet B Part 1 Column 25 Lines (and where applicable Subscript Lines) 25 to 33
- By
- The corresponding day totals on Lines (and where applicable Subscript Lines) 5 through 11 and Line 14 (for inpatient hospital subproviders) from Worksheet S-3 Column 6.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary RCCs will be calculated by dividing:

1. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet B Part 1 Column 25
2. By
3. The individual Line and Subscript amounts for each of the Lines 37 to 63 taken from Worksheet C Part 1 Column 8

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report and the data supplied by AHCCCS to compile the Medicaid Schedule of Costs on the OBRA Limit and CPE Schedule. The Medicaid Schedule of Costs depicts:

1. The governmentally-operated hospital specific Medicaid inpatient and outpatient cost data,
2. The payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services,
3. The Medicaid inpatient and outpatient net cost data,
4. Payments made by AHCCCS including FFS and payments by health plans and program contractors
5. The amount of supplemental Medicaid payments related to inpatient and outpatient hospital services (e.g., GME and CAH)
6. The Medicaid shortfall
7. Adjustments to the calculated Medicaid shortfall to estimate a Medicaid shortfall for a future state plan year.

Uninsured Costs

Each governmentally-operated hospital will collect uninsured days and charges and program data for the hospital's fiscal/CMS Report years that encompass the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient and outpatient days and charges and program data for medical services that would otherwise be eligible for Medicaid should be included in the calculation. Inpatient and outpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days, charges and program information

provided to the state is subject to the same audit standards and procedures as the data included in the cost report.

When providing uninsured days, charges and program information hospitals should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

When submitting uninsured days, charges and program information hospitals should accompany the submission with:

- A listing of all payor types that are included in the uninsured data compilation, and
- A CD or DVD that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted to the financial records of the hospital

The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for each inpatient routine service cost center on the cost report)
2. The uninsured inpatient and outpatient hospital ancillary charges (for each ancillary cost center on the cost report)
3. The amounts of payments received during the hospital's fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services. The information collected shall:
    a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,

b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report (as determined for Medicaid), the uninsured days and charges, and other program data collected by the governmentally-operated hospital to compile the Uninsured Schedule of Costs on the OBRA Limit and CPE Schedule. The Uninsured Schedule of Costs depicts:

1. The governmentally-operated hospital specific uninsured inpatient and outpatient cost data,
2. The payments made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services, and
3. The uninsured inpatient and outpatient cost.
4. Adjustments to the calculated uninsured inpatient and out patient cost to estimate the uninsured inpatient and outpatient cost for a future state plan year.

The Governmentally-Operated Hospital OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

The summation of the estimated Medicaid shortfall (whether positive or negative) and the estimated uninsured costs (whether positive or negative) is the hospital's OBRA limit for a future state plan year and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

Certification

The appropriate official of the governmentally-operated hospital will sign the certification statement on the Governmentally-Operated Hospital OBRA Limit and CPE Schedule. A certification will be signed for each of the three times the OBRA limit for the state plan rate year of the initial DSH payment is calculated as described below under "Reconciliation".

Reconciliation

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for each governmentally-operated hospital three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment based on the cost report(s) and days and charges and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment. This calculation may include an adjustment to the calculated OBRA limit of the state plan rate year two years prior to the state plan rate year of the initial DSH payment in order to estimate the OBRA limit of the state plan rate year of the initial DSH payment.

2. The OBRA limit will be recalculated when the cost report(s) for the state plan rate year of the initial DSH payment are filed. In recalculating the OBRA limit the cost data from the as-filed cost report(s) and program data (days, charges, and payments) from the actual cost reporting period(s) will be used in the calculation. This calculation may not include any adjustment to the calculated OBRA limit of the state plan rate year of the initial DSH.
3. The final calculation of each governmentally-operated hospital's OBRA limit will be performed when the cost report(s) for the state plan rate year of the initial DSH payment are finalized. In finalizing the OBRA limit the cost data from the finalized cost report(s) and program data (days, charges, and payments) from the actual cost reporting period(s) will be used in the calculation.

EXHIBIT 2 to ATTACHMENT C

AHCCCS
Disproportionate Share Hospital Payment Methodology
Calculation of OBRA Limits for
Arizona State Hospital
A Hospital with a Per Diem Ancillary Cost Allocation Method
Approved by Medicare

Arizona State Hospital (ASH), a governmentally-operated hospital that is an all-inclusive rate provider under Medicare, shall compute, report and certify its OBRA limit as prescribed by this Exhibit. Because ASH only provides inpatient services, the OBRA limit will by calculated based only on inpatient information. ASH's OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient hospital services to individuals with no source of third party coverage for the inpatient hospital services they received (uninsured costs).

The steps to computing ASH's OBRA limit are:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). The hospital must complete the cost report to determine per diems (for inpatient routine services and for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.
2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and other program data collected by the hospital from its claims and financial records, other systems, and the cost report.
4. Finally, ASH will compile and summarize the calculations on The OBRA Limit and CPE Schedule. In compiling and summarizing the OBRA calculations, ASH may make adjustments to the calculated OBRA limit to estimate the OBRA limit for a future state plan year. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS. The Schedule will be submitted to AHCCCS, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan rate year(s) under review.

The Medicaid Shortfall

AHCCCS will provide ASH with a report from the PMMIS system and other agency financial reporting systems to assist ASH in completing required schedules. The information to be provided by AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for the single inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for the single inpatient routine service cost center on the cost report)
3. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital FFS services
4. The amounts of Medicaid payments made by AHCCCS for inpatient hospital FFS services
5. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital services for health plans and program contractors
6. The amounts of Medicaid payments made by health plans and program contractors for inpatient hospital services for health plans and program contractors
7. Other amounts of Medicaid payments for Medicaid inpatient services furnished during the Medicaid state plan rate year under review (e.g. GME, CAH, etc.)

ASH will use a single total per diem calculated from the cost report and the inpatient days extracted from PMMIS to determine the cost of providing inpatient Medicaid services. The Medicaid shortfall will be calculated for ASH for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the discussion entitled "Data on a State Plan Year Basis".

The single total per diem amount will be calculated by summing the inpatient per diem amount and the ancillary per diem amount.

The inpatient per diem amount will be found by dividing the amounts on Worksheet B Part 1 Column 25 Line 25 by the day total on Line 5 from Worksheet S-3 Column 6. Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 25, Line 25 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 6, Line 5 should have added the amount appearing on Line 26 (observation bed days).

The ancillary per diem amount will be calculated by:

1. Summing the Line and Subscript amounts for each of the Lines 37 to 63 (but excluding Subscript Lines 63.5 to 63.99) taken from Worksheet B Part 1 Column 25
2. Dividing the amount determined in step 1 above by the amount determined in step 3 below

3. Summing the Lines 5 and 17 from Worksheet S-3 Column 6

ASH will use the single total per diem calculated from the cost report and the data supplied by AHCCCS to compile the Medicaid Schedule of Costs on the OBRA Limit and CPE Schedule. The Medicaid Schedule of Costs depicts:

1. The governmentally-operated hospital specific Medicaid inpatient cost data (determined by multiplying the single total per diem by the number of inpatient Medicaid days),
2. The payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital services,
3. The Medicaid inpatient net cost data,
4. Payments made by AHCCCS including FFS and payments by health plans and program contractors
5. The amount of supplemental Medicaid payments (e.g., GME and CAH)
6. The Medicaid shortfall
7. Adjustments to the calculated Medicaid shortfall to estimate a Medicaid shortfall for a future state plan year.

Uninsured Costs

ASH will collect uninsured days and program data for the hospital's fiscal/CMS Report years that encompass the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient days and program data for medical services that would otherwise be eligible for Medicaid should be included in the calculation. Inpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days and program information provided to the state is subject to the same audit standards and procedures as the data included in the cost report.

When collecting uninsured days and program information ASH should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are

considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

The uninsured costs will be calculated for ASH for each fiscal/CMS Report year that encompasses the state plan year. The resulting uninsured costs for each fiscal/CMS Report year will be prorated to derive the state plan year uninsured costs according to the discussion entitled "Data on a state Plan Year Basis".

