CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBERS: **11-W-00032/09 (Title XIX)**
21-W-00009/9 (Title XXI)

TITLE: **Arizona Medicaid Section 1115 Demonstration**

AWARDEE: **Arizona Health Care Cost Containment System (AHCCCS)**

All Medicaid and State Children's Health Insurance Program requirements expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning October 27, 2006, through September 30, 2011. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

1. Proper and Efficient Administration **Section 1902(a)(4) (42 CFR 438.52, 438.56)**

To permit the State to limit acute care enrollee's and ALTCS enrollees' choice of managed care plans to a single Prepaid Inpatient Health Plan (PIHP) -- Children's Rehabilitative Services Program (CRS) – for the treatment of conditions covered under that program and to permit the State to limit acute care enrollees' choice of managed care plans to a single PIHP – the Arizona Department of Health Services Division of Behavioral Health – for the treatment of behavioral health conditions, as long as enrollees in such plans may request change of primary care provider at least at the times described in Federal regulations at 42 CFR 438.56(c).

To permit the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same PIHP in which he or she was previously enrolled.

To permit the State to restrict the ability to disenroll without cause after an initial 30 day period from a managed care plan.

To permit the state to restrict beneficiary disenrollment based on 42 CFR 438.56(d)(2)(iv), which provides for disenrollment for causes including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs

2. Cost Sharing **Section 1902(a)(14) (42 CFR 447.51 and 447.52)**

To enable the State to charge a premium to parents of ALTCS Medicaid qualified disabled children (under 18 years of age) when the parent's annual adjusted gross income is at or exceeds 400 percent of the FPL.

3. Disproportionate Share Hospital (DSH) Requirements **Section 1902(a)(13)**

To relieve the State from the obligation to make payments for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients in accordance with the provisions for disproportionate share hospital payments that are described in the STCs.

4. Freedom of Choice **Section 1902(a)(23)**
(42 CFR 431.51)

To enable the State to restrict freedom of choice of providers by furnishing benefits through enrollment of eligible individuals in managed care organizations and/or Prepaid Inpatient Health Plans.

5. Drug Rebate **Section 1902(a) (54)**
(42 CFR 456.700 through 456.725)

To enable the State to receive payment for FFS and PIHP outpatient drugs without having to comply with the requirements of section 1927(g) of the Act pertaining to drug use review.

6. Retroactive Eligibility **Section 1902(a) (34)**
(42 CFR 435.914)

To enable the State to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made for AHCCCS.

7. Amount, Duration, Scope of Services **Section 1902(a)(10)(B)**
(42 CFR 440.240 and 440.230)

To enable the State to offer different or additional services to some categorically eligible or medically needy individuals, than to other eligible individuals, based on differing care arrangements in the Spouses as Paid Caregivers Program.

To permit managed care organizations (MCOs) and PIHPs to provide additional or different benefits to enrollees, that may not be available to other eligible individuals.

8. Estate Recovery **Section 1902(a)(18)()**
(42 CFR 433.36)

To enable the State to exempt from estate recovery as required by section 1917(b), the estates of acute care enrollees age 55 or older who receive long-term care services.

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9. Eligibility Based on Institutional Status **Section 1902(a)(10)(A)(ii)(V)**
(42 CFR 435.217 and 435.236)

To the extent that the State would be required to make eligible individuals who are in an acute care hospital for greater than 30 days and who do not meet the level of care standard for long term care services.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBERS: **11-W-00032/09**
21-W-00009/9

TITLE: **Arizona Medicaid Section 1115 Demonstration**

AWARDEE: **Arizona Health Care Cost Containment System (AHCCCS)**

Medicaid Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of this demonstration, be regarded as matchable expenditures under the State's Medicaid State plan:

I. Expenditures Related to Administrative Simplification and Delivery Systems

1. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) of the Act specified below. AHCCCS's managed care plans participating in the demonstration will have to meet all the requirements of section 1903(m) except the following:

    a. Section 1903(m)(2)(A)(i), but only insofar as the provisions of section 1903(m)(1)(A)(i) would otherwise preclude Native Americans from having a choice to enroll in either Indian Health Service facilities or AHCCCS plans.

    b. Section 1903(m)(2)(A)(vi) insofar as it requires compliance with requirements in section 1932(a)(4) and 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period after enrollment to disenroll without cause that would be longer than 30 days.

    c. Section 1903(m)(2)(A)(xii), but only insofar as it requires the State to comply with section 1932(a)(3) and 42 CFR 438.52 to offer a choice of at least two MCOs in the Arizona Long Term Care Service (ALTCS) and Comprehensive Medical and Dental Program (CMDP) programs, as long as enrollees in such plans have a choice of at least two primary care providers, and may request change of primary care provider at least at the times as described in 42 CFR 438.56(c). Notwithstanding this authority, the State must offer a choice of at least two MCOs to elderly and physically disabled individuals in Maricopa County.

d. Section 1903(m)(2)(H) and 42 CFR 438.56(g), but only insofar as to allow the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan from which the individual was previously enrolled.

2. Expenditures that would have been disallowed under section 1903(u) of the Act and 42 CFR 431.865 based on Medicaid Eligibility Quality Control (MEQC) findings.

3. Expenditures for outpatient drugs which are not otherwise allowable under section 1903(i)(10.

4. Expenditures for outpatient drugs which are not otherwise allowable under section 1903(i)(23).

5. Expenditures for direct payments to Critical Access Hospitals (CAH) for services provided to AHCCCS enrollees in the Acute Care and ALTCS managed care programs that are not otherwise allowable under 42 CFR §438.60.

6. Expenditures for inpatient hospital and long-term care facility services, other institutional and non-institutional services (including drugs) provided to AHCCCS fee-for-service beneficiaries that exceed the amounts allowable under section 1902(a)(30)(A) (42 CFR 447.250 through 447.280, 447.300 through 447.334) but are in accordance with Special Term and Condition (STC) #53 entitled "Applicability of Fee-for-Service Upper Payment Limit."

7. Expenditures for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients but are not allowable under sections 1902(a)(13)(A) and 1923 of the Act, but are in accordance with the provisions for disproportionate share hospital (DSH) payments that are described in the STCs.

II. Expenditures Related to Expansion of Existing Eligibility Groups based on Eligibility Simplification

8. Expenditures related to:

    a. Medical assistance furnished to ALTCS enrollees who are eligible only as a result of the disregard from eligibility of income currently excluded under section 1612(b) of the Act, and medical assistance that would not be allowable for some of those enrollees but for the disregard of such income from post-eligibility calculations.
    b. Medical assistance furnished to ALTCS enrollees who are financially eligible with income equal to or less than 300 percent of the Federal Benefit Rate and who are eligible for ALTCS based on the functional, medical, nursing, and social needs of the individual.

c. Medical assistance furnished to some dependent children or spouses who qualify for ALTCS based on a disregard of income and resources of legally responsible relatives or spouses during the month of separation from those relatives or spouses.
d. Medical assistance furnished to individuals who are eligible as Qualified Medicare Beneficiary (QMB), Special Low Income Beneficiary (SLMB), Qualified Individuals-1 (QI-1), or Supplemental Security Income Medical Assistance Only (SSI-MAO) beneficiaries based only on a disregard of in-kind support and maintenance (ISM).
e. Medical assistance furnished to individuals who are eligible based only on an alternate budget calculation for ALTCS and SSI-MAO income eligibility determinations when spousal impoverishment requirements of section 1924 of the Act do not apply or when the applicant/recipient is living with a minor dependent child.
f. Medical assistance furnished to individuals who are eligible in SSI-MAO groups based only on a disregard of resources in the form of insurance and burial funds, household goods, mineral rights, oil rights, timber rights, and personal effects.
g. Medical assistance furnished to individuals who are eligible only based on the disregard of interest and dividend from resources, and are in the following eligibility groups:

    i. The Pickle Amendment Group under 42 CFR 435.135;
    ii. The Disabled Adult Child under Section 1634(c);
    iii. Disabled Children under Section 1902(a)(10)(A)(i)(II); and
    iv. The Disabled Widow/Widower group under Section 1634(d).

h. Medical assistance furnished to ALTCS enrollees under the eligibility group described in section 1902(a)(10)(A)(ii)(V) of the Act that exceeds the amount that would be allowable except for a disregard of interest and dividend from the post-eligibility calculations.
i. Medical assistance provided to individuals who would be eligible but for excess resources under the "Pickle Amendment," section 503 of Public Law Number 94-566; section 1634(c) of the Act (disabled adult children); or section 1634(b) of the Act (disabled widows and widowers).
j. Medical assistance that would not be allowable but for the disregard of quarterly income totaling less than $20 from the post-eligibility determination.

III. Expenditures Related to New Eligibility Groups

9. Expenditures to extend ALTCS eligibility to individuals under the age of 65 who are not disabled but who are found to need nursing facility services based on mental illness or mental retardation on the preadmission screening instrument.

10. Expenditures associated with the provision of Home & Community-Based Services (HCBS) to individuals with income levels up to 300 percent of the SSI income level, as well as individuals enrolled in the ALTCS Transitional program.

11. Expenditures for family planning services for up to 24-months, with an annual re-determination at 12 months, for uninsured women that have lost Medicaid pregnancy coverage within the last year at the conclusion of their 60-day postpartum period and who are not otherwise eligible for Medicare, Medicaid (including other components of this section 1115 demonstration), Children's Health Insurance Program (CHIP), or have other public or creditable private health insurance coverage (Family Planning Extension Program).

12. Expenditures for services to an AHCCCS enrollee age 21 to 64 residing in an Institution for Mental Disease (IMD) for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days. The proportion of total State expenditures that will be recognized under this demonstration will be phased out, in accordance with STC #55, and will expire entirely in fiscal year 2009.

13. Expenditures for demonstration caregiver services provided by spouses of the demonstration participants.

14. Expenditures to provide coverage through employer-sponsored insurance for eligible employees of small businesses and with family income below 200 percent of the Federal poverty level (FPL) that would not otherwise be allowable because it is not cost effective.

15. Expenditures to provide Medicaid coverage to individuals who have medical bills incurred by the family unit sufficient to reduce the adjusted net countable family income to 40 percent or less of the FPL, and who are not otherwise eligible for Medicaid.

16. Expenditures to provide Medicaid coverage to individuals with adjusted net countable family income at or below 100 percent of the FPL who are not otherwise eligible for Medicaid.

17. Expenditures to provide coverage to parents of Medicaid or CHIP children with adjusted net countable income from 100 percent up to and including 200 percent of the FPL who are not otherwise eligible for Medicare, Medicaid, or CHIP and for whom the State may claim title XIX funding when title XXI funding is exhausted.

Medicaid Requirements Not Applicable

Medicaid populations made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are not subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration. The following Medicaid requirements will not apply to such demonstration populations:

1. Cost-Sharing **Section 1902(a)(14) (42 CFR 447.50 through 447.56)**

To enable the State to impose cost sharing, to the extent necessary, for parents of Medicaid or CHIP children with adjusted net countable income from 100 percent up to and including 200 percent of the FPL, for those in the employer-sponsored insurance program individuals without dependent children between 0 percent to 100 percent of the FPL, and for the MED expansion group.

2. Amount, Duration, Scope of Services **Section 1902(a)(10)(B) (42 CFR 440.210)**

To enable the State to modify the Medicaid benefits package for those in the employer-sponsored insurance program in order to offer a different benefit package than would otherwise be required under the State plan. This authority is granted only to the extent necessary to allow those in the employer-sponsored insurance plan to receive coverage through a private or employer-sponsored insurance plan, which may offer a different benefit package than that available through the State plan.

3. Retroactive Coverage **Section 1902(a)(34) (42 CFR 435.914)**

Individuals who enroll in the employer-sponsored insurance program and parents of Medicaid or CHIP children with adjusted net countable income from 100 percent up to and including 200 percent of the FPL, individuals without dependent children between 0 percent to 100 percent of the FPL, and for the MED expansion group will not be retroactively eligible.

4. Providing Medical Assistance **Section 1902(a)(10)**

To enable the State to deny eligibility for medical assistance to parents of Medicaid or CHIP children who have voluntarily terminated health insurance coverage during the 3-month period prior to application and who have adjusted net countable income from 100 percent up to and including 200 percent of the FPL.

