Arizona Health Care Cost Containment System
Medicaid Section 1115 Waiver Amendment Proposal
Supporting Uncompensated Care

I. Overview

In the face of extraordinary economic pressures, the State of Arizona is fighting unprecedented levels of unemployment and immense strain on its healthcare system. After decades of maintaining among the most robust levels of optional Medicaid coverage in the country, the Arizona Health Care Cost Containment System (AHCCCS) has been forced to scale back state-sponsored coverage due to a lack of available state revenue sources to support the non-federal share of escalating Medicaid costs. While necessary, these changes will have a measurable impact on AHCCCS providers, most notably safety net, rural and Critical Access, and Disproportionate Share Hospital providers. In order to offset some of the new uncompensated care burden that will result from reductions in AHCCCS coverage and allow for investments to support a long-term sustainable model of care for Medicaid recipients, Arizona is proposing to establish new funding mechanisms under the authority of its section 1115 waiver.

Pursuant to new state legislation (SB1357) signed into law by Governor Brewer on April 25, 2011, AHCCCS is authorized to use local funds to provide care to individuals who will no longer be covered through AHCCCS under the new waiver proposed to begin October 1, 2011. Under this state authority, AHCCCS is proposing to establish two funds to support continued access to services, as well as necessary delivery system reforms to improve the quality and efficiency of care for AHCCCS and other low income patients.

II. Safety Net Care Pool

AHCCCS proposes to establish a Safety Net Care Pool ("SNCP") to fund the unreimbursed costs incurred by eligible providers in caring for the uninsured and AHCCCS populations. Such SNCP funds have been established in multiple states including Massachusetts, California, and Florida, under authority of their respective Medicaid Section 1115 waivers.

A. Authorized SNCP Entities

1. Eligible SNCP Providers

AHCCCS is proposing to establish eligibility criteria for providers to ensure uncompensated care funding is directed to those providers that serve the greatest proportion of Medicaid and uninsured patients. Eligible entities will be those that meet any of the following criteria. AHCCCS is proposing to establish an annual list of potential eligibile entities, and maintain it as an attachment to the special terms and conditions (STCs).

a. Safety Net Hospital Systems

Safety Net Hospital Systems are defined as defined as the health system in each of the state's two largest metropolitan statistical areas that (a) are providing the highest percentage of care (measured in terms of discharges) within their MSA for adult AHCCCS and low-income uninsured patients and (b) sponsor multiple adult residency programs.

b. Rural or Critical Access Hospitals

Rural Hospitals are defined as: (1) Arizona hospitals that are not in Pima or Maricopa Counties; or (2) Arizona hospitals that are in counties of 500,000 or fewer persons. Both definitions reach the same universe of hospitals at this time.

Critical access hospitals (CAHs) are rural community hospitals that meet defined criteria outlined in the Conditions of Participation at 42 C.F.R. 485, Subpart F and 42 C.F.R. 440.170(g).

c. DSH Hospitals

Disproportionate Share Hospitals (DSH) are hospitals that qualify for a DSH payment under the Special Terms and Conditions in the Arizona 1115 Waiver. The criteria for qualification can change from year to year. Indian Health Services and 638 hospitals can also qualify for DSH funding.

2. SNCP Eligible Costs and Reimbursement Protocol

AHCCCS proposes that SNCP funds are eligible to reimburse costs of care and services that meet the definition of "medical assistance" as defined in section 1905(a) of the Act that are incurred by hospitals, clinics, and other providers as agreed upon between CMS and the State and designated by Eligible Entities.

To ensure that payments are compliant with all applicable limits, AHCCCS will work with CMS to establish a reporting and reimbursement protocol that will specify the methodology for capturing costs eligible for reimbursement from the SNCP. Preliminary proposals for identified provider types are provided below. AHCCCS is prepared to work quickly with CMS to refine these approaches, and develop appropriate waiver documentation and attachments to finalize these protocol.

a. Hospital Uncompensated Care

Hospital uncompensated costs for each eligible provider will be calculated using the hospital's OBRA limit.

SNCP payments would be made subsequent to Medicaid disproportionate share hospital ("DSH") payments. Medicaid DSH payments will continue to be made in correspondence with currently approved DSH payment methodologies, current legislative authority, and approved sources of non-federal share. Any remaining uncompensated costs not covered by these DSH payments, up to each eligible hospital's hospital-specific OBRA limit, will be eligible for reimbursement from the SNCP.