The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for the single inpatient routine service cost center on the cost report)
2. The amounts of payments received during the hospital's fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient hospital services. The information collected shall:
    a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,
    b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

ASH will use the total inpatient per diem calculated from the cost report (as determined for Medicaid), the uninsured days, and other program data collected by ASH to compile the Uninsured Schedule of Costs on the OBRA Limit and CPE Schedule. The Uninsured Schedule of Costs depicts:

1. The ASH specific uninsured inpatient cost data (determined by multiplying the single total per diem by the number of uninsured inpatient days),
2. The payments made by or on behalf of patients and payments made by third parties related to uninsured inpatient hospital services, and
3. The uninsured inpatient cost.
4. Adjustments to the calculated uninsured inpatient and out patient cost to estimate the uninsured inpatient and outpatient cost for a future state plan year.

The Governmentally-Operated Hospital OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit and is depicted on the OBRA Limit and CPE Schedule.

The summation of the estimated Medicaid shortfall (whether positive or negative) and the estimated uninsured costs (whether positive or negative) is the hospital's OBRA limit for a future state plan year and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

Certification

The appropriate official of ASH will sign the certification statement on the OBRA Limit and CPE Schedule. A certification statement will be signed for each of the three times the OBRA limit for the state plan year of the initial DSH payment is calculated as described below under "Reconciliation".

Reconciliation

The OBRA limit for the state plan rate year of the initial DSH payment will be computed for ASH three times:

1. The OBRA limit will be calculated in the state plan rate year of the initial DSH payment based on the cost report(s) and days and other program data for the state plan rate year two years prior to the state plan rate year of the initial DSH payment. This calculation may include an adjustment to the calculated OBRA limit of the state plan rate year two years prior to the state plan rate year of the initial DSH payment in order to estimate the OBRA limit of the state plan rate year of the initial DSH payment.
2. The OBRA limit will be recalculated when the cost report(s) for the state plan rate year of the initial DSH payment are filed. In recalculating the OBRA limit the cost data from the as-filed cost report(s) and program data (days and payments) from the actual cost reporting period(s) will be used in the calculation. This calculation may not include any adjustment to the calculated OBRA limit of the state plan rate year of the initial DSH.
3. The final calculation of ASH's OBRA limit will be performed when the cost report(s) for the state plan rate year of the initial DSH payment are finalized. In finalizing the OBRA limit the cost data from the finalized cost report(s) and program data (days and payments) from the actual cost reporting period(s) will be used in the calculation.

EXHIBIT 3 to ATTACHMENT C

AHCCCS
Disproportionate Share Hospital Payment Methodology
Pool Funding Amount for SPY 2014

This Exhibit contains the amount of funding for six pools in the Arizona DSH pool methodology.

For State Plan Year (SPY) 2008 and 2009, funding will be allocated among six pools (pools 1, 1A, 2, 2A, 3, and 4). For SPY 2010, funding will be allocated among seven pools (pools 1, 1A, 2, 2A, 3, 4, and 5). For SPY 2011, SPY 2012, SPY 2013, and 2014 the funding will be allocated among six pools (pools 1, 1A, 2, 2A, 4, and 5).

Pools 1, 1A, 2, 2A, and 3 - Non-governmentally-operated hospitals
The funding for pools 1 and 2 will be sufficient to provide an average payment amount of $6,000 for all hospitals qualifying for both of the two pools. No hospital in pools 1 or 2 will receive less than $5,000. Therefore, the amount of funding for pools 1 and 2 will be determined by multiplying the number of hospitals qualifying for pools 1 and 2 by $6,000.

The funding for pools 1A, 2A and 3 (if applicable) will be derived by subtracting the total amount allocated for pools 1 and 2 from the amount of DSH authorized by the Legislature for non-governmentally operated hospitals. Beginning SPY 2011, these remaining funds will be split with 15% for Pool 1A and 85% for Pool 2A.

- For SPY 2008, the funding for pools 1, 2, 1A, and 2A and 3 will be $26,147,700.
- For SPY 2009, the funding for pools 1, 2, 1A, and 2A and 3 will be $26,147,700.
- For SPY 2010, the funding for pools 1, 2, 1A, and 2A and 3 will be $500,000.
- For SPY 2011, the funding for pools 1, 2, 1A, and 2A will be $9,284,800.
- For SPY 2012, the funding for pools 1, 2, 1A, and 2A will be $9,284,800.
- For SPY 2013, the funding for pools 1, 2, 1A, and 2A will be $9,284,800.
- For SPY 2014, the funding for pools 1, 2, 1A, and 2A will be $9,284,800.

Pool 4 – Governmentally-operated hospitals
The funding for pool 4 is the amount authorized by the Legislature for governmentally operated hospitals.

- For SPY 2008, the funding for pool 4 is $117,914,800.
- For SPY 2009, the funding for pool 4 is $128,427,000.
- For SPY 2010, the funding for pool 4 is $132,596,900.
- For SPY 2011, the funding for pool 4 is $128,637,400.
- For SPY 2012, the funding for pool 4 is $119,784,246 - $2,404,156.73 reallocated to Pool 5 = $117,380,089.27.
- For SPY 2013, the funding for pool 4 is $118,352,300.
- For SPY 2014, the funding for pool 4 is $118,352,600.

For SPY 2009, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated and distributed to DSH-qualifying hospitals in pools 1, 1A, 2, 2A or 3 until September 30, 2011. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

For SPY 2010, funding will be reallocated first to pools 1, 1A, 2, 2A, and 3, should the state make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2009 pool allocations. For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2010 relative weights as described in the "Determination of Payment Amounts" section of this Attachment C. SPY 2010 payments made from reallocated funds will be added to the hospital's original SPY 2010 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2010, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, 3, and 5 until September 30, 2012. A determination will be made by June 30, 2012, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

For SPY 2011, funding will be reallocated first to pools 1, 1A, 2, and 2A should the state make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2011 pool allocation For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2011 relative weights as described in the "Determination of Payment Amounts" section of this Attachment C. SPY 2011 payments made from reallocated funds will be added to the hospital's original SPY 2011 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2011, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, and 5 until September 30, 2013. A determination will be made by June 30, 2013, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

For SPY 2012, funding will be reallocated first to pools 1, 1A, 2, and 2A should the state make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2012 pool allocation For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2012 relative weights as described in the "Determination of Payment Amounts" section of this Attachment C. SPY 2012 payments made from reallocated funds will be added to the hospital's original SPY 2012 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2012, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, and 5 until September 30, 2014. A determination will be made by June 30, 2014, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

For SPY 2013, funding will be reallocated first to pools 1, 1A, 2, and 2A should the state make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2013 pool allocation For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2013 relative weights as described in the "Determination of Payment Amounts" section of this Attachment C. SPY 2013 payments

made from reallocated funds will be added to the hospital's original SPY 2013 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2013, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, and 5 until September 30, 2015. A determination will be made by June 30, 2015, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

For SPY 2014, funding will be reallocated first to pools 1, 1A, 2, and 2A should the State make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2013 pool allocation For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2013 relative weights as described in the "Determination of Payment Amounts" section of this Attachment C. SPY 2013 payments made from reallocated funds will be added to the hospital's original SPY 2013 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2013, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, and 5 until September 30, 2015. A determination will be made by June 30, 2015, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

Additionally, for SPY 2010 forward, any remaining excess funding may be reallocated to pool 5. Additional DSH payments from Pool 5 are funded by transfers per IGAs. If more than one hospital has available voluntary match, the reallocation will be allocated based proportionately according to the hospital's LOM scores, subject to the lower of each hospital's remaining OBRA limit or the total computable matching fund amount designated for each hospital per the applicable IGA. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds. Any additional payments will be limited to a hospital's overall OBRA limit.