Medicaid Requirements Not Applicable to the Family Planning Extension Program:

1**. Amount, Duration, and Scope (Comparability)** **Section 1902(a)(10)(B) (42 CFR 440.240)**

To the extent necessary to allow the State to offer the demonstration population a benefit package consisting only of CMS-approved family planning services.

2. **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** — **Section 1902(a)(43)(A) (42 CFR 440.40 and 441.50 through 441.62)**

   The State will not furnish or arrange for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to the demonstration population.

3. **Retroactive Eligibility** — **Section 1902(a)(34) (42 CFR 435.914)**

   Individuals in the Family Planning Extension program will not be retroactively eligible.

4. **Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics** — **Section 1902(a)(15) (42 CFR 447.371)**

   To enable the State to establish reimbursement levels to these clinics that would compensate them solely for family planning services.

5. **Eligibility Re-determination** — **Section 1902(a)(19) (42 CFR 435.916)**

   To enable the State to exempt women, who are eligible for the family planning program by virtue of losing Medicaid eligibility at the conclusion of their 60-day postpartum period (SOBRA women), from reporting changes in income during their 12-month eligibility period.

CHIP Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A), State expenditures described below, shall, for the period of this project and to the extent of the State's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the State's title XXI plan. All requirements of title XXI will be applicable to such expenditures for the demonstration populations described below, except those specified below as not applicable to these expenditure authorities.

1. **Childless Adults**. Subject to STC #38, expenditures to provide coverage to uninsured individuals over age 18 with adjusted net countable family income between 40 percent and 100 percent of the FPL, who are childless adults, and who are not otherwise eligible for Medicare, Medicaid (except for demonstration title XIX expansion groups), or have other creditable health insurance coverage.
2. **Parents.** Subject to STC #38, expenditures to provide health care coverage to uninsured individuals whose adjusted net countable family income above 100 percent of the FPL up to and including 200 percent of the FPL, who are parents of children

enrolled in the Arizona Medicaid or title XXI program, and who are not otherwise eligible for Medicare, Medicaid, or have other creditable health insurance coverage.

3. **Employer-Sponsored Insurance**. Expenditures to provide coverage to CHIP-eligible children up to age 19 with incomes above 100 percent of the FPL up to and including 200 percent of the FPL who meet the definition of a targeted low-income child and who elect to receive coverage through the State's Employer-Sponsored Insurance (ESI) program rather than through CHIP State plan direct coverage. Such children are no longer subject to the title XXI requirements listed below.

CHIP Requirements Not Applicable to SCHIP Expenditure Authorities

1. **General Requirements, Eligibility, and Outreach** — **Section 2102 (42 CFR 457.90)**

   The State child health plan does not have to reflect the demonstration population, and eligibility standards do not have to be limited by the general principles in section 2102(b) of the Act. The State must perform eligibility screenings to ensure the demonstration populations do not include individuals otherwise eligible for Medicare, Medicaid (except for childless adults described in CHIP CNOM #1), or have other creditable health insurance coverage.

2. **Federal Matching Payment and Family Coverage Limits** — **Section 2105 (42 CFR 457.618)**

   The State will be allowed to receive Federal matching payment for the Demonstration Populations without the restrictions described in section 2105(c)(2) that would otherwise require the State to cover populations other than targeted low-income children under the 10 percent administrative cap. This provision does not waive the 10 percent administrative cap for title XXI expenditures. It does, however, allow the State to cover a population besides children outside of a health service initiative and the 10 percent administrative cap, which would be the customary vehicle for covering a population other than targeted low-income children.

3. **Annual Reporting Requirements** — **Section 2108 (42 CFR 457.700 through 457.750)**

   The State does not have to meet the annual reporting requirements (the submission of an annual report into the State Annual Report Template System/SARTS) of section 457.750 for the demonstration populations. The State will report on issues related to the demonstration populations in quarterly and annual reports and enrollment data through the Statistical Enrollment Data System (SEDS).

4. **Cost Sharing** **Section 2103(e) (42 CFR 457.530 through 457.560)**

Rules governing cost sharing under section 2103(e) of the Act shall not apply to the demonstration populations to the extent necessary to impose cost sharing for parents, childless adults, and for those in the ESI program.

5. **Restrictions on Coverage and Eligibility To Targeted Low-Income Children** **Section 2103 and 2110**

Coverage and eligibility for the demonstration populations are not restricted to targeted low-income children.

6. **Benefit Package Requirements** **Section 2103**

To permit the State to offer a benefit package for the ESI program that does not meet the requirements of section 2103 of the Act, outlined at 42 CFR 457.410(b)(1).

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

MEDICAID SECTION 1115 DEMONSTRATION

NUMBER: 11-W-00032/09
21-W-00009/9

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 27, 2006, through September 30, 2011. 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 27, 2006, unless otherwise specified. All previously approved STCs are superseded by the STCS set forth below.

The STCs have been arranged into the following subject areas: Program Overview; General Program Requirements; General Reporting Requirements; Demonstration Program Design Inclusive of Eligibility; Benefits and Enrollment; Cost-Sharing for Acute Care Services; Long Term Care Services; Health Insurance Flexibility & Accountability (HIFA); Family Planning; Institution for Mental Disease Phase-Down; Evaluation; General Financial Requirements; Monitoring Budget & Allotment Neutrality; and a Timeline of State Deliverables.

II. PROGRAM OVERVIEW AND HISTORICAL CONTEXT

Until 1982, Arizona was the only State that did not have a Medicaid program under title XIX. In October 1982, Arizona implemented the AHCCCS as a section 1115 demonstration project.

From October 1982 until December 1988, AHCCCS covered only acute care services, except for 90-day post-hospital skilled nursing facility coverage. In November 1988, a 5-year extension of the program was approved (later amended to 6 years) by CMS to allow Arizona to implement a capitated long term care (LTC) program for the elderly and physically disabled (EPD) and the developmentally disabled (DD) populations. The Arizona Long Term Care System (ALTCS)

began in December 1988 for DD members and in January 1989 for EPD members. It is administered as a distinct program from the acute care program.

On October 1, 1990, AHCCCS began phasing in comprehensive behavioral health services, beginning with coverage of seriously emotionally disabled children under the age of 18 years who require residential care. Over the next 5 years, behavioral health coverage was extended to all Medicaid-eligible persons.

In November of 2000, Arizona voters approved Proposition 204, which expanded income limits to 100 percent of the Federal poverty level (FPL) for full acute care Medicaid. This expansion was approved in January 2001 by CMS and included coverage up to 100 percent for traditional Temporary Assistance for Needy Families and SSI populations as well as adults without dependent children in addition to the Medical Expense Deduction (MED) program for Medicaid-eligible persons.

In 2001, Arizona submitted a HIFA amendment and the State received permission from CMS to use title XXI funds to expand coverage to two populations: (1) adults over age 18 without dependent children and with adjusted net family income at or below 100 percent of the FPL, and (2) individuals with adjusted net family income between 100 to 200 percent FPL who are parents of children enrolled in the Arizona Medicaid program or State Children's Health Insurance Program (CHIP), but who themselves are not eligible for either program. Children enrolled in the Arizona CHIP program, are known as "KidsCare."

On March 13, 2006, Arizona submitted a "Demonstration Renewal Proposal" for its entire section 1115 demonstration. This renewal is significant in that it is the first time that the ALTCS portion of the demonstration is required to establish budget neutrality.

On April 10, 2008, Arizona submitted an amendment to implement a statewide premium assistance program for title XXI CHIP eligible children with family income between 100 percent up to and including 200 percent of FPL who have access to employer sponsored insurance (ESI). This amendment was required by STC# 36(b), which stipulates that the State must implement an ESI program by December 1, 2008 or face penalty of losing title XXI expenditure authority for HIFA eligible populations. Arizona's ESI program will include coverage provided through any commercial group package offered by the employer. Benefits will vary by the commercial health care plan provided by each employer, but all plans must provide a basic primary care package of inpatient hospital services, outpatient services, laboratory and x-ray services, pharmacy services, and behavioral health services. The State will subsidize premium assistance through a monthly per child subsidy. Parents can incidentally be covered if the monthly subsidy is adequate to cover the entire family premium. Arizona is requiring employers to contribute at least 30 percent of the total premium in order to participate in the program. All children will have the choice to opt back into CHIP direct coverage at any time.

On February 11, 2009, Arizona submitted a request to increase monthly premiums for parents of Medicaid and CHIP children enrolled in the demonstration. Specifically, the State will increase monthly premiums from 4 percent of net household income to 5 percent of net household income for parents between 151-175 percent of the FPL.

On July 20, 2009, Arizona provided a written 60-day notice that the State was terminating the HIFA title XXI parents program (HIFA II) on October 1, 2009, and modifying the Federal funding source for the childless adults (HIFA I) served under its 1115 demonstration. CMS acknowledged the State's termination of the title XXI HIFA II parents program on September 30, 2009,

On October 1, 2009 Arizona submitted an amendment to the demonstration to include Community Transition Services (CTS) as a Home and Community Based Service (HCBS) provided under Arizona Long Term Care Services (ALTCS). The State also requested that the CTS benefit be defined consistent with CMS State Medicaid Director letter #02-008.

On February 1, 2010 Arizona submitted a request to amend its Demonstration to provide Expenditure Authority for the costs associated with inpatient psychiatric services provided to individuals under age 21 through an inpatient psychiatric program located in a hospital not accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and this request remains under CMS review. On August 16, 2010, CMS published the final FY 2011 IPPS rule giving States greater flexibility in obtaining accreditation necessary to participate in the Medicaid program. Psychiatric hospitals and hospitals with inpatient psychiatric programs will have the choice of undergoing a State survey or of obtaining accreditation from a national accrediting organization whose hospital accreditation program has been approved by CMS. Upon notice of the final rule, Arizona subsequently withdrew its amendment request on August 6, 2010.

On March 18, 2010 as a result of Arizona's significant budget crisis and recent legislative action, AHCCCS submitted notice to CMS of its plan to amend its section 1115 Demonstration to eliminate the Childless Adult and Medical Expense Deduction (MED or spend down) populations beginning January 1, 2011. One March 23, 2010 the Patient Protection and Affordable Care Act (Affordable Care Act) became law. The Affordable Care Act contains maintenance of effort provisions that require states to temporarily maintain current levels of eligibility in both the Medicaid and CHIP programs in order to receive federal funding for the Medicaid program. Accordingly, on May 6, 2010, the Governor Arizona signed SB 1043, restoring funding for this expanded population. Since funding has been reinstated, AHCCCS withdrew its amendment request on May 12, 2010.

On May 21, 2010 in response to fiscal challenges, the state proposed to implement several changes to the adult benefit package for optional services, and requested federal approval for flexibility to the STCs to permit "Benefits for the expansion population authorized by the 1115 Demonstration project to mirror all benefits as defined in the Medicaid State Plan."

On July 13, 2010, in response to section 5006(d) under the American Recovery and Reinvestment Act (ARRA), the State requested guidance regarding Section 5006(d) under ARRA which requires that health plans who contract with the State:

(1) Include sufficient Indian health care providers within their network to ensure timely access to covered Medicaid managed care services; and

(2) Make payments directly to those Indian health care providers for care furnished to American Indians (AIs) enrolled in a health plan "at a rate equal to the rate negotiated between such entity and the provider involved or, if a rate has not been negotiated, at a rate that is not less than" the amount the health plan would pay for the services if furnished by a non-Indian health care provider.

Given Arizona's current practice of allowing American Indian members enrolled with Managed Care Organizations to receive services from any Indian health care provider and directly reimbursing Indian health care providers for such services, the Demonstration's Expenditure Authority was subsequently amended to include costs associated with the provision of health care services provided by Indian Health Services or 638 facilities that are not otherwise allowable under section 1932(h).

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 Child 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.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** 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[s] 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 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 or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid or CHIP State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits (if determined to be warranted by CMS), enrollee rights, delivery systems, reimbursement, cost sharing, evaluation design, Federal financial participation (FFP), sources of non-Federal share funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. The state shall not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive except as otherwise specified in these STCs 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. Amendment requests must include, but are not limited to, the following:

    a. An explanation of the public process used by the State, consistent with the requirements of paragraph 15, to reach a decision regarding the requested amendment;

    b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall 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;

    c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

    d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

    e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

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 chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

As part of the Demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

a. Demonstration Summary and Objectives: The State must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

b. Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

c. Waiver and Expenditure Authorities: The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

d. Quality: The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

e. Compliance with the Budget Neutrality Cap: The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In addition, the State must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

f. Draft report with Evaluation Status and Findings: The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 10 a phase-out plan shall not be shorter than six months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. 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. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 9, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

11. **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.

