

STATE OF ARIZONA
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL CARE

The steps to computing the OBRA limit are:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). Each hospital must complete the cost report to determine cost center-specific 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 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 and other AHCCCS financial reporting systems.

The information from 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 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 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 managed care organizations for inpatient

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- 9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan year under review (e.g. GME, CAH, etc.)
- 10. AHCCCS may apply trending factors for the initial payment to account for changes in utilization (e.g., due to changes in Medicaid eligibility criteria), supplemental payments, and Medicaid payments and rates. The adjustments may increase or decrease the days, costs, charges, or payments reflected on the cost reports, Medicaid and/or uninsured information. 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.

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 I Column 24 Lines (and where applicable Subscript Lines) 30 to 35 and Lines 40 to 43
- By
- The corresponding day totals on Line 1, Lines (and where applicable Subscript Lines) 8 through 13 and Lines 16 to 18(for inpatient hospital subproviders) from Worksheet S-3, Part I Column 8.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 24, Line 30 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 8, Line 1 should have added the amount appearing on Line 28 (observation bed days).

The ancillary RCCs will be calculated by dividing:

- 1. The individual Line and Subscript amounts for each of the Lines 50 to 76 and Lines 90 to 93 taken from Worksheet B, Part I Column 24
- 2. By
- 3. The individual Line and Subscript amounts for each of the Lines 50 to 76 and Lines 90 to 93 taken from Worksheet C, Part I Column 8

Costs will be offset by the payments made by ~~or on behalf of~~ patients ~~and payments made by~~

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~~third parties~~ related to Medicaid inpatient and outpatient hospital services as well as payments made by AHCCCS including FFS payments and payments by managed care

Attachment 4.19-A

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adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS. The Schedule will be submitted to AHCCCS during the application process, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan year(s) under review.

The Medicaid Shortfall

AHCCCS will provide each governmentally-operated hospital with a report from PMMIS 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 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 managed care organizations for inpatient and outpatient hospital services
9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan 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.

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Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services.

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The per diem amounts will be calculated by dividing:

- The individual amounts on Worksheet B, Part I Column 24 Lines (and where applicable Subscript Lines) 30 to 35 and Lines 40 to 43
- By
- The corresponding day totals on Line (and where applicable Subscript Line) 1, Lines 8 through 13 and Lines 16 to 18 (for inpatient hospital subproviders) from Worksheet S-3, Part I, Column 8.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 24, Line 30 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 8, Line 1 should have added the amount appearing on Line 28 (observation bed days).

The ancillary RCCs will be calculated by dividing:

1. The individual Line and Subscript amounts for each of the Lines 50 to 76 and Lines 90 to 93 taken from Worksheet B, Part I, Column 24
2. By
3. The individual Line and Subscript amounts for each of the Lines 50 to 76 and Lines 90 to 93 taken from Worksheet C, Part I, 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, etc.)

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6. The Medicaid shortfall
7. Adjustments to the calculated Medicaid shortfall to estimate a Medicaid shortfall

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explanation/justification and is subject to review by AHCCCS and CMS. The Schedule will be submitted to AHCCCS during the application process, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan year(s) under review.

The Medicaid Shortfall

AHCCCS will provide ASH with a report from PMMIS 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 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 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 from Worksheet B, Part I Column 24, Line 30 by the day total on Line 1 from Worksheet S-3, Part I Column 8. Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 24, Line 30 should have deducted the amounts

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appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part

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I, Column 8, Line 1 should have added the amount appearing on Line 28 (observation bed days).

The ancillary per diem amount will be calculated by:

1. Summing the Line and Subscript amounts for each of the Lines 50 to 76 and Lines 90 to 93 (but excluding Subscript Lines 88 to 89) taken from Worksheet B Part 1 Column 24 dividing the amount determined in step 1 above by the amount determined in step 3 below
2. Summing Line 1 and 28 from Worksheet S-3, Part I, Column 8

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, etc.)
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 and submit to AHCCCS uninsured days and program data for 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

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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:

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