Pool 5 – Voluntary Intergovernmental Agreements
The funding for pool 5 will be provided through voluntary intergovernmental transfers to hospitals designated by political subdivisions, universities, and tribal governments. Political subdivisions, public universities, and tribal governments will notify AHCCCS of the hospitals that will be designated to receive funds and of the amount of matching funds that will be available through their intergovernmental agreements (IGAs). AHCCCS will provide CMS with a list of designated pool 5 hospitals as soon as it becomes available.

- For SPY 2010, the funding for pool 5 is $26,000,000
- For SPY 2011, the funding for Pool 5 is $16,000,000.
- For SPY 2012, the funding for Pool 5 is $25,000,000 + $2,404,156.73 reallocated from Pool 4 = $27,404,156.73.
- For SPY 2013, the funding for Pool 5 is $ is $34,178,795.
- For SPY 2014, the funding for Pool 5 is the FY 2014 Arizona DSH allotment total computable amount minus $127,637,400.

Upon reconciliation, the non-federal portion of any Pool 5 funds that has to be recouped due to changes in hospital qualification or payment limits will be returned to the local match entity. The resulting federal funds will be returned to CMS.

[To Be Placed on Public Hospital Letter Head]

State Plan Year _____

☐ Initial

☐ Final

CERTIFICATION STATEMENT
DISPROPORTIONATE SHARE HOSPITAL PAYMENT

As the of Maricopa Medical Center, I certify that:

- Maricopa Medical Center has expended local funds in an amount equal to the OBRA Limit(s) indicated below.

- The local funds were not obligated to match other federal funds for any federal program and these funds are not federal funds.

- The attached Maricopa Medical Center OBRA Limit and CPE Schedule is true, accurate and complete to the best of my knowledge and belief and the information presented thereon is either identified and supported in the Hospital's accounting system, has been supplied to me by AHCCCS, or is supported by the attached documentation. I understand that the information presented on the Schedule is subject to audit.

- Maricopa Medical Center and I understand that the Disproportionate Share Hospital Payment received by the hospital will be from Federal funds, that any overpayment of those funds to the hospital will be recovered by AHCCCS, and that any falsification or concealment of a material fact made to receive payment of those funds may be prosecuted under Federal and/or state laws.

The estimated OBRA Limit Calculation for State Plan Year _____ is $ _____.

(Another line to certify a finalized amount will be added in the future)

_____ _____
Signature of CEO or CFO Printed Name

_____ _____
Title Date

[To Be Placed on Public Hospital Letter Head]

state Plan Year __2008_____ ☐ Initial

☐ Final

CERTIFICATION STATEMENT
DISPROPORTIONATE SHARE HOSPITAL PAYMENT

As the of Arizona state Hospital, I certify that:

- Arizona state Hospital has expended state funds in an amount equal to the OBRA Limit(s) indicated below.

- The state funds were not obligated to match other federal funds for any federal program and these funds are not federal funds.

- The attached Arizona state Hospital OBRA Limit and CPE Schedule is true, accurate and complete to the best of my knowledge and belief and the information presented thereon is either identified and supported in the Hospital's accounting system, has been supplied to me by AHCCCS, or is supported by the attached documentation. I understand that the information presented on the Schedule is subject to audit.

- Arizona state Hospital and I understand that the Disproportionate Share Hospital Payment received by the hospital will be from Federal funds, that any overpayment of those funds to the hospital will be recovered by AHCCCS, and that any falsification or concealment of a material fact made to receive payment of those funds may be prosecuted under Federal and/or state laws.

The estimated OBRA Limit Calculation for state Plan Year _____ is $ _____.

(Another line to certify a finalized amount will be added in the future)

_____ _____
Signature of CEO or CFO Printed Name

_____ _____
Title Date

Spreadsheets – Excel Files

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Disabled and Elderly Health Programs Group
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

Letter Summary

This letter clarifies some methods by which HCBS waivers under section 1915(c) may aid in the transitioning of individuals from institutional settings to their own home in the community through coverage of one-time transitional expenses. This clarification was promised in the HHS New Freedom Report to the President.

SMDL #02-008

May 9, 2002

Dear State Medicaid Director:

Medicaid home and community-based services (HCBS) waivers are the statutory alternative to institutional care. Many states have found in HCBS waivers a cost-effective means to implement a comprehensive plan to provide services in the most integrated setting appropriate to the needs of individuals with disabilities.

However, individuals seeking a return to the community from institutions are faced with many one-time expenses, and many states are unclear about the extent to which waivers cover transition costs. Examples of those expenses include the cost of furnishing an apartment, the expense of security deposits, utility set-up fees, etc. Other states have expressed interest in having the waivers pay for apartment/housing rent. This letter is designed to answer such questions.

Federal funding under Medicaid HCBS waivers is not available to cover the cost of rent. States may offset rental expenses from state-only funds that augment federal HCBS resources, but federal financial participation (FFP) for such a purpose is not available for any apartment/housing rental expenses.

As the HHS Report for the President's *New Freedom Initiative* stated, however, states may secure federal matching funds under HCBS waivers for one-time, set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community, such as security deposits, that do not constitute payment for housing rent.

States may pay the reasonable costs of *community transition services*, including some or all of the following components:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential furnishings and moving expenses required to occupy and use a community domicile;
- Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating);
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

By reasonable costs, we mean necessary expenses in the judgment of the state for an individual to establish his or her basic living arrangement. For example, essential furnishings in the above context would refer to necessary items for an individual to establish his or her basic living arrangement, such a bed, a table, chairs, window blinds, eating utensils, and food preparation items. We would not consider essential furnishings to include diversional or recreational items such as televisions, cable TV access or VCRs.

States that choose to include community transition services in their HCBS waivers must demonstrate that this service, in combination with other services furnished under the waiver, would be cost-neutral to the Medicaid program. (In the streamlined HCBS waiver format, this cost neutrality is demonstrated in appendix G.) To be eligible for FFP, the service must be included in the individual's written plan of care (service plan) and fit within the service definitions established by the state.

For more than three years CMS has awarded "Nursing Facility Transition Grants" to states in which transition costs have been paid from grant funds. Those states found that coverage of transition expenses has been manageable, cost-effective and has greatly facilitated the expeditious integration of individuals into their communities from prior institutional living arrangements. Contacts and other relevant information about those states may be found on the CMS website.

Any questions concerning this letter may be referred to Mary Jean Duckett at (410) 786-3294.

Sincerely,

/s/

Dennis G. Smith
Director

cc:

CMS Regional Administrators
CMS Associate Regional Administrators
for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials

Jim Frogue
Acting Director, Health and Human Services Task Force
American Legislative Exchange Council

Trudi Matthews
Senior Health Policy Analyst
Council of State Governments

Attachment D
REIMBURSEMENT FOR CRITICAL ACCESS HOSPITALS

Subject to the availability of state funds, beginning May 1, 2002, supplemental payments will be made to non-I.H.S., non-638 facility in-state hospitals, certified by Medicare as Critical Access Hospitals (CAHs) under 42 CFR 485, Subpart F and 42CFR 440.170(g). These supplemental CAH payments shall be made in addition to the other payments described in Attachments 4.19-A (inpatient hospital) and 4.19-B (outpatient hospital). Supplemental payments shall be made based on each CAH designated hospital's percentage of total inpatient and outpatient Title XIX reimbursement paid relative to other CAH designated hospitals for the time period from July 1 through June 30 of the previous year.

AHCCCS will allocate the amount available through legislative appropriation in the following manner:

(1) Gather all adjudicated claims/encounters with dates of service from July 1 through June 30 of the prior year for each CAH-designated hospital.

(2) Sum the AHCCCS payments for inpatient and outpatient services for the year to establish a hospital-specific hospital paid amount.

(3) Total all AHCCCS payments for inpatient and outpatient services for the year to establish a total paid amount.

(4) Divide the hospital paid amount by the total paid amount to establish the hospital's utilization percentage.

(5) Divide the annual CAH appropriation by twelve to get the monthly CAH allocation.

(6) Multiply each hospital's monthly relative utilization by the monthly CAH allocation to establish each hospital's monthly payment.