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

13. **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 [and/or XXI]. 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.

14. **Adequacy of Infrastructure.** The State must 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.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section

1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, 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, 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, amendment, and /or renewal of this Demonstration. In the event that the State conducts additional consultation activities consistent with these requirements prior to the implementation of the demonstration, documentation of these activities must be provided to CMS.

16. **FFP.** No Federal matching funds for expenditures for this amended Demonstration will take effect until the effective date identified in the amended Demonstration approval letter.

IV. GENERAL REPORTING REQUIREMENTS

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

18. **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.

19. **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.

20. **Encounter Data.** Any MCOs or PIHPs in the Demonstration shall be responsible for the collection of all data on services furnished to enrollees through encounter data or other methods as specified by the State, and the maintenance of these data at the plan level. The State shall, in addition, develop mechanisms for the collection, reporting, and analysis of these data (which should at least include all inpatient hospital and physician services), as well as a process to validate that each plan's encounter data are timely, complete and accurate. The State will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The State shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion.

21. **Encounter Data Validation Study for New MCOs or PIHPs.** If the State contracts with new MCOs or PIHPs, the State shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of Demonstration enrollees.

22. **Submission of Encounter Data.** The State shall submit encounter data to the Medicaid Statistical Information System (MSIS) as is consistent with Federal law and section VIII of this document. The State must assure that encounter data maintained at MCOs or PIHPs can be linked with eligibility files maintained at the State.

23. **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.

24. **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;
    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 individuals enrolled in the family planning extension program at the end of the quarter, as well as the number of individuals receiving services during the prior quarter;
    e. HIFA data as required by paragraph 38(f) of this Agreement as well as information on any issues which arise in conjunction with the Employer Sponsored Insurance (ESI) portion of the program, including but not limited to enrollment, quality of care, grievances, and other operational issues; and
    f. Evaluation activities.
25. **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, HIFA, ESI and Family Planning 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.

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

27. **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
        i. The Children's Rehabilitative Services Program (CRS) contractor; and
        ii. The Comprehensive Medical and Dental Program (CMDP) at the Arizona DES.

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

29. **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.

V. ELIGIBILITY, ENROLLMENT, BENEFITS & COST SHARING

30. **Eligibility:** Arizona covers all of the mandatory Medicaid eligibility groups, 12 optional groups and 4 expansion groups. Mandatory and optional State plan groups described below are subject to all applicable Medicaid laws and regulations except as expressly waived. Those groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are not subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration. The criteria for Arizona eligibility groups are as follows (Table 1):

Table 1 – Demonstration Groups

Description	Program	Social Security Act Cite	42CFR Cite
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

Description	Program	Social Security Act Cite	42CFR Cite
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
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
"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 100% 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
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
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

Description	Program	Social Security Act Cite	42CFR Cite
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)	
MANDATORY TITLE XIX COVERAGE GROUPS Adoption Assistance and Foster Care Children			
Children in adoption subsidy/foster care Title IV-E programs	AACP ALTCS	473(b)(l) 1902(a)(10)(A)(i)(I)	435.145
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
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	
TITLE XIX AND XXI EXPANSION GROUPS			

Description	Program	Social Security Act Cite	42CFR Cite
Individuals with adjusted net countable income at or below 100% FPL who are not otherwise eligible for Medicaid.	AACP	ARS 36-2901.01	
Uninsured parents of Medicaid or CHIP children with family income from 100% up to and including 200% of the FPL for whom the State is claiming Title XXI funding.	AACP	2006 Ariz. Sess. Laws, Ch. 331. §32	
AHCCCS eligible women who lose SOBRA eligibility at 60 days postpartum and who are not otherwise eligible for Medicare or Medicaid (up to 24 months following the postpartum period).**	Family Planning	ARS 36-2907.04	
Medical Expense Deduction – Individuals, couples, or families whose income exceeds the Medicaid limits may be eligible after deducting their medical expenses from their income.	AACP	ARS 36-2901.04	
Expenditures to provide coverage to CHIP eligible children up to age 19 with incomes above 100 percent of the FPL up to and including 200 percent of the FPL who meet the definition of a targeted low-income child and who elect to receive coverage through the State's ESI program rather than through CHIP State plan direct coverage. Such children are no longer subject to the title XXI requirements listed in the CNOM title XXI expenditure authority.	XXI		

*Arizona's 1115 Demonstration provides the authority to waive some of the provisions.
** A phase down of individuals currently covered with other insurance will occur pursuant to STC #37.

31. **Arizona Acute Care Program (AACP)**. The AACP is a statewide, managed care system which delivers acute care services through prepaid, capitated 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 behavioral health services and certain specialty care services for children eligible under the CRS Program on a "carve-out" basis through separate PIHP contracts.
    a. **AACP Eligibility –** Those Groups are identified in paragraph 30, 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 and the MED population. 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, Freedom to Work recipients, and parents of children eligible for title XIX or XXI. Individuals determined eligible must then select and enroll in a Health Plan, or they will be auto-assigned by the AHCCCS administration.
    c. **Benefits** – Benefits for AACP and the expansion population authorized by the 1115 Demonstration will mirror all benefits as defined in the Medicaid State Plan (see Attachment G), unless otherwise noted within these STCs.

i. **Notice -** The State must notify CMS (Central and Regional Offices) in writing within 30 days when proposing a State Plan amendment (SPA) that would impact the expansion population authorized by the 1115 Demonstration inclusive of:
    1. The proposed date of implementation;
    2. The date the State plans to submit the SPA; and
    3. 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. **Applicability –** Any changes to the benefits for AACP, made after December 17, 2010 will impact all adults 21 years and older. Children under the age of 21 will continue to receive the full benefit package available under the Early Periodic Screening Diagnosis and Treatment (EPSDT) program.

iv. Behavioral health services are outlined in Attachment G 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 Consistent with STC paragraph 55.	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** – With the exception of individuals eligible for the title XIX Demonstration group (the MED Expansion Group and adults without dependent children 0 percent to100 percent FPL), cost sharing does not exceed nominal cost sharing limits. Individuals eligible for the title XIX Demonstration group are subject to the following co-payments:

i. Generic prescriptions or brand name prescriptions if generic is not available - $4

ii. Brand name prescriptions when generic is available - $10

iii. Non-emergency use of the emergency room - $30
iv. Physician office visit - $5

32. **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.
    a. **Federal Financial Participation**. FFP will not be available for:
        1. 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
        2. Activities integral to the administration of the foster care program excluding any health care related activities.

33. **Children Rehabilitative Services (CRS)**. AHCCCS contracts on a sole-source, capitated basis for the CRS program. Children enrolled in the Acute Care and ALTCS plans with qualifying conditions receive their specialty care for these conditions through the CRS contractor while they remain enrolled in their acute care or ALTCS plan.

34. **Arizona Long Term Care System (ALTCS).** The ALTCS program is for individuals who are age 65 and over, blind, or disabled and who need ongoing services at a nursing facility level of care. Program eligibles 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. ALTCS participants are also covered for medical care identical to the 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 separate, statewide, managed care system which delivers acute, long-term care, home-and-community based services, and behavioral health care services through capitated MCOs that AHCCCS calls "Program Contractors." ALTCS enrollees receive most Medicaid-covered services through the Program Contractors, but receive certain specialty care services for children eligible under the CRS program on a "carve-out" basis through a separate PIHP contract.

With one exception, ALTCS contracts are awarded using the same GSA system as the AACP. This exception is for the ALTCS MCO contract with the Arizona DES/DDD to provide services on a statewide basis to all individuals with developmental disabilities. ALTCS enrollees in Maricopa County 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 paragraph #30, Table 1 requiring health care services at a nursing facility 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. Persons with AHCCCS approved income-only trusts may have income in excess of the FBR.
    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 31(c).
    ii. **ALTCS Behavioral Health Care** - Enrollees receive behavioral health care services as defined in paragraph 31(c)..
    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.
            b. 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.
            c. 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 (Attachment E)

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 of eligible ALTCS enrollees, so that the members can remain in their own home for HCBS. 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 either a Medicare/Medicaid approved nursing facility, hospice, ICF/MR, inpatient psychiatric hospital, Level I behavioral health residential treatment center, or a Level I behavioral health sub-acute facility if the member requires the level of care in these facilities.

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.

35. **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.
    a. 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 #34.

36. **Arizona Health Insurance Flexibility and Accountability (HIFA)** On July 20, 2009 the State provided a written 60-day notice terminating the HIFA title XXI parents program (HIFA II) on October 1, 2009, and modify the Federal funding source for the childless adults (HIFA I) served under its 1115 demonstration.

    The Centers for Medicare & Medicaid Services (CMS) acknowledged the State's termination of the title XXI HIFA II parents program on September 30, 2009. In accordance with sub-paragraph 36(g), the State may no longer claim title XXI funds for the HIFA I childless adult population as of September 30, 2009, the date that coverage for the HIFA II population terminated. CMS also acknowledges that the State may begin claiming title XIX funds for claims associated with childless adults with dates of service beginning October 1, 2009.

    The State has existing expenditure authority under the Demonstration to claim title XIX funding for childless adult coverage. Expenditures for the title XIX HIFA I childless adult population is subject to the budget neutrality limit for AHCCCS in paragraph 61.

    The State is not authorized to claim Title XXI enhanced matching funds for either HIFA I childless adults or HIFA II parents program after September 30, 2009. Title XXI enhanced matching funds are available for the HIFA II parents program for expenditures and/or expenditure adjustments for dates-of-service on or before September 30, 2009.

    Unless and until the State obtains approval to amend the demonstration project to reinstitute the use of Title XXI funding for these populations under HIFA, the following provisions of this paragraph are suspended: a.ii., b., c.ii., d.ii., d.iii., e.ii.-iv., and g.

    a. **Eligible Populations:** The State will use title XXI funds to expand coverage to two populations:

i. The **Health Insurance Flexibility and Accountability I (HIFA I)** population includes uninsured adults without dependent children over the age of 18 years, with income from 40 percent up to and including 100 percent of the FPL who are not otherwise eligible for Medicare, Medicaid (except for title XIX demonstration expansion groups), CHIP, or have other creditable health insurance coverage.

ii. The **Health Insurance Flexibility and Accountability II (HIFA II)** population includes uninsured eligible parents of KidsCare and/or SOBRA eligible children with income from 100 percent up to and including 200 percent of the FPL who are not otherwise eligible for Medicare, Medicaid (including other components of this section 1115 demonstration), CHIP, or have other creditable health insurance coverage.

b. **Employer-Sponsored Insurance (ESI):** Arizona must obtain State legislative authority as well as implement and provide services through the ESI program described in this STC by December 1, 2008.

i. **Penalty.** Failure to implement the ESI program by December 1, 2008, and to maintain its effective operation throughout the duration of the demonstration period will result in the elimination, beginning July 1, 2007, of title XXI expenditure authority and funds for the HIFA eligible demonstration populations. This does not preclude the State from providing coverage to these demonstration populations using title XIX expenditure authority as specified in this paragraph and paragraph #58. However, the State is not required to meet the 60-day written notification requirements of this paragraph and paragraph 58, and funding may be changed retroactively.

ii. **Eligibility:** Children eligible under the State CHIP program (in the last group described in Table 1), whose family income is between 100 percent up to and including 200 percent of FPL, and who have access to a qualifying employer sponsored insurance (ESI) plan, as described in (v) and (vi) below.

iii. **Enrollment Process:** Prior to enrollment in the ESI, children (either directly or through their parents or guardians) must specify that they are declining enrollment in CHIP and instead requesting enrollment in the ESI. Before such a request is accepted, the individual must receive information/counseling in order to ensure that enrollment is an informed choice. ESI enrollees will have the choice to opt back into CHIP direct coverage at any time.