AHCCCS would make interim SNCP payments to eligilble providers based upon projected uncompensated care costs pursuant with the description above. Payments would be made on a quarterly basis. Given the significant increases in uncompensated care expected as a result of the eligbility and rate changes implemented through this waiver amendment, and as a result of budget requirements in Arizona, AHCCCS is proposing to use a blended cost report and prior claims history methodology to estimate uncompensated care in the first year for the purpose of making preliminary SNCP payments. In future years when the cost baseline has been established, AHCCCS may tranisition to a cost report-only based methodology. Given the expected volatility in uncompensated care in the first year, AHCCCS will conduct mid-year

review of uncompensated costs, and may adjust payments accordingly.

At the close of the fiscal, AHCCCS would reconcile SNCP and other payments against each hospital's OBRA limit. Any amounts found to be paid over the OBRA limits would be recouped from SNCP (rather than DSH) payments to the hospital, and any remaining unreimbursed costs would be reimbursed to the hospital through a year-end SNCP reconciliation payment.

b. Professional Uncompensated Care

The SNCP would also provide reimbursement for unreimbursed or under-reimbursed physician and other non-physician professional services. Payment would be based upon an established cost reporting methodology, and would incorporate expenditure information currently captured on the CMS-2552 cost report, or through an alternative cost reporting vehicle to be developed and agreed upon between CMS and AHCCCS. SNCP funding will be available for eligible physician and non-physician professional services provided to uninsured patients as well as unreimbursed costs associated with provision of care to eligible and enrolled Medicaid members as designated by Eligible Entities.

Similar to SNCP hospital payments, AHCCCS would make interim payments from the SNCP to eligible professional providers on a quarterly basis. Interim payments will be based upon a projection of uncompensated costs consistent with the methodology and data sources described in the preceding paragraph. The annual budget amount would be reviewed mid-year and may be adjusted as appropriate. At the close of the fiscal year, payments would be reconciled against the as-filed CMS-2552 cost report or alternative cost reporting vehicle to ensure that payments were compliant with the reporting and reimbursement protocol.

c. Pharmacy Uncompensated Care

Uncompensated inpatient hospital pharmacy costs would be part of the SNCP hospital reimbursement protocol described above. However, SNCP funds would be available to support uncompensated costs for outpatient pharmacies operated by eligible hospitals or clinics. Payments from the SNCP would be available to support outpatient pharmacy costs for uninsured patients. No payments would be made for prescription drugs provided to AHCCCS patients. AHCCCS will work with CMS to develop an appropriate cost reporting protocol for eligible pharmacies, and will employ an interim payment (quarterly) and final reconciliation (year-end) process similar that described for hospital and professional providers.

d. Home Health Uncompensated Care Costs

SNCP funds would be available to support uncompensated costs for home health services provided by eligible providers as identified by the Eligible Entity. AHCCCS would make payments for the uncompensated costs of home health services by applying a cost-to-charge ratio to the charges for AHCCCS and uninsured patients, derived from the home health cost report. Patient payments and AHCCCS reimbursement would be subtracted from the total. AHCCCS would employ an interim payment (quarterly) and final reconciliation (year-end) process similar that described for hospital and professional providers.

e. Emergency and Non-Emergency Transportation

Payments from the SNCP would be available to support emergency and non-emergency transportation costs incurred in providing services to uninsured patients. Eligible providers will

be defined by an Eligible Entity. AHCCCS will work with CMS to develop an appropriate cost reporting protocol for eligible providers, and will employ an interim payment (quarterly) and final reconciliation (year-end) process similar that described for hospital and professional providers.

f. Non-Hospital Clinics

Payments from the SNCP would also be available to support non-hospital community clinic costs incurred in providing services to uninsured patients. Clinic costs may include FQHCs, FQHC look alikes and rural health clinics. Eligible providers will be defined by an Eligible Entity, and will have an agreement in place with said Entity regarding responsibilities relating to providing care to the uninsured. AHCCCS will work with CMS to develop an appropriate cost reporting protocol for eligible providers, and will employ an interim payment (quarterly) and final reconciliation (year-end) process similar that described for hospital and professional providers.

g. Adjustments for Non-Qualified Aliens

AHCCCS will work with CMS to ensure that SNCP funds are not used to reimburse costs associated with provision of non-emergency medical services to non-qualified aliens. Given approvals in other states, AHCCCS generally proposes a gross adjustment to eligible and reported SNCP costs to account for the share of services provided to non-qualified aliens.