Funding will be distributed based on the number of CAH-designated hospitals in each month and their Medicaid utilization. Because there may be a different number of CAH-designated hospitals each month, the hospital-specific weightings and payments may fluctuate from month to month. The calculations will be computed monthly and the distribution of the CAH dollars to the CAH-designated hospitals will be made twice a year.

Attachment E
Safety Net Care Pool Claiming Protocol

In accordance with the special terms and conditions (STC) Section VI, this Attachment E serves as the claiming protocol for Arizona's Safety Net Care Pool (SNCP) uncompensated care payments to hospitals listed in Exhibit 1 of Attachment E that were part of the SNCP through December 31, 2013 and for Phoenix Children's Hospital (PCH) only through December 31, 2015. The protocol provides for the computation of the uncompensated care cost limit for each provider type that was authorized to receive uncompensated care payments in accordance with Section VI through December 31, 2013 (Exhibit 1 of Attachment E) and for Phoenix Children's Hospital through December 31, 2015. For each demonstration Year (DY), aggregate uncompensated care payments will be a distribution of the SNCP pool established in Section VI for each DY, and payments to each individual provider cannot exceed the uncompensated care cost limit as determined by this cost claiming protocol for each DY.

Generally, the uncompensated care cost limit is determined based on each provider's uncompensated costs pertaining to Section 1905(a) medical services furnished to Medicaid eligible and uninsured individuals. Allowable patient care costs, consistent with Medicare and Medicaid cost principles and OMB Circular A-87, A-121, and A-122 where applicable, are identified using a CMS-approved cost report. Such costs are apportioned to the eligible Medicaid and uninsured services and then offset by all applicable revenues. SNCP payments made based on interim computation of the uncompensated care cost limit (using prior period cost data) must be subsequently limited to a recomputation of the uncompensated care costs using the provider's as-filed and audited cost reports for the actual service period covered by the DY.

For those providers eligible for SNCP payments up to December 31, 2013, if a provider was eligible under both section A-D (Safety Net Hospital Systems) and under section E (City of Phoenix Hospitals) of Exhibit 1 of this Attachment E, payments to the provider was to first be credited against the previous Phoenix Hospital Limit, and any remaining eligible uncompensated costs for that provider was to be credited against the previous Safety Net Hospital System Limit. Under no circumstances will total SNCP payments to PCH (eligible up to December 31, 2015) and any other provider (eligible up to December 31, 2013), including payments credited against the PCH limit in STC paragraph 25(c), the previous Phoenix Hospital Limit, and the previous Safety Net Hospital Limit as well as any disproportionate share hospital payments or other supplemental payments, exceed the provider's uncompensated costs, as described in paragraph 25 and in this Attachment E. In the instance that a provider eligible up to December 31, 2013 first received an allocation from the Phoenix Hospital Limit pool, the prior period uncompensated care cost data used as the allocation basis from the Safety Net Hospital System Limit pool was that provider's prior period uncompensated care cost reduced by the Phoenix Hospital Limit pool distribution already made to the provider.

<u>Hospital Inpatient and Outpatient Uncompensated Care Costs</u>

To be eligible for Federal financial participation (FFP), SNCP uncompensated care payments to PCH (eligible up to December 31, 2015) and any other hospital (eligible up to December 31, 2013) cannot exceed the uncompensated care costs as computed by the following steps:

Interim Computation of Uncompensated Care Costs

SNCP uncompensated care payments must be made to PCH on or before December 31, 2015. Each DY's SNCP will be distributed based on the provider's projected uncompensated care subject to the PCH Limit described in STC paragraph 25(c), to the extent that sufficient local matching funds are available. This interim computation of uncompensated care costs will be used as the basis for SNCP distribution and will also serve as the uncompensated care cost limit for SNCP payments made to the provider in each demonstration year.

1. The process of determining the hospital's interim uncompensated care cost limit begins with the use of each hospital's CMS 2552(s) filed with its Medicare contractor. The most recent CMS 2552 filed with the hospital's Medicare contractor will be utilized.
2. Per diem amount for each hospital routine cost center is computed by dividing:
   - The individual amounts on Worksheet B, Part I, Column 25, Lines (and where applicable subscripted lines) 25 to 33 of CMS 2552-96 or Worksheet B, Part I, Column 24, Lines (and where applicable subscripted lines) 30-43 of CMS 2552-10

   by- The corresponding day totals on Lines (and where applicable subscripted lines) 5 through 11 and Line 14 (for inpatient hospital subproviders) from Worksheet S-3, Part I, Column 6 of CMS 2552-96 or Lines 7 through 13 and Lines 16-18 (for inpatient hospital subproviders) from Worksheet S-3, Part I, Column 8 of CMS 2552-10 consistent with the instructions below regarding observation bed days.

Note when computing the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 24, Line 25 of CMS 2552-96 (Worksheet B, Part I, Column 25, Line 30 of CMS 2552-10) should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 (for swing bed and private room differential adjustments, respectively) of CMS 2552-96 and CMS 2552-10, and the amount on Worksheet S-3, Part I, Column 6, Line 5 of CMS 2552-96 (Worksheet S-3, Part I, Column 8, Line 7 of CMS 2552-10) should have added the amount appearing on Line 26 (observation bed days) of CMS 2552-96 (Line 28 of CMS 2552-10).

Ancillary ratio of cost-to-charges (RCC) for each hospital ancillary cost center is computed by dividing:

- The individual line and subscript amounts for each of the Lines 37 to 63, taken from Worksheet B, Part I, Column 25 of CMS 2552-96 or the individual line and subscript amounts for each of the Lines 50 to 93, taken from Worksheet B, Part I, Column 24 of CMS 2552-10.
- by
- The individual line and subscript amounts for each of the Lines 37 to 63, taken from Worksheet C, Part I, Column 8 of CMS 2552-96 or the individual line and subscript amounts for each of the Lines 50 to 93, taken from Worksheet C, Part I, Column 8 of CMS 2552-10.

(Note that the above cost report references are based on the CMS-2552-96 and CMS 2552-10. For later versions of the CMS-2552, the equivalent worksheets, columns and lines should be identified.)

3. For each hospital routine cost center, the per diem amount computed in Step #2 is applied to the number of Medicaid and uninsured hospital inpatient days for the service period as defined in Step #1. Only hospital inpatient days are to be included; all days pertaining to long term care units or any other non-hospital units must be excluded. The number of Medicaid and uninsured hospital inpatient days must be derived from auditable sources, including the state's PMMIS, managed care encounter data, and provider patient accounting records. Hospital Medicaid and uninsured days are identified for each hospital routine cost center. The result is the facility's Medicaid and uninsured hospital routine cost.

For each hospital ancillary cost center, the RCC computed in Step #2 is applied to the Medicaid and uninsured hospital inpatient and hospital outpatient ancillary charges for the service period as defined in Step #1. Only hospital ancillary charges are to be included; all charges pertaining to non-hospital units, including Rural Health Clinics, Federally Qualified Health Centers, and clinics that are not recognized as hospital outpatient departments, must be excluded. The Medicaid and uninsured hospital ancillary charges must be derived from auditable sources, including the state's PMMIS, managed care encounter data, and provider patient accounting records. Hospital Medicaid and uninsured ancillary charges are identified for each hospital ancillary cost center. The result is the facility's Medicaid and uninsured hospital inpatient and hospital outpatient ancillary cost.

4. The Medicaid and uninsured costs computed in Step #3 will be offset by all revenues received by the hospital for the Medicaid and uninsured hospital inpatient and hospital outpatient services, including but not limited to Medicaid FFS and supplemental payments made by AHCCCS; Medicaid payments made by health plans and program contractors; payments made by or on behalf of patients; payments made by third parties; and any other payments received by for uninsured services that are not excluded from offset under Section 1923(g)(1)(A) of the Social Security Act as state-only or local-only indigent care program payments.