iv. **Premium Assistance Benefits**: The State will subsidize premium assistance through a monthly per child subsidy that will not exceed the per capita cost of direct CHIP coverage for the child. This monthly subsidy does not need to be allocated between eligible and ineligible family members.

v. **Minimum Employer Contribution.** Qualifying ESI must include employer contributions of at least 30 percent of the total premium or cost under the employer plan.

vi. **Minimum Benefit package.** Qualifying ESI will include coverage that provides a basic primary care package of inpatient hospital services, outpatient services, laboratory and x-ray services, pharmacy services, and behavioral health services. Coverage may be provided through any commercial group package or self-insurance program offered by the employer

to all employees in a class. Within these parameters, benefits may vary between employers.

vii. **Choice of ESI Plans.** To the extent that premium assistance is extended to individuals, the individuals must agree not to exercise choice among available ESI plans without obtaining State concurrence. The State will not, however, deny coverage based on a prior exercise of such choice.

c. **Eligibility Processes.**

i. The eligibility process for uninsured adults without dependent children is identical to the eligibility process currently practiced under title XIX.

ii. The eligibility process for uninsured parents of Medicaid or CHIP children is identical to the eligibility process currently practiced under title XXI.

d. **Benefits.**

i. Uninsured adults without dependent children receive the adult AACP benefits package.

ii. Uninsured parents receive the adult AACP benefits package.

iii. Enrollees in the ESI program will receive the benefit package available through the employer-sponsored insurance product. Wrap-around services are not provided.

e. **Cost Sharing.**

i. As of October 1, 2006, adults without dependent children follow all AHCCCS cost sharing rules per paragraph 31(d). The State may choose to implement the following co-payments for adults without dependent children:

1. Generic prescriptions or brand name prescriptions if generic is not available - $4;
2. Brand name prescriptions when generic is available - $10;
3. Non-emergency use of emergency room - $30; and
4. Physician office visit - $5

The State will notify CMS in writing at least 60 days prior to implementation of these co-payments and include documentation of public notice per paragraph 15.

ii. Parents will have the following fee schedule:

	100%-150% FPL	**151%-175% FPL**	**176%-200% FPL**
Premiums (effective May 1, 2009)	3% of Net Household Income	5% of Net Household Income	5% of Net Household Income
Enrollment Fee	$15	$20	$25
Deductibles	None	None	None
Co-payments	None	None	None
ER Co-pays	$1 if no emergency	$1 if no emergency	$1 if no emergency

iii. Arizona must submit a revised allotment neutrality budget and documentation of public notice before implementing a change in premiums for parents. The revised budget and public notice documentation must be submitted to CMS 60 days prior to implementation

iv. Enrollees in the ESI program will have cost sharing set by their employer-based coverage.

f. **Enrollment Data.** Each quarter, the State will provide CMS with end of quarter actual and unduplicated ever-enrolled figures. These enrollment data will be entered

into the Statistical Enrollment Data System within 30 days after the end of each quarter. The data will also be referenced in the quarterly reports described in paragraph 24. Arizona will report each demonstration population on a separate 21W form in SEDS as long as the State is claiming title XXI for each population. Arizona will use the sub-category "Other adults covered in demonstration" to report adults without dependent children enrollment, and Arizona will use the sub-category "Parents/Caretaker relatives (not Medicaid eligible)" to report parent enrollment. In addition, the State will provide monthly enrollment data as specified by CMS in the monthly Eligibility and Enrollment Reports.

g. **Funding.** The State will establish a monitoring process to ensure that expenditures for the HIFA amendment do not exceed available title XXI funding (i.e., the title XXI allotment or reallocated funds) and the appropriated State match. The State will use title XXI funds to cover services for the CHIP and HIFA populations in the following priority order:

    1) Title XXI State plan eligibles, as well as children that opt for ESI, who are children up to age 19 years with family incomes up to and including 200 percent of the FPL.
    2) Uninsured individuals with adjusted net countable family income above 100 percent of the FPL up to and including 200 percent of the FPL who are parents of children enrolled in the Arizona Medicaid or CHIP programs but who themselves are not eligible for either program.
    3) Uninsured adults without dependent children over age 18 years with income above 40 percent of the FPL up to and including 100 percent of the FPL who are also eligible under the Medicaid section 1115 eligibility expansion.
    4) If the State determines that title XXI funding will be exhausted, available title XXI funding will first be used to cover costs associated with the title XXI State plan population. The State will not close enrollment, institute waiting lists, or decrease eligibility standards with respect to the children covered under its title XXI State plan while the HIFA amendment is in effect.
    5) For the purpose of administering the priority system, no distinction will be made between parents of Medicaid children and parents of CHIP children. The State may also, for the Medicaid or CHIP parents and childless adults:
        - Lower the FPL used to determine eligibility, and/or
        - Suspend eligibility determination and/or intake into the program, or
        - Discontinue coverage.

       Taking action regarding the FPL will require an amendment to the Demonstration. Action regarding suspension of intake into the program or discontinuation of coverage will require 60-day notice to CMS prior to implementation of the change. If the expansion to parents of Medicaid and CHIP children is not continued by the State, Arizona will no longer receive title XXI funding for adults without dependent children.
    6) For adults without dependent children and parents, title XIX Federal matching funds will be provided if title XXI funding is exhausted. The State must provide CMS with 60 days notification before it begins to draw down title XIX funding for either of these populations. For the parent

population, the State must also negotiate budget neutrality before drawing down title XIX matching funds. Once the State has used title XIX funding for parents and/or adults without dependent children, should title XXI funds become available again for these populations, the State must provide CMS with 60 days notification and must submit a revised allotment neutrality budget for CMS approval prior to modifying the Federal funding source.

37. **Family Planning Extension Program.** Family planning services are provided to eligible recipients who lose SOBRA eligibility at 60 days postpartum for up to 24 months with a re-determination of eligibility, including income, at 12 months. The income limit for re-determination of eligibility is 133 percent of the FPL.
    a. **Duplicate Payments.** The State must not use title XIX funds to pay for individuals enrolled in regular Medicare, Medicaid, CHIP, any other federally-funded program (i.e., title X), or component of this section 1115 demonstration who seek services under the family planning extension program. Effective October 1, 2007, the State shall only enroll or reenroll individuals into the family planning demonstration that are uninsured (defined as not having creditable coverage). The State will have up to 1 year from the date of the approval letter to begin disenrolling insured individuals at their annual eligibility redetermination. During this 1-year period, the State shall pursue third-party-liability reimbursement for any individual who has other insurance and ensure that Medicaid will be the payer of last resort.
    b. **Primary Care Referral.** The State shall facilitate access to primary care services for enrollees in the family planning extension program. The State shall submit to CMS a copy of the written materials that are distributed to the family planning extension program participants as soon as they are available. The written materials must explain to the participants how they can access primary care services. In addition, the State must evaluate the impact of providing referrals for primary care services. This component of the evaluation must be highlighted in the evaluation design that will be submitted to CMS as specified in paragraph 40(b) of this document.
    c. **Eligibility Re-determinations.** The State will ensure that re-determinations of eligibility for this component of the Demonstration are conducted, at a minimum, once every 12 months in accordance with Federal regulations at 42 CFR 435.916. The State shall submit for CMS approval its process for eligibility re-determinations within 30 days of the date of the Demonstration award letter. The process for eligibility re-determinations shall not be passive in nature, but will require that an action be taken by the family planning expansion program recipient in order to continue eligibility for this program. The State may satisfy this requirement by having the recipient sign and return a renewal form to verify the current accuracy of the information previously reported to the State.
    d. **Reporting Requirements Related to Family Planning Extension.**
        i. In each annual report described in paragraph 25, the State shall report 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 through age 1 year. (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.)

ii. In each annual report described in paragraph 25, the State shall report the number of actual births that occur to family planning extension demonstration participants (Participants include all individuals who obtain one or more covered medical family planning services through the family planning extension program) each year.

iii. The State will submit to CMS base-year fertility rates and a methodology for calculating the fertility rates no later than March 31, 2007. For purposes of this section, "fertility rate" means birth rate. These rates must:

1. Reflect fertility rates during Base Year 2003 for women, age 19-44 years, with family incomes between 100 percent to 133 percent of the FPL and ineligible for Medicaid except for pregnancy.
2. Be adjusted for age, using age bands, for all potential Demonstration participants.
3. Include births paid for by Medicaid.
4. At the end of each demonstration year (DY), a DY fertility rate will be determined by summing the age-specific rates using the age distribution of the Demonstration participants during that DY to weight the age-specific fertility rates, unless the State demonstrates that the age distribution is consistent with the prior DY(s). The annual age distribution categories will correspond with the base-year age-specific fertility rates. The intent of the Demonstration is to avert unintended pregnancies to offset the cost of family planning services for Demonstration participants. The base-year fertility rate and the DY fertility rate will be used to calculate a measure of births averted through the demonstration using the following formula: 'Births Averted' = the [(base year fertility rate) minus (fertility rate of demonstration participants during DY)] multiplied by the (number of demonstration participants during DY).

iv. No later than 30 days after the Demonstration approval letter, the State will provide to CMS for approval an appropriate methodology for ensuring the integrity of annual eligibility determinations of individuals covered under the family planning extension program. The State will use this methodology to conduct reviews of the eligibility determination process on an annual basis. As part of the submission, the State will also develop an eligibility determination error rate methodology. If annual reviews of the eligibility determination process suggest error rates beyond a State established threshold, the State will develop a corrective action plan for CMS approval.

e. **Extent of Federal Financial Participation for Family Planning Extension Program.** CMS shall provide FFP for CMS-approved services (including prescriptions) provided to women under the family planning extension program at the following rates and as described in Attachment C:

i. For procedures or services clearly provided or performed for the primary purpose of family planning (contraceptives and sterilizations) and which are provided in a family planning setting, FFP will be available at the 90-percent Federal matching rate. Procedure codes for office visits, laboratory tests, and certain other procedures must carry a diagnosis that specifically identifies them

as a family planning service.

ii. 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 sexually transmitted infections as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. Subsequent treatment would be paid for at the applicable Federal matching rate for Arizona. For testing or treatment not associated with a family planning visit, no FFP will be available.

iii. CMS will provide FFP at the appropriate 90 percent administrative match rate for administration of the offering, arranging, and furnishing of family planning services. General administration costs of the program, including for example, outreach costs, claims processing, program development, and monitoring will receive the appropriate 50 percent administrative match rate.

iv. Arizona will provide to CMS an updated list of Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding Systems (HCPCS) codes covered under the Demonstration on January 31 of each DY. The revised code list should reflect only changes due to updates in the services and should only include services for which the State has already received approval.

v. Changes to Attachment C will require an amendment to the Demonstration.

VI. DELIVERY SYSTEMS

38. **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 30 days to review and approve changes.

39. **Health Services to Native American Populations.** The plan currently in place for patient management and coordination of services for Medicaid-eligible Native Americans, developed in consultation with the Indian tribes and/or representatives from the Indian health programs located within the State, shall continue in force for this extension period.

VII. EVALUATION

40. **State Must Separately Evaluate Components of the Demonstration.** As outlined in subparagraphs (a), (b), and (c), 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 State must submit to CMS for approval a draft evaluation design no later than February 1, 2007. The evaluation must outline and address evaluation questions for all of the following components:

a) The State must submit to CMS for approval a draft evaluation design no later than 6 months after the demonstration award. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations within the Acute Care, ALTCS, and HIFA/ESI programs within the demonstration. 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 draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

b) **Family Planning Extension Program**. The draft design must include a discussion of the goals, objectives, and evaluation questions specific to this component of the Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the family planning extension program, particularly among the target family planning population, during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the family planning extension program shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation. The report should also include an integrated presentation and discussion of the specific evaluation questions (including those that focus specifically on the target population for the family planning program) that are being tested. At a minimum, the following data elements will be included in the measurement methodology:

Measure	Number	Percentage Change
Enrollment		
Averted Births		
Family Planning Patients Receiving a Clinical Referral for Primary Care	**(estimate can be based on a sample)**	

c) **HIFA Evaluation**. Arizona must conduct an evaluation of the HIFA demonstration as described in paragraph 41. The State shall report on its progress in the quarterly and annual reports. AHCCCS will monitor and report on the progress toward agreed-upon goals for reducing the rate of uninsurance. AHCCCS will also 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). Finally, AHCCCS will study the goals, objectives, and hypotheses that have been proposed as part of this HIFA demonstration with a specific focus on the link between parental and adult coverage under this Demonstration and health care coverage for children.

41. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft

design, within 60 days of receipt, and the State must submit a final design within 60-days of receipt of CMS comments. The State must implement the evaluation design, and submit to CMS a draft of the evaluation 120 days after the expiration of the demonstration. CMS shall provide comments within 60 days of receipt of the draft evaluation. Within 60 days of receipt of comments from CMS, a revised final report must be submitted.

42. **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.

VIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

43. **Quarterly Expenditure Reports.** Effective with the quarter beginning October 1, 2006, 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.

44. **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, 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. AC/MED

iv. ALTCS-DD
v. ALTCS-EPD
vi. Family Planning Extension
vii. HIFA II (Parents)*
viii. DSH and Critical Access Hospital Payments (CAHP)**

* Reporting Expenditures in the Demonstration for individuals in these categories must be in accordance with paragraph 58.

**Critical Access Hospital Payments as defined in Attachment F

c. **Family Planning Extension**. For the family planning extension component (defined as the AHCCCS-eligible women who lose SOBRA eligibility at 60 days postpartum and receive family planning services for up to 24 months) of the Demonstration, the State should report Demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:
   i. Allowable family planning expenditures eligible for reimbursement at the State's Federal medical assistance percentage rate (FMAP) should be entered in Column (B) on the appropriate waiver sheets.
   ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets.

d. **Expenditures Subject to the Budget Neutrality Cap**. For purposes of section VIII, 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.

e. **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.

f. **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.

g. **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.

45. **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:
            (a) Eligibility Group 1:AFDC / SOBRA
            (b) Eligibility Group 2: SSI
            (c) Eligibility Group 3: ALTCS-DD
            (d) Eligibility Group 4: ALTCS–EPD
        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 AC/MED Group – described in paragraph 30 as:
        i. AC - Individuals with adjustable net countable income at or below 100% FPL who are not otherwise eligible for Medicaid.
        ii. MED - Medical Expense Deduction - Individuals, couples, or families whose income exceeds the Medicaid limits and who are eligible after deducting their medical expenses from their income.

46. **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.

47. **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;
    c) Net expenditures and prior period adjustments made with dates of service during the operation of the Demonstration.

48. **Medicare Part D Drugs.** No FFP is available for this Demonstration for Medicare Part D drugs.

49. **Sources of Non-Federal Share.** The State certifies that the non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used to match any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the 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. 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.
    c. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. 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.

50. **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 currently claims Federal matching dollars using CPEs as the funding mechanism, the State may continue to use a payment methodology and cost documentation process in place prior to October 1, 2006. All other requirements of this term and condition are still applicable and the State is subject to any policy guidance or regulation released by CMS regarding the use of CPEs. Any changes made to these methodologies through the Medicaid State plan are subject to review and are bound to all applicable rules governing sources of non-Federal share.

ii. To the extent that Arizona institutes the use of CPEs after October 1, 2006, 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.

iii. The State must submit a disproportionate share hospital (DSH) payment methodology for the Arizona State Hospital (ASH) and the Maricopa Medical Center prior to June 30, 2007. This payment methodology will be cost reimbursement and will utilize CPEs as the funding system. The methodology and the cost identification/reconciliation process must be approved by CMS prior to the State claiming Federal match for DSH payments effective July 1, 2007. This DSH payment methodology will be an amendment to the DSH methodology in Attachment D.

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.

51. **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.

52. **Proper and Efficient Administration of the Plan.** Upper Payment Limits allow the State to enhance Medicaid payments to health care providers as long as the payments do not exceed what Medicare payment principles would have paid for the same service. By March 31, 2007, the State must submit to CMS a report that provides justification for any areas in which the State's rate setting methodology may not be in compliance with section 1902(a)(30)(A) of the Act. The report will describe any changes to the fee-for-service rate setting methodology the State plans to implement.

53. **Institutions for Mental Disease (IMD) Phase Down –** Allowable expenditures that will be recognized for purposes of this demonstration will be phased down for services to Arizona enrollees ages 21 through 64 years of age residing in IMDs for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days. Allowable expenditures will be recognized in accordance with the chart below.

Period	Allowable Portion of Expenditures
October 1, 2006-September 30, 2007	100%
October 1, 2007-September 30, 2008	50%
October 1, 2008-September 30, 2009	0%

54. **Fraud and Abuse Recoveries**: Medicaid is the largest source of funding for medical and health-related services for people with limited income. States are primarily responsible for policing fraud in the Medicaid program and CMS provides technical assistance, guidance, and oversight in these efforts. CMS is requiring:
    a. The State to develop and submit for review an action plan by April 1, 2007, to enhance Medicaid fraud and abuse recoveries by the end of the Demonstration extension period ending September 30, 2011.
    b. The State must provide CMS with an annual report of the State's action plan as required in paragraph 25.
    c. The State to demonstrate by September 30, 2010, that their level of recoveries is equal to, or greater than, the level approved by CMS.

IX. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

55. **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.

56. **Tracking CHIP Expenditures.** In order to track title XXI expenditures under this Demonstration, the State will report Demonstration expenditures through the MBES/CBES, following routine CMS-21 reporting instructions as outlined in section 2115 of the State Medicaid Manual. Title XXI Demonstration expenditures will be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver (i.e., HIFA1 and HIFA Parents), 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).
    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

57. **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. In addition, failure to implement and maintain the ESI program as described in paragraph 36(b) will result in the State repaying the difference between title XXI FFP and title XIX FFP so that the State receives the lower FFP rate for the adult HIFA populations beginning July 1, 2007, through the end of the renewal period.

58. **Drawdown of Title XIX Funds.**

a. **Adults without Dependent Children (HIFA1)**. For Adults without Dependent Children, title XIX Federal matching funds will be provided if title XXI funding is exhausted. As of October 1, 2006, Arizona is claiming title XIX matching funds and is including such funds in its Budget Neutrality calculations. The State must provide CMS with 60-days notification before it begins to draw down title XIX matching funds for this demonstration population. Once the State has used title XIX funding for this population, should title XXI funds become available again for this population, the State must provide CMS with 60 days written notification and must submit a revised allotment neutrality budget for CMS approval prior to modifying the Federal funding source.

The State is not authorized to claim Title XXI enhanced matching funds for either HIFA I childless adults or HIFA II parents program after September 30, 2009. Title XXI enhanced matching funds are available for the HIFA II parents program for expenditures and/or expenditure adjustments for dates-of-service on or before September 30, 2009.

b. **Parents (HIFA II)**. For Parents, title XIX Federal matching funds will be provided if title XXI funding is exhausted. The State must provide CMS with 60 days notification before it begins to draw down title XIX matching funds for this demonstration population. The State must also negotiate budget neutrality before drawing down title XIX matching funds for this demonstration population in accordance with section X – "Monitoring Budget Neutrality." Once the State has used title XIX funding for this population, should title XXI funds become available again for this population, the State must provide CMS with 60 days written notification and must submit a revised allotment neutrality budget for CMS approval prior to modifying the Federal funding source.

The State is not authorized to claim Title XXI enhanced matching funds for either HIFA I childless adults or HIFA II parents program after September 30, 2009. Title XXI enhanced matching funds are available for the HIFA II parents program for expenditures and/or expenditure adjustments for dates-of-service on or before September 30, 2009.

59. **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.

X. MONITORING BUDGET NEUTRALITY

60. **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.

61. **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.

62. **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.

63. **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: ALTCS-DD
    d. Eligibility Group 4: ALTCS–EPD
    e. Program Group 1: DSH

64. **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 63 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 45 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 6 has been increased by the appropriate growth rate included in the President's Federal fiscal year 2007 budget for DYs 7, 8, 9, and 10, as outlined below.

Eligibility Group	Trend Rate	DY 6 FFY 2007	DY 7 FFY 2008	DY 8 FFY 2009	DY 9 FFY 2010	DY 10 FFY 2011
AFDC / SOBRA	7.2%	$421.27	$451.60	$484.12	$518.98	$556.35
SSI	7.2%	$632.50	$678.04	$726.86	$779.19	$835.29
ALTCS - EPD	7.2%	$3409.91	$3655.42	$3918.61	$4200.75	$4503.20
ALTCS - DD	7.2%	$3516.33	$3769.51	$4040.91	$4331.86	$4643.75

   iv. The annual budget neutrality expenditure cap for the Demonstration as a whole is the sum of DSH allotment plus the annual expenditure caps for each eligibility group calculated in subparagraph 64(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 64(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 44 during the Demonstration period.

c) Apply the effective FMAP that is determined from the MBES/CBES Schedule C report.

65. **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
Years 1 through 6	Budget neutrality expenditure cap plus	1.0 %
Years 1 through 7	Combined budget neutrality expenditure caps plus	0.75 %
Years 1 through 8	Combined budget neutrality expenditure caps plus	0.5 %
Years 1 through 9	Combined budget neutrality expenditure caps plus	0.25 %

Years 1 through 10	Combined budget neutrality expenditure caps plus	0.0 %

66. **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.

XI. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	**Deliverable**
September 30, 2010	Written Notice of State's Intent to Extend the Demonstration Under 1115
March 31, 2011	Complete Demonstration Extension Application (1115)
January 31, 2012	Submission of final Evaluation Design STC # 41
May 30, 2012	Submit Draft Evaluation Report - STC # 40
September 30, 2012	Final Evaluation Report due-clause 41. Final Report - STC# 26. End of Demonstration Period.
Monthly Deliverables	Monthly call - STC# 23
	HIFA Enrollment Data by demonstration group - STC# 36(f)
	Family Planning Enrollment Data – STC # 25
Quarterly Deliverables	Requirements for Quarterly Reports – STC # 24,
	Quarterly Budget Neutrality Reports – STC # 19
	Expenditure Reports CMS 64 and CMS21 - STC# 43 and STC# 555
	Member Months Report - STC# 45
	SEDS Enrollment Data - STC# 36(f)
Annual Deliverables	Requirement for Annual Report - STC# 25,
	Requirement for annual HCBS Report on March 31st - STC# 34 (f)(iv)
	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 – STC # 60 (b)
	Annual Fertility Rates – October 31 STC # 37(d)(iii)(4)

Attachment A - Quarterly Report Guidelines

As written in STC paragraph 24, 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.

HIFA Issues:
Identify all significant program developments/issues/problems that have occurred in the current quarter. Include an analysis of current title XXI allotment availability, and include enrollment data, point-in-time and ever enrolled, by HIFA coverage groups.

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

Family Planning Extension Program:
Identify all significant program developments/issues/problems that have occurred in the current quarter. Include enrollment data.

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 – Family Planning Procedure Codes - 2010

The services listed in this attachment do not guarantee coverage by the State. The inclusion of services is solely for the purposes of indicating the codes for which Federal financial participation is available under this Family Planning Extension Program.