3. Permissible Sources of Non-Federal Share

SNCP payments may be funded with any permissible source of non-federal share as defined in federal regulation. Generally, payments from the SNCP are envisioned to be funded using intergovernmental transfers (IGTs), though could potentially be funded through certified public expenditure (CPE), or other sources as legislatively authorized or permitted under federal law and regulation. Where an IGT will be used as the source of non-federal share, AHCCCS and the transferring party will have an IGT agreement in place specifying the terms of the transfer and payment.

At no time should any authority within the SNCP terms of the waiver be interpreted as an obligation on the state legislature or AHCCCS to fund payments using state general revenue.

4. Payments

Payments may be made by the State to an eligble entity for all providers identified or the State may pay directly to all providers identified by the Eligible Entity.

5. SNCP Annual Funding Limits

a. DYxx: Up to $300 million
b. DYxy: Up to $320 million
c. DYxz: Up to $341 million

III. Arizona Health System Improvement Pool (AHSIIP)

Any long term plan for reining in AHCCCS costs and enhancing the value of care purchased by AHCCCS will require significant reforms of the health care delivery system. Some providers are already implementing reforms based on changes in Medicare and commercial payer policies. For safety net providers who rely disproportionately on AHCCCS funds to support care to low income populations, however, funding can be more scarce to allow for capital investments necessary to implement delivery system reforms.

To support delivery system transformation to improve provider efficiency and enhance quality of care for AHCCCS patients, AHCCCS is proposing to create an Arizona Health System Improvement Pool under the authority of its section 1115 waiver to fund delivery system improvement and transformation. Authority for this funding reflects similar need to that addressed through California's Delivery System Reform Incentive Pool within its 1115 waiver, but is targeted to needs specific AHCCCS, its members, and providers.

1. AHSIP Authorized Expenditures

Safety net health systems and other hospitals that are eligible for the SNCP would also be eligible for payment from the Arizona Health System Improvement Pool (AHSIP). Payments from the pool would be available for activities conducted by hospitals that are consistent with CMS's Triple Aim for better care, better health, and reduced per capita costs. Payments from the pool will be available to fund projects within the following categories, and will only be made based upon an approved plan, submitted by an Eligible Entity, and approved by AHCCCS.

a. *Infrastructure Development:* This category would include investments in infrastructure that will enhance the providers' ability to serve its community and continuously improve services, such as investments in expanded primary care, enhanced primary care workforce training, expanded specialty care, establishing disease management registries, enhancing interpretation services and culturally sensitive care, collecting accurate race, ethnicity and language data to reduce disparities, nurse advice lines, collecting quality data, telemedicine, etc.

b. *Innovation & Redesign:* These investments would be targeted on restructuring the way care is delivered, and would include activities such as establishing patient-centered medical homes, chronic disease management systems, primary care redesign cost-saving redesigns, integrating physical and behavioral health care, increasing specialty care access/referral process, patient care navigation programs, improved emergency department patient flow, palliative care, medication management, care transitions, and reducing hospital acquired infections.

c. *Population-Focused Improvement:* Under this category, eligible health systems would focus on measuring and improving care to particular high cost patient populations, such as diabetes care management, improving chronic care management or outcomes, reducing readmissions, etc.

d. *Urgent Improvements in Care:* Hospitals would agree to undertake two or three specified interventions for which there is substantial evidence that major improvement in care is possible within a measurable and relatively short time frame. In California, these include severe sepsis detection and management, central line-associated bloodstream infection prevention, surgical site infection prevention, hospital acquired pressure ulcer prevention, stroke management, venous thromboembolism prevention and treatment and falls with injury prevention.

Payments from the AHSIP are incentive payments, and would not be considered payments for patient services. As such, AHSIP payments would not be counted in any calculation of various Medicaid payment limits, including DSH limits and upper payment limits (UPL).

The State match required for these payments must be derived from local sources

2. ASHIP Annual Funding Limits

a. DYxx: Up to $75 million
b. DYxy: Up to $90 million
c. DYxz: Up to $110 million