5. The computed Medicaid and uninsured uncompensated care costs based on a prior period may be inflated to the current period using CMS market basket. Furthermore, the state may apply trending factors to account for changes in utilization (e.g., due to changes in Medicaid eligibility criteria) and Medicaid payment rates to ensure that interim uncompensated care costs approximate final uncompensated care costs for the current service period as closely as possible. Such trending factors must account for both increases and decreases affecting a provider's uncompensated care costs.

6. The hospital's Medicaid and uninsured costs must be further adjusted to remove costs related to non-emergency services furnished to unqualified aliens. For this purpose, the hospital's uncompensated care costs will be reduced by 12.88% to the extent that such unqualified alien non-emergency service costs are not fully reimbursed by DSH dollars.

7. For any Phoenix High Uncompensated Care Hospital with a hospital-based inpatient facility located outside of Phoenix, the hospital's Medicaid and uninsured costs will be further adjusted to remove costs related to the non-Phoenix facility. For this purpose, the costs will be adjusted by an estimate of the percentage of costs related to the Phoenix facility. This percentage will be calculated as the ratio of Medicaid revenues of the Phoenix facility to total Medicaid revenues for the Phoenix and non-Phoenix facilities.

8. For SNCP uncompensated care payments, the state must ensure that the payments made to hospitals are accounted for in the facility's disproportionate share hospital (DSH) OBRA 93 hospital-specific limit. There cannot be any duplication of payments for the same hospital uncompensated care costs under the SNCP and under DSH.

9. The interim computation of hospital uncompensated care cost limit as described above uses the same prior period cost report and other relevant data as that used by the state in its initial OBRA 93 hospital-specific limit computation for DSH payments for the current DSH state Plan Rate Year.

(Note that interim payments for other hospitals eligible up to December 31, 2013 were made under the prior version (prior to the December 26, 2013 amendment to the STCs) of this SNCP protocol. Those previously-made interim payments are subject to the reconciliations steps that follow.)

Interim Reconciliation

Each hospital's uncompensated care costs must be recomputed based on the hospital's as-filed cost report for the actual service period. The cost report is filed with the Medicare contractor five months after the close of the cost reporting period. SNCP uncompensated care payments made to the hospital for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual hospital's uncompensated care cost limit, the overpayment will be recouped from the hospital, and the federal share will be properly credited to the federal government.

The interim reconciliation follows the same computation as outlined above in the Interim Computation of Uncompensated Care Costs steps, except that the per diems and RCCs, Medicaid and uninsured days and charges, and payment offset amounts used will pertain to the actual service period (rather than the prior period). Per diems and RCCs will be derived from the as-filed cost report; and Medicaid and uninsured days, charges and payments will be derived from the latest available auditable data for the service period. No trending factor will be applied. The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens. The state must ensure that there is no duplication of payments for the same hospital uncompensated care costs under the SNCP and under DSH; SNCP payments must be accounted for in the hospital's OBRA 93 hospital-specific limit.

A hospital's uncompensated care cost limit is determined for the twelve month period in each DY, except for 1) for PCH in DY 5 in which the uncompensated care cost limit is computed for

the three month period ending December 31, 2015 and 2) for all other hospitals in DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013.. Where a hospital's cost reporting period does not coincide with the DY (or partial DY in DY3 or DY 5), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY). This is consistent with the methodology for the computation of the OBRA 93 hospital-specific limit for a given DSH State plan rate year.

The interim reconciliation described above will be performed and completed within six months after the filing of the hospital Medicare cost report(s).

Final Reconciliation

Each hospital's uncompensated care costs must be recomputed based on the hospital's audited cost report for the actual service period. The cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. SNCP uncompensated care payments made to the hospital for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual hospital's uncompensated care cost limit, the overpayment will be recouped from the hospital, and the federal share will be properly credited to the federal government.

The final reconciliation follows the same computation as outlined above in the Interim Computation of Uncompensated Care Costs steps, except that the per diems and RCCs, Medicaid and uninsured days and charges, and payment offset amounts used will pertain to the actual service period (rather than the prior period). Per diems and RCCS will be derived from the audited cost report, and Medicaid and uninsured days, charges and payments will be updated with the latest available auditable data for the service period. No trending factor will be applied. The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens. The state must ensure that there is no duplication of payments for the same hospital uncompensated care costs under the SNCP and under DSH; SNCP payments must be accounted for in the hospital's OBRA 93 hospital-specific limit.

A hospital's uncompensated care cost limit is determined for the twelve month period in each DY, except 1) for PCH in DY 5 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2015, and 2) for all other hospitals in DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a hospital's cost reporting period does not coincide with the DY (or partial DY in DY3 or DY 5), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY). This is consistent with the methodology for the computation of the OBRA 93 hospital-specific limit for a given DSH State Plan Rate Year.

The final reconciliation described above will be performed and completed within six months after the audited hospital Medicare cost report(s) are made available.

The final computation of hospital uncompensated care cost limit as described above uses the same final cost report and other relevant data as that used by the state in its final OBRA 93 hospital-specific limit computation for DSH payments for the given DSH State Plan Rate Year.

Federally Qualified Health Center Lookalike (FQHC-LA) Uncompensated Care Costs

(Note that the FQHC-LA steps in this section are not applicable to PCH but are retained here as references for reconciliation purposes for payments made for other providers who were eligible up to December 31, 2013.)

To be eligible for Federal financial participation (FFP), SNCP uncompensated care payments to each individual FQHC-LA cannot exceed the uncompensated care cost limit as computed by the following steps:

Interim Computation of Uncompensated Care Costs

SNCP uncompensated care payments will be made to eligible providers and claimed for FFP in quarterly installments per DY. Each DY's SNCP will be distributed based on the provider's proportionate share of projected uncompensated care, to the extent that sufficient local matching funds are available. This interim computation of uncompensated care costs will be used as the basis for SNCP distribution and will also serve as the uncompensated care cost limit for SNCP payments made to the provider in each demonstration year.

1. The process of determining the FQHC-LA's interim uncompensated care cost limit begins with the use of each clinic's most recently available average cost per visit used for Medicaid reimbursement, as computed under the FQHC Alternative Payment Methodology in the Arizona State plan Attachment 4.19-B.

The average cost per visit is derived from FQHC-LA cost reports filed with AHCCCS. (The State plan provides that this average cost per visit is computed based on costs and visits for two consecutive cost reporting periods.) The State must ensure that the FQHC-LA cost report accounts for only allowable costs related to FQHC health care services, including staff and other healthcare costs and allocable overhead; removes any costs related to non-FQHC services and any overhead allocable to non-reimbursable activities; allows only for costs that are consistent with Medicare and Medicaid cost principles and applicable OMB Circulars; and defines a visit consistent with the State plan definition of an FQHC visit.

2. The average cost per visit is multiplied by the number of uninsured visits pertaining to the most recently available cost reporting period. The number of uninsured FQHC-LA visits must be derived from auditable sources. The result is the facility's uninsured cost.

Note that for interim computation of uncompensated care costs, Medicaid visits are not included, as these Medicaid visits are reimbursed at the average cost per visit being used to estimate current period actual cost per visit.

3. The uninsured costs computed in Step #2 will be offset by all revenues received by the FQHC-LA for the uninsured services, including but not limited to payments made by or on behalf of patients and any other payments received for uninsured services including applicable grants.

5. The average cost per visit has already been trended to the current period. However, the State can apply trending factors to account for known changes in uninsured utilization to ensure that interim uncompensated care costs approximate final uncompensated care costs for the current service period as closely as possible. Such trending factors must account for both increases and decreases affecting a provider's uncompensated care costs.

6. The FQHC-LA's uninsured costs must be further adjusted to remove costs related to non-emergency services furnished to unqualified aliens. For this purpose, the clinic's uncompensated care costs will be reduced by 12.88.

Interim Reconciliation

Each FQHC-LA's uncompensated care costs must be recomputed based on the actual as-filed cost report for the actual service period. The cost report is filed with AHCCCS covering the federal fiscal year (ending September 30) by April of the following year. SNCP uncompensated care payments made to the FQHC-LA for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual clinic's uncompensated care cost limit, the overpayment will be recouped from the clinic, and the federal share will be properly credited to the federal government.