CODE	DESCRIPTION	90% FFP	90% FFP with V25 or FP
00851	ANES;TUBAL LIGATION/TRANSECTION	X	
11975	INSERTION, IMPLANTABLE CONTRACEPTIVE CAPSULES	X	
11976	REMOVAL WITHOUT REINSERTION, IMPLANT	X	
11977	REMOVAL WITH REINSERTION IMPLANTABLE CONTRACEPTIVE CAPSULES	X	
36415	COLLECT VENOUS BLOOD BY VENIPUNCTURE		X
57170	DIAPHRAGM FITTING.WITH INSTRUCTIONS	X	
58300	INSERT INTRAUTERINE DEVICE	X	
58301	REMOVE INTRAUTERINE DEVICE	X	
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography or hysterosalpingography		X
58345	Transcervical introduction of fallopian tube catheter for diagnosis and or re-establishing patency (any method), with or without hysterosalpingography		X
58565	HYSTEROSCOPY W/ BILATERAL FALLOPIAN TUBE CANNULATION TO INDUCE OCCLUSION BY PLACEMENT OF PERMANENT IMPLANTS		X
58600	DIVISION OF FALLOPIAN TUBES	X	
58615	OCCLUSION OF FALLOPIAN TUBE, DEVICE	X	
58670	LAPAROSCOPY, TUBAL CAUTERY	X	
58671	LAPAROSCOPY, TUBAL BLOCK	X	
62311	INJECTIONS; LUMBAR, SACRAL		X
62319	INJECT SPINE W/CATH L/S (EPIDURAL OR CAUDAL)		X
74740	Hysterosalpingography, radiologic supervision and interpretation		X
74742	Transcervical catherterization of fallopian tube, radiological supervidion and interpretation.		X
80047	BASIC METABOLIC PANEL WITH CALCIUM IONIZE		X
80048	BASIC METABOLIC PANEL WITH CALCIUM TOTAL		X
80050	GENERAL HEALTH SCREEN PANEL		X
80051	ELECTROLYTE PANEL		X
80061	LIPID PROFILE		X
81000	URINALYSIS WITH MICROSCOPY		X
81001	URINALYSIS, AUTO, W/SCOPE		X
81002	ROUTINE URINE ANALYSIS		X
81003	URINALYSIS, BY DIP STICK OR TABLET R		X
81005	URINALYSIS		X
81025	URINE PREG TEST-BY VISUAL COLOR COMP		X
82948	STICK ASSAY OF BLOOD GLUCOSE		X
82962	GLUCOSE, BLOOD, BY GLUCOSE MONITORIN		X
83020	ASSAY HEMOGLOBIN		X
83021	ASSAY HEMOGLOBIN CHROMATOGRAPHY		X
84520	ASSAY BUN		X
84550	ASSAY BLOOD URIC ACID		X

CODE	DESCRIPTION	90% FFP	90% FFP with V25 or FP
84702	GONADOTROPIN,CHORIONIC; QUANTITATIVE		X
84703	GONADOTROPIN,CHORIONIC;QUALITATIVE		X
85013	SPUN HEMATOCRIT		X
85014	BLOOD COUNT OTHER THAN SPUN HEMATOCRIT		X
85018	BLOOD COUNT: HGB		X
86592	SYPHILIS TEST(S),QUALITATIVE		X
86593	SYPHILIS TEST, QUANTITATIVE		X
86631	ANTIBODY;CHLAMYDIA		X
86645	ANTIBODY;CYTOMEGALOVIRUS		X
86687	ANTIBODY; HTLV-I		X
86688	ANTIBODY; HTLV-II		X
86689	CONFIRMATORY TEST HYLV or HIV		X
86701	ANTIBODY; HIV-1		X
86702	ANTIBODY; HIV2		X
86703	ANTIBODY; HIV 1 AND 2 SINGLE ASSAY		X
87070	CULTURE SPECIMEN, BACTERIA		X
87075	CULTURE SPECIMEN, BACTERIA		X
87081	BACTERIA CULTURE SCREEN		X
87110	CULTURE, CHLAMYDIA, ANY SOURCE		X
87210	SMEAR, STAIN & INTERPRET		X
87270	CHYLMD TRACH AG, DFA		X
87320	CHYLMD TRACH AG, EIA		X
87390	HIV-1 AG, EIA		X
87391	HIV-2 AG, EIA		X
87480	CANDIDA, DNA, DIR PROBE		X
87481	CANDIDA, DNA, AMP PROBE		X
87490	CHYLMD TRACH, DNA, DIR PROBE		X
87491	CHYLMD TRACH, DNA, AMP PROBE		X
87528	HERPES SIMPLEX VIRUS, DIRECT PROBE TECHNIQUE		X
87529	HERPES SIMPLEX VIRUS, AMPLIFIED PROBE TECHNIQUE		X
87590	N.GONORRHOEAE, DNA, DIR PROB		X
87591	N.GONORRHOEAE, DNA, AMP PROB		X
87620	HPV, DNA, DIR PROBE		X
87621	HPV, DNA, AMP PROBE		X
87810	CHLAMYDIA TRACHOMATIS		X
87850	N. GONORRHOEAE ASSAY W/OPTIC		X
88108	CYTOPATHOLOGY,FLUIDS,WASHINGS		X
88141	CYTOPATH CERV/VAG INTERPRET		X
88142	CYTOPATH CERV/VAG THIN LAYER		X
88143	CYTPATH C/VAG T/LAYER REDO		X
88147	CYTPATH C/VAG AUTOMATED		X
88148	CYTPATH C/VAG AUTO RESCREEN		X
88152	CYTOPATH CERV/VAG AUTO		X
88153	CYTPATH C/VAG REDO		X
88154	CYTPATH C/VAG SELECT		X
88155	CYTOPATH,(PAP);W/ DEF.HORMONAL EVAL		X
88160	CYTOPATHOLOGY		X
88161	CYTOPATH . . .; PREP, SCREEN INTERP.		X
88162	CYTOPATH . . .; EXT. STUDY.+5 SLIDES, MULTI		X
88164	CYTPATH TBS C/VAG MANUAL		X
88165	CYTPATH TBS C/VAG REDO		X

CODE	DESCRIPTION	90% FFP	90% FFP with V25 or FP
88166	CYTPATH TBS C/VAG AUTO REDO		X
88167	CYTPATH TBS C/VAG SELECT		X
88173	FINE NEEDLE ASPIRATE..;INTERP/REPORT		X
88174	CYTOPATH, C/VAG (ANY REP.SYSTEM)		X
88175	CYTOPATHOLOGY WITH SCREENING		X
88300	SURGICAL PATHOLOGY, GROSS		X
88302	SURGICAL PATHOLOGY, COMPLETE		X
96372	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION		X
93000	ROUTINE ECG W/AT LEAST 12 LEADS (only for routine pre-operative sterilization procedures)		X
99000	HANDLING AND/OR CONVEYANCE OF SPECIMEN FOR TRANSFER FROM PHYSICIAN OFFICE TO LAB		X
99201	OFFICE,NEW,PROBLEM, STRAIGHTFORWARD		X
99202	OFFICE,NEW PT,EXPANDED,STRAIGHTFORWARD		X
99203	OFFICE,NEW PT, DETAILED, LOW COMPLEX		X
99204	OFFICE,NEW PT, COMPREHEN, MOD COMPLX		X
99205	OFFICE,NEW PT, COMPREHEN, HIGH COMPX		X
99211	OFFICE, EST PT, MINIMAL PROBLEMS		X
99212	OFFICE,EST PT, PROBLEM,STRAITFORWD		X
99213	OFFICE, EST PT, EXPANDED, LOW COMPLX		X
99214	OFFICE,EST PT, DETAILED, MOD COMPLX		X
99215	OFFICE,EST PT, COMPREHEN,HIGH COMPLX		X
99241	OFF CONSULT,NEW OR EST. PT,PRBLM,STRTFWD		X
99242	OFF CONSLT,NEW OR EST. PT,XPND PBLM, STRTFWD		X
99243	OFF CNSLT,NEW OR EST. PT,DTLD, LO CMPLXY		X
99244	OFF CNSLT,NEW OR EST. PT,CMPHSV,MOD CMPLXY		X
99245	OFF CNSLT,NEW OR EST. PT,CMPHSV,HI CMPLXY		X
99395	PERIODIC COMPREHENSIVE MEDICINE VISIT-EST. PT; 18-39 YRS. OLD		X
A4261	CONTRACEPTIVE SUPPLY	X	
A4266	DIAPHRAGM FOR CONTRACEPTIVE USE	X	
A4267	CONTRACEPTIVE SUPPLY	X	
A4268	CONTRACEPTIVE SUPPLY	X	
A4269	CONTRACEPTIVE SUPPLY	X	
A9531	Iodine I-131 sodium iodidie, diagnostic, per microcurie (up to 100 microcuries)		X
A9698	Nonradioactive contrast imaging material, not otherwise specified		X
J1055	DEPO-PROVERA INJ 150MG	X	
J1056	LUNELLE MONTHLY CONTRACEPTION INJ	X	
J3490	UNCLASSIFIED DRUG (USE FOR IMPLANON)	X	
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	X	
J7302	MIRENA	X	
J7303	CONTRACEPTIVE SUPPLY	X	
J7304	CONTRACEPTIVE SUPPLY	X	
Q0091	SCREENING PAPANICOLAOU (PAP) SMEAR		X
Q0111	SCREENING PAP SMEAR		X
Q0112	POTASSIUM MYDROXIDE PREPARATIONS		X
T1002	RN SERVICES		X
	CONTRACEPTIVE DRUGS, SUPPLIES, AND ITEMS IDENTIFIED WITH A NDC CODE	X	

ATTACHMENT D
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.

Except in the case where a hospital's fiscal year is identical to the State Plan Year – the

[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.

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. $9/12^{th}$ of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/08, and
2. $3/12^{th}$ 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:

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

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 hospitals receiving a Medicaid payment and providing information to AHCCCS by the specified date, 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 registered hospitals that have provided information to AHCCCS by the specified date 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 3 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:

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

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 D. 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 non-governmental hospital the all payor per diem and ratio 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 amount will be calculated by dividing:

- The sum of the amounts on Worksheet B Part 1 Column 25 Lines 25 to 33 less the amounts appearing on Worksheet D-1, Part I Lines 26 and 36
- By
- The sum of the amounts on Line 12, Line 14 (for inpatient hospital subproviders), and Line 26 (for observation bed days) from Worksheet S-3 Part I Column 6.

The ancillary RCC will be calculated by dividing:

- The sum of the amounts on Worksheet B Part 1 Column 25 Lines 37 to 63, less Lines 63.5 to 63.99 , (Note: if costs for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 63.5 to 63.99, these cost amounts should also be deducted.)
- By
- The sum of Lines 37 to 63, less Lines 63.5 to 63.99, from Worksheet C Part I Column 8. (Note: 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.)

For each governmentally-operated 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 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 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 non-governmental hospital the all payor per diem and ratio 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.

For each governmentally-operated 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.

Attachment D - AHCCCS Disproportionate Share Hospital (DSH) Payments 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 D.

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 D 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 D

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 the final information for the state plan year of the initial payment. All adjustments must

[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 D.

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 D

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 D

AHCCCS
Disproportionate Share Hospital Payment Methodology
Pool Funding Amounts for SPY 2008, SPY 2009, and SPY 2010

This Exhibit contains the amount of funding for six pools of the Arizona DSH pool methodology for State Plan Year (SPY) 2008 and 2009, and seven pools for SPY 2010. For SPY 2011 the funding will be allocated among six pools

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 will be derived by subtracting the total amount allocated for pools 1 and 2 from $26,147,700, the amount of DSH authorized by the Legislature for non-governmentally operated hospitals for SPY 2008 and SPY 2009. For SPY 2010, the funding for pools 1, 2, 1A, 2A, and 3 will be $500,000. For SPY 2011, the funding for pools 1, 2,1A and 2A will be $9,284,800.

The funding for pool 4 is $117,914,800, the amount authorized by the Legislature for governmentally operated hospitals for SPY 2008. For SPY 2009, the funding amount for governmentally operated hospitals in pool 4 is $128,427,000. For SPY 2010, the funding amount for governmentally operated hospitals in pool 4 is $132,596,900. For SPY 2011, the funding amount for governmentally operated hospitals in pool 4 is $128,637,400.

The funding for pool 5 is $26,000,000 and 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 2011, the funding amount for Pool 5 is $16,000,000.

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, 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. 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.

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 D. 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 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 D. 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.

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.

[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

Attachment E

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

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 F
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 G
AACP Acute Care and Behavioral Health Services

The following chart summarizes the services available to expansion populations covered under the Demonstration. It is not intended to be a detailed or comprehensive statement of benefit coverage. Except as specifically noted in the chart or elsewhere in the List of Waivers, CNOM's, and/or the Special Terms and Conditions, the scope of services for the expansion populations are as set forth in the Arizona State Plan.