The interim reconciliation follows the same computation as outlined above in the Interim Computation of Uncompensated Care Costs steps, except that:

- The cost per visit is computed based on allowable FQHC-LA cost and total visits pertaining to the actual service period cost report.
- Both Medicaid visits and uninsured visits furnished during the service period are applied to the actual cost per visit to determine the clinic's Medicaid and uninsured costs. Medicaid and uninsured visits must be derived from auditable sources, including the State's PMMIS, managed care encounter data, and provider patient accounting records.
- Both Medicaid and uninsured revenues, applicable to actual service period and derived from auditable sources, are offset against Medicaid and uninsured costs to arrive at the clinic's uncompensated care costs.
- No trending factor will be applied.

The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens.

An FQHC-LA's uncompensated care cost limit is determined for the twelve month period in each DY, except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a clinic's cost reporting period does not coincide with the DY (or partial DY in DY3), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY).

The interim reconciliation described above will be performed and completed within six months after the filing of the FQHC-LA cost report(s).

Final Reconciliation

Each FQHC-LA's uncompensated care costs must be recomputed based on the actual audited cost report for the actual service period. The cost report is audited to ensure costs are allowable consistent with Medicare and Medicaid cost principles and applicable OMB Circulars; and that FQHC services and visits are recognized consistent with the Medicaid State plan. SNCP uncompensated care payments made to the FQHC-LA for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual clinic's uncompensated care cost limit, the overpayment will be recouped from the clinic, and the federal share will be properly credited to the federal government.

The final reconciliation follows the same computation as outlined above in the Interim Computation of Uncompensated Care Costs steps, except that:

- The cost per visit is computed based on audited allowable FQHC-LA cost and total visits pertaining to the actual service period cost report.
- Both Medicaid visits and uninsured visits furnished during the service period are applied to the audited cost per visit to determine the clinic's Medicaid and uninsured costs. Medicaid and uninsured visits must be derived from the latest available auditable sources, including the State's PMMIS, managed care encounter data, and provider patient accounting records.
- Both Medicaid and uninsured revenues, applicable to actual service period and derived from the latest available auditable sources, are offset against Medicaid and uninsured costs to arrive at the clinic's uncompensated care costs.
- No trending factor will be applied.

The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens.

An FQHC-LA's uncompensated care cost limit is determined for the twelve month period in each DY, except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a clinic's cost reporting period does not coincide with the DY (or partial DY in DY3), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY).
The final reconciliation described above will be performed and completed within eighteen months after the filing of FQHC-LA cost report(s).

Physician Professional Service Uncompensated Care Costs

To be eligible for Federal financial participation (FFP), SNCP uncompensated care payments to each provider cannot exceed the uncompensated care costs as computed by the following steps. The eligible providers include hospitals that employ and contract for physician services and incur physician professional service costs (whether the professional services are billed by the hospital or by the physicians) and physician practice groups that provide physician services in hospital and other settings and incur the physician professional service costs directly.

Interim Computation of Uncompensated Care Costs

SNCP uncompensated care payments will be made to PCH on or before December 31, 2015. Each DY's SNCP will be distributed based on the provider's projected uncompensated care subject to the PCH limit as described in STC paragraph 25(c), to the extent that sufficient local matching funds are available. This interim computation of uncompensated care costs will be used as the basis for SNCP distribution and will also serve as the uncompensated care cost limit for SNCP payments made to the provider in each demonstration year.

1. Steps for PCH incurring physician professional service costs

a. The professional component of physician costs are identified from the hospital's CMS 2552 cost report Worksheet A-8-2, Column 4. The most recent CMS 2552 filed with the hospital's Medicare contractor will be utilized. These professional costs are:

1. Limited to allowable and auditable physician compensations that have been incurred by the hospital;
2. For the professional, direct patient care furnished by the hospital's physicians;
3. Identified as professional costs on Worksheet A-8-2, Column 4 of the cost report of the hospital claiming payment (or, for registry physicians only, Worksheet A-8, if the physician professional compensation cost is not reported by the hospital on Worksheet A-8-2 because the registry physicians are contracted solely for direct patient care activities (i.e., no administrative, teaching, research, or any other provider component or non-patient care activities). Registry physicians are excluded from the cost determination for hospitals eligible for payment pursuant to Section D of Attachment J.);
4. Supported by a time study, accepted by Medicare for Worksheet A-8-2 reporting purposes, that identified the professional, direct patient care activities of the physicians (not applicable to registry physicians discussed above); and
5. Removed from hospital costs on Worksheet A-8.

b. The professional costs on Worksheet A-8-2, Column 4 (or Worksheet A-8 for registry physicians) are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare and Medicaid cost principles and applicable OMB Circulars. However, Medicare physician reasonable compensation equivalents are not applied for physician professional cost determination purposes. The professional costs are further subject to offsets to account for any applicable non-patient care revenues that were not previously offset or

accounted for by the application of time study. The resulting costs represent the net allowable professional service costs incurred by the hospitals.

c. Reimbursement for other professional practitioner service costs that have also been identified and removed from hospital costs on the Medicare cost report. The practitioner types to be included are:

Certified Registered Nurse Anesthetists
Nurse Practitioners
Physician Assistants
Dentists
Certified Nurse Midwives
Clinical Social Workers
Clinical Psychologists
Optometrists

d. To the extent these practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from PCH costs through an A-8 adjustment on the Medi-Cal cost report, these costs may be recognized if they meet the following criteria:

- the practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medicaid separate from PCH services;
- for all non physician practitioners there must be an identifiable and auditable data source by practitioner type;
- a CMS-approved time study must be employed to allocate practitioner compensation between clinical and non-clinical costs; and
- the clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with Medicare cost principles and offset of applicable non-patient care revenues that were not previously offset or accounted for by the application of CMS-approved time study.

The resulting net clinical non-physician practitioner compensation costs are allowable costs. The compensation costs for each non-physician practitioner type are identified separately.

e. Professional costs incurred for freestanding clinics (clinics that are not recognized as hospital outpatient departments on the 2552) are not included in this protocol.

f. The hospital may additionally include physician support staff compensation, data processing, and patient accounting costs as physician-related costs to the extent that:

1. These costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician professional services;
2. They are directly identified on ws A-8 as adjustments to hospital costs;
3. They are otherwise allowable and auditable provider costs; and

4. They are further adjusted for any non-patient-care activities such as research based on physician time studies.

If these are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be stepped down to the physician cost centers based on the accumulated physician professional compensation costs. Other than the physician and non-physician practitioner compensation costs and the A-8 physician-related adjustments discussed above, no other costs are allowed.

g. Total billed professional charges by cost center related to physician services are identified from auditable provider records. Similarly, for each non-physician practitioner type, the total billed professional charges are identified from provider records. Charges must be identified for all professional services for which PCH incurred its cost (whether salaried or contracted). Where the professional services are not billed by PCH directly, PCH must obtain those professional charges from the billing party.

h. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-f of subsection 1 by the total billed professional charges for each cost center as established in paragraph g of subsection 1. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each practitioner type as established in paragraphs a-f of subsection 1 by the total billed professional charges for each practitioner type as established in paragraph g of subsection 1.

i. The total professional charges for each cost center related to eligible Medicaid and uninsured physician services are identified using auditable records. PCH must map the charges to their cost centers. Each charge may only be mapped to one cost center to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period defined by paragraph a of subsection 1.

For each non-physician practitioner type, the eligible Medicaid and uninsured professional charges are identified using auditable records. The hospital must map the charges to non-physician practitioner type. Each charge may only be mapped to one practitioner type to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

Auditable records include the state's PMMIS, managed care encounter data, and hospital records.

j. The total Medicaid and uninsured costs related to physician practitioner professional services are determined for each cost center by multiplying total Medicaid and uninsured charges as established in paragraph i of subsection 1 by the respective cost to charge ratio for the cost center as established in paragraph h of subsection 1.

For each non-physician practitioner type, the total Medicaid and uninsured costs related to non-physician practitioner professional services are determined by multiplying total Medicaid and uninsured charges as established in paragraph i of subsection 1 by the respective cost to charge ratios as established in paragraph h of subsection 1.

k. The total Medicaid and uninsured uncompensated care costs are determined by subtracting all revenues received for the Medicaid and uninsured physician/practitioner services from the Medicaid and uninsured costs as established in paragraph j of subsection 1. The revenues are derived from auditable records. All revenues received for the Medicaid and uninsured professional services will be offset against the computed cost; these revenues include but are not limited to all Medicaid payments from the state or its program contractors, payments from or on behalf of patients, and payments from any other third party payer. The total professional service uncompensated care costs as computed above should be reduced by 12.88% to account for non-emergency care furnished to unqualified aliens.

l. The Medicaid and uninsured physician/practitioner amount computed in paragraph k of subsection 1 above can be trended to current period to account for cost inflation based on CMS market basket update factor. Furthermore, the state may apply trending factors to account for changes in utilization (e.g., due to changes in Medicaid eligibility criteria) and Medicaid payment rates to ensure that interim uncompensated care costs approximate final uncompensated care costs for the current service period as closely as possible. Such trending factors must account for both increases and decreases affecting a provider's uncompensated care costs.

2. Steps for physician practice group incurring physician professional service costs (this step #2 and its subparagraphs do not apply to PCH and only applied to interim payments made for physician practice group up to December 31, 2013, but will be retained here as reference for reconciliation purposes)

a. The physician compensation costs are identified from the physician practice group's trial balance or other auditable financial records and reported on a CMS-approved physician practice group cost report for the latest available cost reporting period. These professional compensation costs are limited to identifiable and auditable costs that have been incurred by the physician practice group for the professional patient care furnished in all applicable sites of service, including services rendered at non-hospital physician office sites operated by the practice groups and at sites not owned or operated by the practice group for which the practice group bills for and collects payment.

The physician compensation costs are reduced by National Institute of Health (NIH) grants to the extent the research activities component is not removed via physician time studies.

b. On the physician practice group cost report, these physician compensation costs net of NIH grants as applicable, reported by cost centers/departments, are then allocated between clinical and non-clinical activities using a CMS-approved time-study tool. The result of the CMS-approved time study tool is the physician compensation costs pertaining only to clinical, patient care activities. SNCP dollars allocated for physician professional service costs incurred by a physician practice group cannot be claimed for FFP until such a time study tool is approved by CMS. For DYs 1-3, a CMS-approved benchmark RVU methodology can be used in lieu of a CMS-approved time study. The benchmark RVU methodology will determine a direct patient care percentage for each cost center/department based on a ratio of actual direct patient care work RVUs for the period to benchmark RVUs for the department which would have been

produced if the physicians were working 100% in direct patient care. Where the physician's compensation is first incurred by another entity and the physician practice group then reimburses the entity for the physician direct patient care costs, the physician clinical costs recognized is the lower of 1) the total physician's total compensation multiplied by the direct patient care percentage; or 2) the amount incurred by the physician practice group in paying for physician direct patient care costs.

c. The physician clinical costs are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare and Medicaid cost principles and applicable OMB Circulars. However, Medicare physician reasonable compensation equivalents are not applied for professional cost determination purposes. The professional costs are further subject to offsets to account for any applicable non-patient care revenues that were not previously offset or accounted for by the application of time study. The resulting costs represent the net allowable professional service costs incurred by the physician practice group.

d. The above physician compensation costs must not be duplicative of any costs claimed on PCH cost reports.

e. Additional costs that can be recognized as professional direct costs are costs for non-capitalized medical supplies and equipment used in the furnishing of direct patient care.

f. Indirect costs incurred by the physician practice group and allocable to the physicians' direct patient care will be also recognized. Where a cognizant agency-approved indirect cost rate is available for the physician practice group, the indirect rate will be applied to the total direct cost, calculated above, based on each center/department's physician compensation costs determined to be eligible for Medicaid reimbursement and identifiable medical supply/equipment costs to arrive at total allowable costs for each cost center If an indirect rate is not available, then actual indirect costs incurred will be identified using auditable financial records including the general ledger. The indirect costs claimed must be allowable under Medicare and Medicaid cost principles and applicable OMB Circulars. The indirect costs may include indirect costs incurred by the physician practice group (including physician group practice clinical support staff salaries and benefits, physician department administrative and office staff salaries and benefits, and other non-salary costs incurred by each physician department) or by its home office as reported on a Medicare-approved home office cost statement and allocated in the cost statement to the physician practice group by approved Medicare allocation methodology. Adjustments to the indirect costs must be made to arrive at allowable indirect costs consistent with the applicable cost principles. The allowable indirect costs must either then be directly assigned or allocated (using accumulated costs as an allocation basis) to each physician department/cost center of the physician practice group.

To determine the additional costs that are allocable to direct patient care, the direct patient care percentage from step 2.b above (resulting from the time study or the time study proxy tool) will be applied the costs identified in steps 2.e and 2.f above at a departmental/cost center level.

g. Total billed professional charges by cost center related to physician services are identified from auditable provider records. Charges must be identified for all professional services for which the physician practice group incurred its cost.

h. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-f of subsection 2 by the total billed professional charges for each cost center as established in paragraph g of subsection 2.

i. The total professional charges for each cost center related to eligible Medicaid and uninsured physician services are identified using auditable records. The physician practice group must map the claims to their cost centers. Each charge must be mapped to only one cost center to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

Auditable records include the state's PMMIS, managed care encounter data, and hospital records.

j. The total Medicaid and uninsured costs related to physician practitioner professional services are determined for each cost center by multiplying total Medicaid and uninsured charges as established in paragraph i of subsection 2 by the respective cost to charge ratio for the cost center as established in paragraph h of subsection 2.

k. The total Medicaid and uninsured professional service uncompensated care costs are determined by subtracting all revenues received for Medicaid and uninsured physician practitioner services from the Medicaid and uninsured costs as established in paragraph j of subsection 2. The revenues are derived from auditable records. All revenues received for the Medicaid and uninsured professional services will be offset against the computed cost; these revenues include but are not limited to all Medicaid payments from the state or its program contractors, payments from or on behalf of patients, and payments from any other third party payer. The total professional service uncompensated care costs as computed above should be reduced by 12.88% to account for non-emergency care furnished to unqualified aliens.

l. The uninsured physician amount computed in paragraph k above can be trended to current year to account for cost inflation based on CMS market basket update factor. Furthermore, the state can apply trending factors to account for changes in utilization (e.g., due to changes in Medicaid eligibility criteria) and Medicaid payment rates to ensure that interim uncompensated care costs approximate final uncompensated care costs for the current service period as closely as possible. Such trending factors must account for both increases and decreases affecting a provider's uncompensated care costs.

(Note that the above cost report references are based on the CMS-2552-96 and CMS 2552-10. For later versions of the CMS-2552, the equivalent worksheets and columns should be identified.)

(Note that interim payments for providers other than PCH incurring physician professional costs eligible up to December 31, 2013 were made under the prior version of this SNCP protocol. Those previously-made interim payments are subject to the reconciliations steps that follow.)

Interim Reconciliation

Each hospital's or physician practice group's uncompensated care costs must be recomputed based on the as-filed cost report for the actual service period. The hospital cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The physician practice group cost report is filed with the state also five months after the close of the cost reporting period. SNCP uncompensated care payments made to the hospital or the physician practice group for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual hospital's or physician practice group's uncompensated care cost limit, the overpayment will be recouped, and the federal share will be properly credited to the federal government.

The interim reconciliation follows the same computation as outlined above in the Interim Computation of Uncompensated Care Costs steps, except that the RCCs, Medicaid and uninsured charges, payment offset amounts and any other relevant statistics such as time study or time study proxy data used will pertain to the actual service period (rather than the prior period). RCCs will be derived from the as-filed cost report; and Medicaid and uninsured charges and payments will be derived from the latest available auditable data for the service period. No trending factor will be applied. The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens.