Benefit	**Title XIX**		**Title XXI**
Age	< 21 yrs	≥ 21 yrs	< 19 yrs
Inpatient Hospital Services	X	X	X
Outpatient Hospital Services and Rural Health Clinic Services	X	X	X
Other Lab and X-ray Services	X	X	X
Nursing Facility Services for Individuals 21 age or older other than services in an institution for mental disease	X	X	X
EPSDT- medical services and other services covered by Title XXI	X		X
Family Planning Services and Supplies	X	X	
Physician Services	X	X	X
Medical and surgical services of a dentist	X	X	X
Medical or other remedial care provided by licensed practitioners	X	X	X
Home Health Services	X	X	X
Private Duty Nursing Services	X	X	X
Clinic Services	X	X	X
Dental Services	X	X	X
Physical Therapy and Related Services	X	X	X
Occupational Therapy	X	X	X
Services for individuals with speech hearing and language disorders	X	X	X
Prescribed Drugs	X	X	X
Prosthetic Devices	X	X	X
Eyeglasses	X	X	X
Diagnostic Services	X	X	X
Screening Services	X	X	X
Preventive Services	X	X	X
Rehabilitative services			
Inpatient hospital services, nursing facility services and intermediate care facility services for individuals age 65 or older in institutions for mental disease	X	X	X
Inpatient psychiatric facility services for individuals under 21 years of age	X		X
Nurse mid-wife services	X	X	X
Hospice Care		X	
Case Management and Tuberculosis related services	X	X	X
Respiratory care services	X	X	X
Certified Pediatric or family nurse practitioners' services	X	X	X
Transportation	X	X	X
Services of nurses in Religious Non-Medical Health Care Institutions	X	X	X
Nursing facility services for patients under 21 years of age	X		X
Emergency hospital services	X	X	X
Personal Care Services	X	X	X
Behavioral Health	See Table 2 in STC #31		

Non-Governmental Hospital
SPY 2006 PFIS Cover Sheet

State Plan Year	**2006**		
Begins	**10/1/2005**	**Ends**	**9/30/2006**

Hospital Medicare Cost Report (MCR) Year End

Hospital Name				0			0	
Hospital Fiscal Year 1	Begin		End	☐	As Filed		☐	As Filed
Hospital Fiscal Year 2	Begin		End	☐	Revision		☐	Revision
AHCCCS Provider ID				☐	Final (Settled)		☐	Final (Settled)
Medicare Provider ID								

Please use the most recent version of the cost report for each year -- As Filed, Revision, or Final (Settled)
If this hospital is an all-inclusive rate provider under Medicare, please contact AHCCCS for additional information.

A. Attachments

Attach an electronic version of this package including PFIS Cover Sheet, the PFIS and the Uninsured information.

Attach copies of the following schedules from the Medicare Cost Report (CMS 2552-96) from each of the cost report years indicated in the upper right hand corner of this Form

- Worksheet S, Part I and II, Cover Sheet (signed)
- Worksheet S-2
- Worksheet S-3 Part I
- Worksheet A-8
- Worksheet A-8-2
- Worksheet B Part I
- Worksheet C Part I
- Worksheet D-1 Part I and D-1 Part II (for hospital and all subproviders)

Attach a DVD with the claim numbers/other records that were used to compile the charity care amounts reported in Section IV.

Attach a spreadsheet enumerating the payor types that were used to compile the uninsured amounts reported on the Uninsured Schedule. Also attach a DVD with the claim numbers/other records that were used to compile the Uninsured amounts reported on the Uninsured Schedule.

B. Certifications

To be completed by hospital CEO or CFO:

I have examined the information included in this document and the attachments and made such inquiries as seem prudent with respect to its content. The information is true, accurate and complete, to the best of my knowledge and belief. I understand that AHCCCS will rely on this Certification Statement at the time AHCCCS certifies its expenditures to the Centers for Medicare and Medicaid Services on the CMS-64 report. I further understand that the hospital is responsible for reimbursing the AHCCCS Administration the pro rata share of any federal recoupment as well as the full amount of any overpayment, and that any falsification, or concealment, of a material fact may be prosecuted under Federal and State laws.

Check One

☐ I certify that the hospital currently has and has had since the beginning of the current state plan year at least two obstetricians with staff privileges who have agreed to provide obstetric services (emergency and nonemergency) to individuals eligible for Medicaid.

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

☐ I certify that the hospital 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.

Signature	Date
Typed Name	Title

C. Hospital Contact for AHCCCS

		Alternate	
Name		Name	
Address		Address	
Phone		Phone	
e-mail		e-mail	
Fax		Fax	

Non-Governmental Hospital
SPY 2006 Private PFIS Sheet

ALL CELLS SHADED YELLOW ARE TO HAVE DATA PROVIDED BY THE HOSPITAL
ALL CELLS SHADED GREEN ARE TO HAVE DATA PROVIDED BY AHCCCS ENTERED BY THE HOSPITAL
ALL CELLS SHADED BLUE ARE AUTOMATICALLY CALCULATED OR POPULATED

I. Data Obtained from the CMS 2552

A. Data for Calculation of Medicaid Inpatient Utilization Rate (MIUR)

			MCR 0	MCR 0
1. Total Inpatient Days				
Data Source: CMS 2552 96 Worksheet S-3, Part I, Column 6, Line 1, Lines 6 through 11 and Line 14 (hospital subproviders) and Line 26 (observation beds); please include all subscript lines!				
Line 1 Adults and Peds				
Line 6 Intensive Care Unit				
Line 7 Coronary Care Unit				
Line 8 Burn Intensive Care Unit				
Line 9 Surgical Intensive Care Unit				
Line 10 Other Special Care				
Line 11 Nursery				
Line 14 Total of Subprovider Days				
Sub Total Days			-	-
Line 3 Adults and Peds Swing Bed SNF				
Line 4 Adults and Peds Swing Bed NF				
Line 26 Observation Beds Days				

B. Data for Calculation of the Hospital Low Income Utilization Rate (LIUR)

			MCR 0	MCR 0
1. Total Inpatient Hospital Charges			$ -	$ -
Data Source: CMS 2552-96 Worksheet C Part I, Column 6, Line 101 less Lines 34 to 36 and less Lines 64 to 68. Also exclude Lines 63.5 through 63.99 (RHCs and FQHCs). If charges for RHCs and FQHCs appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101.				
Total Inpatient Charges (Line 101)				
Line 34 (Including all Subscripts) Skilled Nursing Facility				
Line 35 (Including all Subscripts) Other Nursing Facility				
Line 36 (Including all Subscripts) Other Long Term Care				
Line 64 (Including all Subscripts) Home Program Dialysis				
Line 65 (Including all Subscripts) Ambulance Services				
Line 66 (Including all Subscripts) Durable Medical Equipment - Rented				
Line 67 (Including all Subscripts) Durable Medical Equipment - Sold				
Line 68 (Including all Subscripts) Other Reimbursable				
Subtotal Lines 63.5 to 63.59 Rural Health Clinic				
Subtotal Lines 63.60 to 63.84 Federally Qualified Health Clinic				
Subtotal Lines 63.85 to 63.99 Rural Health Clinic				

			MCR 0	MCR 0
2. Total Inpatient and Outpatient Charges for Patient Services			$ -	$ -
Data Source: CMS 2552-96 Worksheet C Part I, Column 8, Line 101 less Lines 34 to 36 and less Lines 64 to 68. Also exclude Lines 63.5 through 63.99 (RHCs and FQHCs). If charges for RHCs and FQHCs appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be deducted from Line 101.				
Total Charges (Line 101)				
Line 34 (Including all Subscripts) Skilled Nursing Facility				
Line 35 (Including all Subscripts) Other Nursing Facility				
Line 36 (Including all Subscripts) Other Long Term Care				
Line 64 (Including all Subscripts) Home Program Dialysis				
Line 65 (Including all Subscripts) Ambulance Services				
Line 66 (Including all Subscripts) Durable Medical Equipment - Rented				
Line 67 (Including all Subscripts) Durable Medical Equipment - Sold				
Line 68 (Including all Subscripts) Other Reimbursable				
Subtotal Lines 63.5 to 63.59 Rural Health Clinic				
Subtotal Lines 63.60 to 63.84 Federally Qualified Health Clinic				
Subtotal Lines 63.85 to 63.99 Rural Health Clinic				

	MCR 0	MCR 0
3. Ratio of Total Inpatient Hospital Charges to Total Inpatient/Outpatient Charges for Patient Services	-	-

C. Data Required for Calculation of the Hospital OBRA Limit

	MCR 0	MCR 0
1. Total Inpatient Routine Cost Per Diem	$ -	$ -

Data Source: CMS 2552-96 Worksheet B, Part I, Column 25, sum Lines 25 - 33 divided by CMS 2552-96 Worksheet S-3, Part I, Column 6, sum Lines 12 & 14

Inpatient Routine (Total) Costs from Worksheet B, Part I, Column 25	MCR 0	MCR 0
Line 25 (Including all Subscripts) Adults and Pediatrics		
Line 26 (Including all Subscripts) Intensive Care Unit		
Line 27 (Including all Subscripts) Coronary Care Unit		
Line 28 (Including all Subscripts) Burn Intensive Care Unit		
Line 29 (Including all Subscripts) Surgical Intensive Care Unit		
Subtotal Line 30 Other Special Care Units		
Subtotal Line 31 (Including all Subscripts) Subproviders		
Line 33 (Including all Subscripts) Nursery		
Total Routine Costs	$ -	$ -

1.A Total Inpatient Routine Cost Per Diem for Hospitals with Swing Beds and Private Room Differential	$ -	$ -

Data Source: CMS 2552-96 Worksheet D-1, Part I, Lines 26 and 36

Line 26 Swing Bed Costs		
Line 36 Private room cost differential adjustment		
Total Routine Costs	$ -	$ -

MCR 0	MCR 0
-	-

2. Inpatient and Outpatient Ancillary Ratio of Costs to Charges

Data Source: CMS 2552-96 Worksheet B, Part I, Column 25, sum Lines 37-63 (excluding Lines 63.5 through 63.99 - RHC and FQHC.) divided by Worksheet C, Part I, Column 8, sum Lines 37-63 (excluding Lines 63.5 through 63.99 - RHC and FQHC). If costs and charges for RHCs and FQHCs appear anywhere other than on Lines 63.5 to 63.99, these cost and charge amounts should also be excluded.

	MCR 0	MCR 0
Ancillary Costs Worksheet B, Part I, Column 25		
Line 37 (including all subscript lines) Operating Room		
Line 38 (including all subscript lines) Recovery Room		
Line 39 (including all subscript lines) Delivery Room and Labor Room		
Line 40 (including all subscript lines) Anesthesiology		
Line 41 (including all subscript lines) Radiology Diagnostic		
Line 42 (including all subscript lines) Radiology Therapeutic		
Line 43 (including all subscript lines) Radioisotope		
Line 44 (including all subscript lines) Laboratory		
Line 45 (including all subscript lines) PBP Clinical Laboratory		
Line 46 (including all subscript lines) Whole Blood & Packed Red Blood Cells		
Line 47 (including all subscript lines) Blood Storing, Processing, & Trans		
Line 48 (including all subscript lines) Intravenous Therapy		
Line 49 (including all subscript lines) Respiratory Therapy		
Line 50 (including all subscript lines) Physical Therapy		
Line 51 (including all subscript lines) Occupational Therapy		
Line 52 (including all subscript lines) Speech Pathology		
Line 53 (including all subscript lines) Electrocardiology		
Line 54 (including all subscript lines) Electroencephalography		
Line 55 (including all subscript lines) Medical Supplies Charged to Patients		
Line 56 (including all subscript lines) Drugs Charged to Patients		
Line 57 (including all subscript lines) Renal Dialysis		
Line 58 (including all subscript lines) ASC (Non-Distinct Part)		
Line 59 (including all subscript lines) Other ancillary specify		
Line 60 (including all subscript lines) Clinic		
Line 61 (including all subscript lines) Emergency		
Line 62 (including all subscript lines) Observation Beds (Non-DIS)		
Line 63 (including all subscript lines) Other Outpatient Services Total		
Subtotal Lines 63.5 through 63.99 (RHC & FQHC)		
Total Ancillary Costs	$ -	$ -
Ancillary Charges Worksheet C, Part I, Column 8		
Line 37 (including all subscript lines) Operating Room		
Line 38 (including all subscript lines) Recovery Room		
Line 39 (including all subscript lines) Delivery Room and Labor Room		
Line 40 (including all subscript lines) Anesthesiology		
Line 41 (including all subscript lines) Radiology Diagnostic		
Line 42 (including all subscript lines) Radiology Therapeutic		
Line 43 (including all subscript lines) Radioiscope		
Line 44 (including all subscript lines) Laboratory		
Line 45 (including all subscript lines) PBP Clinical Laboratory		
Line 46 (including all subscript lines) Whole Blood & Packed Red Blood Cells		
Line 47 (including all subscript lines) Blood Storing, Processing, & Trans		
Line 48 (including all subscript lines) Intravenous Therapy		
Line 49 (including all subscript lines) Respiratory Therapy		
Line 50 (including all subscript lines) Physical Therapy		
Line 51 (including all subscript lines) Occupational Therapy		
Line 52 (including all subscript lines) Speech Pathology		
Line 53 (including all subscript lines) Electrocardiology		
Line 54 (including all subscript lines) Electroencephalography		
Line 55 (including all subscript lines) Medical Supplies Charged to Patients		
Line 56 (including all subscript lines) Drugs Charged to Patients		
Line 57 (including all subscript lines) Renal Dialysis		
Line 58 (including all subscript lines) ASC (Non-Distinct Part)		
Line 59 (including all subscript lines) Other ancillary specify		
Line 60 (including all subscript lines) Clinic		
Line 61 (including all subscript lines) Emergency		
Line 62 (including all subscript lines) Observation Beds (Non-DIS)		
Line 63 (including all subscript lines) Other Outpatient Services Total		
Subtotal Lines 63.5 through 63.99 (RHC & FQHC)		
Total Ancillary Charges	$ -	$ -