Even for those particular hospitals who were previously allowed to use hospital departmental charges for interim payment purposes, physician professional charges must be used in the computation of uncompensated cost limit in the Interim Reconciliation here and the Final Reconciliation below.

A hospital's or physician practice group's uncompensated care cost limit is determined for the twelve month period in each DY, except for 1) PCH in DY 5 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2015, and 2) for all other providers in DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a hospital's or physician practice group's cost reporting period does not coincide with the DY (or partial DY in DY3 or DY5), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY).

The interim reconciliation described above will be performed and completed within six months after the filing of the cost report(s).

Final Reconciliation

Each hospital's or physician practice group's uncompensated care costs must be recomputed based on the audited cost report for the actual service period. The hospital cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. The physician practice group's cost report is also audited to ensure costs are allowable consistent with Medicare and Medicaid cost principles and applicable OMB Circulars. SNCP uncompensated care payments made to the hospital or physician practice group for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual hospital's or physician practice group's uncompensated care cost limit, the overpayment will be recouped, and the federal share will be properly credited to the federal government.

The final reconciliation follows the same computation as outlined above in the Interim Computation of Uncompensated Care Costs steps, except that the RCCs, Medicaid and uninsured charges, payment offset amounts, and other relevant statistics such as time study or time study proxy data used will pertain to the actual service period (rather than the prior period). RCCs will be derived from the audited cost report, and Medicaid and uninsured charges and payments will be updated with the latest available auditable data for the service period. No trending factor will be applied. The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens.

Even for those particular hospitals who were previously allowed to use hospital departmental charges for interim payment purposes, physician professional charges must be used in the computation of uncompensated cost limit in the Interim Reconciliation above and the Final Reconciliation here.

A hospital's or physician practice group's uncompensated care cost limit is determined for the twelve month period in each DY, except for 1) for PCH in DY 5 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2015, and 2) for all other providers in DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a hospital's or physician practice group's cost reporting period does not coincide with the DY (or partial DY in DY3 or DY 5), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY).

For hospital-incurred professional service uncompensated care costs, the final reconciliation described above will be performed and completed within six months after the audited hospital Medicare cost report(s) are made available. For the physician practice group-incurred professional service uncompensated care costs, the final reconciliation described above will be performed and completed within eighteen months after the filing of physician practice group cost report(s).

Exhibit 1 to Attachment E

Participating Providers in the SNCP
(Previously approved through December 31, 2013)

A. Hospital Uncompensated Care Cost Payments

- Phoenix Children's Hospital
- University Medical Center
- University Physicians Healthcare Hospital at Kino Campus
- Maricopa Medical Center
- Little Colorado Medical Center (Winslow Memorial Hospital) - effective DYs 2 and 3 only
- Southeast Arizona Medical Center - effective DYs 2 and 3 only
- White Mountain Regional Medical Center - effective DYs 2 and 3 only
- Copper Queen Hospital – effective DYs 2 and 3 only
- Cobre Valley Regional Medical Center – effective DY 3 only
- Benson Hospital – effective DY 3 only
- La Paz Regional Hospital – effective DY 3 only
- Northern Cochise Community Hospital – effective DY 3 only

B. Federally Qualified Health Center Lookalike (FQHC-LA) Uncompensated Care Cost Payments

Avondale Family Health Center
950 E. Van Buren, Avondale 85323
623.344.6800

El Mirage Family Health Center
12428 W. Thunderbird, El Mirage 85335
623.344.6500

Glendale Family Health Center
5141 W. Lamar St., Glendale 85301
623.344.6700

Maryvale Family Health Center
4011 N. 51st Ave., Phoenix 85031
623.344.6900

Chandler Family Health Center
811 S. Hamilton, Chandler 85225
480.344.6100

Guadalupe Family Health Center
5825 E. Calle Guadalupe, Guadalupe 85283
480.344.6000

Mesa Family Health Center
59 S. Hibbert, Mesa 85210

480.344.6200

Comprehensive Healthcare Center
2525 E. Roosevelt St., Phoenix 85008
602.344.1015

McDowell Healthcare Center
1144 E. McDowell Rd., Phoenix 85006
602.344.6550

7th Avenue Family Health Center
1205 S. 7th Ave., Phoenix 85007
602.344.6600

South Central Family Health Center
33 W. Tamarisk St., Phoenix 85041
602.344.6400

Sunnyslope Family Health Center
934 W. Hatcher, Phoenix 85021
602.344.6300

7th Avenue Walk In Clinic
1201 S. 7th Ave.
Phoenix 85007
Phone: (602) 344-6655

C. Physician Professional Service Uncompensated Care Cost Payments
- Phoenix Children's Hospital
- Maricopa Medical Center
- University Physician's Healthcare

D. Non-Physician Practitioner Professional Service Uncompensated Care Cost Payments - effective DYs 2 and 3
- Maricopa Medical Center

E. City of Phoenix High Uncompensated Care Hospital Cost Payments: Hospital and Physician Professional Service Costs
- Banner Estrella Medical Center
- Banner Good Samaritan Medical Center
- John C Lincoln-Deer Valley Hospital
- John C. Lincoln North Mountain Hospital
- Maryvale Hospital Medical Center- Paradise Valley Hospital
- Phoenix Baptist Hospital
- Phoenix Children's Hospital
- St Joseph's Hospital-Phoenix
- St Luke's Medical Center

Attachment F

IHS and 638 Facilities Uncompensated Care Payment Methodology

The methodology outlined below has been approved for structuring a payment that will be made to IHS and 638 facilities that take in to account their uncompensated costs in furnishing specified types of care furnished by IHS and tribal 638 facilities to Medicaid-eligible individuals.

Participating facilities must utilize the methodology described below in determining these payments to the facilities:

Historical Data Methodology

This methodology is comprised of the following that will be used to calculate the total dollar amount of uncompensated care that will be paid to IHS and 638 facilities on a prospective basis.

- The state will calculate a per member per month (PMPM) rate, using historical data, to reflect the services that it removed from the Medicaid state plan effective October 1, 2010, that were furnished in or by IHS/tribal 638 facilities to AHCCCS-enrolled individuals, and would multiply this rate by the total number of adult AI/ANs currently enrolled in the AHCCCS program. This PMPM will be adjusted on an annual basis to mirror the medical inflation adjustment applied to the all-inclusive rate.

Once this aggregate dollar amount has been computed, the state will disburse payments to the IHS and 638 facilities based on payments made to each facility for care provided to AI/AN adults from July 1, 2010 through June 30, 2011.

In addition, the state will annually review whether the PMPMs calculated above were accurate within a reasonable margin of error by reviewing actual records of services furnished by one or more facilities. If the PMPM is not validated, the state will apply an adjustment factor for the following year.

As part of this methodology, the non-Federal share for services provided to non-natives would be calculated based on the following.

1. After analyzing claims data from 2009-10, the state calculated a ratio of claims paid for currently covered Arizona Medicaid state plan services that were provided at IHS and 638 facilities to non-natives to the total number of paid claims to IHS and 638 facilities. Using this ratio, the state calculated that approximately $2 million out of total claims paid to IHS facilities was for services provided to non-natives. As such, the state will pay the non-Federal share of the $2 million. The state will review the claims data on an annual basis and will adjust the non-Federal share amount accordingly.
2. The state will apply the ratio that was calculated of non-native costs to total IHS costs as described above to calculate the non-Federal portion of the service PMPM payments as described above.

Monthly Payment Calculation – Services

Adult Per Member Per Month Service Funding	$15.11
Total Number of AI/AN Adults Enrolled with AHCCCS	56,851

May Services Payment	$859,018.61
Total May Payment to I.H.S and 638 Facilities (Eligibility + Services)	$3,920,484.61
Facility A - Allocation - 1%	$39,204.85
Facility B - Allocation - 5%	$196,024.23