II. Data Obtained from AHCCCS

A. State Cash Subsidies for Identified programs: Inpatient and Outpatient

	HFY 0	HFY 0
	$ -	$ -
Total Inpatient	$ -	$ -
Total Outpatient	$ -	$ -

	HFY 0	HFY 0
1. Payments for Non-Title XIX and Non-Title XXI enrollees in the DES Comprehensive Medical and Dental Program (AHCCCS will provide)	$ -	$ -
Total Inpatient		
Total Outpatient		
2. Payments for Non-Title XIX and Non-Title XXI enrollees in the DHS Behavioral Health Services Program (Payments by RBHAs) (AHCCCS will provide)	$ -	$ -
Total Inpatient		
Total Outpatient		
3. Payments for Non-Title XIX and Non-Title XXI enrollees in the DHS Children's Rehabilitative Service Program (AHCCCS will provide) Since the DHS CRS provides funds for operations without splitting between inpatient and outpatient, enter the payment amounts in the total area and the dollars will be allocated based on the inpatient charges to inpatient and outpatient charges using the ratio calculated in Section I, Subsection B, Number 3.		
Total Inpatient	$ -	$ -
Total Outpatient	$ -	$ -
4. Support of Trauma Centers and Emergency Departments (AHCCCS will provide)		

III. Subsidy Data Obtained from the Hospital's Financial Records

Include subsidies from government for the general support of the hospital or for indigent or uninsured patients.

Do not include federally funded programs, payments for individuals who are adjudicated or incarcerated or made by law enforcement agencies, payments for the health care of employees of state or local governments, or payments from AHCCCS, or AHCCCS Health Plans, or AHCCCS Program Contractors.

Do not include any DSH payments and do not include on any line any amount included on any other line in this Section III.

If the hospital receives funds for operations that are not designated as either inpatient or outpatient, allocate dollars based on inpatient and outpatient charges using the ratios in Section I Subsection B Number 3 of this worksheet.

	HFY 0	HFY 0
	$ -	$ -
Total Inpatient	$ -	$ -
Total Outpatient	$ -	$ -

A. Tax Levies

Include payments from tax levies from a hospital district organized pursuant to A.R.S. Section 48-1901 et seq.

	HFY 0	HFY 0
	$ -	$ -
Total Inpatient		
Total Outpatient		

B. County Subsidies

	HFY 0	HFY 0
	$ -	$ -
Total Inpatient	$ -	$ -
Total Outpatient	$ -	$ -

1. General subsidy or support from the County

	HFY 0	HFY 0
	$ -	$ -
Total Inpatient		
Total Outpatient		

2. Other Payments from the County to fund Operations

	HFY 0	HFY 0
	$ -	$ -
Total Inpatient	$ -	$ -
Total Outpatient	$ -	$ -

Source: _____

	$ -	$ -
Total Inpatient		
Total Outpatient		

Source: _____

	$ -	$ -
Total Inpatient		
Total Outpatient		

Source: _____

	$ -	$ -
Total Inpatient		
Total Outpatient		

C. State Subsidies

Do not include payments Reported in Section II (payments made by the CMDP program of DES, the CRS program of DHS, payments made by RBHAs funded by DHS/DBHS) or any payments from AHCCCS or AHCCCS Health Plans or Program Contractors. Also, do not include Medicaid payments made by any other State.

	HFY 0	HFY 0
	$ -	$ -
Total Inpatient	$ -	$ -
Total Outpatient	$ -	$ -

1. Payments received by primary care clinics for the uninsured

	HFY 0	HFY 0
	$ -	$ -
Total Inpatient		
Total Outpatient		

2. Other State Payments

	HFY 0	HFY 0
	$ -	$ -
Total Inpatient	$ -	$ -
Total Outpatient	$ -	$ -

Source: _____

	$ -	$ -
Total Inpatient		
Total Outpatient		

Source: _____

	$ -	$ -
Total Inpatient		
Total Outpatient		

Source: _____

	$ -	$ -
Total Inpatient		
Total Outpatient		

D. Local and Other Governmental Payments

Other Government Payments

	HFY 0	HFY 0
	$ -	$ -
Total Inpatient	$ -	$ -
Total Outpatient	$ -	$ -

Source: _____

	$ -	$ -
Total Inpatient		
Total Outpatient		

Source: _____

	$ -	$ -
Total Inpatient		
Total Outpatient		

Source: _____

	$ -	$ -
Total Inpatient		
Total Outpatient		

IV. Charity Care Data Obtained from the Hospital's Financial Records

1. Total Inpatient Hospital 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. 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.

HFY 0	HFY 0

Non-Governmental Hospital
SPY 2006 Uninsured Information

0

V. Uninsured Data Obtained from the Hospital's Financial Records

The hospital should collect uninsured days, charges and program data from the hospital's claims and auditable financial records for each of the hospital's fiscal years that encompass the state plan year

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 Medicare Cost Report

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 (RHCs & FQHCs, Lines 63.5 through 63.99 should not be included). If charges for RHCs and FQHCs appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be excluded.)

Attach a spreadsheet enumerating the payor types that were used to compile the uninsured amounts reported on the Uninsured Schedule. Also attach a DVD with the claim numbers/other records that were used to compile the Uninsured amounts reported on the Uninsured Schedule.

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)

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 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.

Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured

Payments made by state or local government are not considered a source of third party payment

ALL CELLS SHADED YELLOW ARE TO HAVE DATA PROVIDED BY THE HOSPITAL
ALL CELLS SHADED GREEN ARE TO HAVE DATA PROVIDED BY AHCCCS ENTERED BY THE HOSPITAL
ALL CELLS SHADED BLUE ARE AUTOMATICALLY CALCULATED OR POPULATED

A.	**Days and Charges for the Uninsured**	HFY 0	HFY 0
1.	Uninsured Inpatient Days		
2.	Uninsured Ancillary Charges (Inpatient and Outpatient) - Excluding RHCs & FQHCs		

B.	**Payments for the Uninsured**	HFY 0	HFY 0
1.	Received from self pay or third parties (excluding state or local government subsidized care)		
2.	Received Under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA		

C.	Does the list of payor types (and the days & charges information) include RBHAs and/or the Behavior Health Division of the Arizona Department of Health Services? (Input either Y or N)	**Y or N**	**Y or N**

D.	Does the list of payor types (and the days & charges information) include the Ryan White Program? (Input either Y or N)	**Y or N**	**Y or N**

E.	**The Ryan White Program** *If the hospital participates in the Ryan White Program, and the Uninsured information above does not include the Ryan White Program, complete the following information*	HFY 0	HFY 0
1.	Ryan White Inpatient Days		
2.	Ryan White Ancillary Charges (Inpatient and Outpatient) - Excluding RHCs & FQHCs		
3.	Payments from self pay or third parties (excluding state and local government)		
4.	Payments from the Ryan White Program		

Maricopa Medical Center
OBRA Limit and CPE Schedule
SPY06 Unins BHS Sched of Costs

Uninsured BHS NTXIX

The hospital should collect uninsured days, charges and program data from the hospital's claims and auditable financial records for each of the hospital's fiscal years that encompass the state plan year

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 Medicare Cost Report

Governmentally-operated hospitals must collect uninsured days and charges on a cost center basis and use cost center-specific per diems and ratios of cost to charges (RCC) from the Medicare Cost Report

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 (RHCs & FQHCs, Lines 63.5 through 63.99 should not be included; If charges for RHCs and FQHCs appear anywhere other than on Lines 63.5 to 63.99, these charge amounts should also be excluded.)

Attach a spreadsheet enumerating the payor types that were used to compile the uninsured amounts reported on the Uninsured Schedule of Costs. Also attach a DVD with the claim numbers/other records that were used to compile the Uninsured amounts reported on the Uninsured Schedule of Costs

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)

It is permissable 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 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.

Individuals with AHCCCS coverage (either Medicaid or KidsCare) are not considered uninsured

Payments made by state or local government are not considered a source of third party payment

ALL CELLS SHADED YELLOW ARE TO HAVE DATA PROVIDED BY THE HOSPITAL
ALL CELLS SHADED GREEN ARE TO HAVE DATA PROVIDED BY AHCCCS ENTERED BY THE HOSPITAL
ALL CELLS SHADED BLUE ARE AUTOMATICALLY CALCULATED OR POPULATED

Schedule 1	Schedule of Uninsured Costs Schedule 1A Uninsured Cost Hospital Fiscal Year 1 Schedule 1B Uninsured Cost Hospital Fiscal Year 2
Schedule 2	Schedule of Uninsured Payments
Schedule 3	Shortfall Analysis

Maricopa Medical Center
OBRA Limit and CPE Schedule
SPY06 Unins BHS Sched of Costs

Schedule 1A: Determination of Unisured BHS Costs Hospital Fiscal Year 1 **Medicare Cost Report Ending 2006**

Line		Inpatient Routine Cost Centers		[1] Cost Center Per Diem Cost	[2] Uninsured Days	[3] Total Cost
25/5		Adults and Pediatrics				
26/6		Intensive Care Unit				
27/7		Coronary Care Unit				
28/8		Burn Intensive Care Unit				
29/9		Surgical Intensive Care Unit				
30/10		Other Specialty Unit <Specify>	PICU			
30/10	50	Other Specialty Unit <Specify>	NICU			
31/14		Hospital Subprovider <Specify>				
33/11		Nursery				
		TOTAL Inpatient Routine Costs				$ -

Line		Inpatient and Outpatient Ancillaries	[1] Ratio of Cost to Charges	[2] Uninsured Ancillary Charges	[3] Total Cost
37		Operating Room			$ -
38		Recovery Room			$ -
39		Delivery Room and Labor Room			$ -
40		Anesthesiology			$ -
41		Radiology Diagnostic			$ -
42		Radiology Therapeutic			$ -
43		Radioiscope			$ -
44		Laboratory			$ -
45		PBP Clinical Laboratory			$ -
46		Whole Blood & Packed Red Blood Cells			$ -
47		Blood Storing, Processing, & Trans			$ -
48		Intravenous Therapy			$ -
49		Respiratory Therapy			$ -
50		Physical Therapy			$ -
51		Occupational Therapy			$ -
52		Speech Pathology			$ -
53		Electrocardiology			$ -
54		Electroencephalography			$ -
55		Medical Supplies Charged to Patients			$ -
56		Drugs Charged to Patients			$ -
57		Renal Dialysis			$ -
58	1	Endoscopy			$ -
58	2	Vascular Lab			$ -

Maricopa Medical Center
OBRA Limit and CPE Schedule
SPY06 Unins BHS Sched of Costs

Line		Inpatient and Outpatient Ancillaries	[1] Ratio of Cost to Charges	[2] Uninsured Ancillary Charges	[3] Total Cost
59		Pulmonary			$ -
60		Clinic			$ -
60	2	Women's Center			$ -
60	3	Eye Clinic			$ -
60	4	Ent Clinic			$ -
60	6	Surgery Clinic			$ -
60	8	Audiology Clinic			$ -
60	10	Pain Clinic			$ -
60	12	OP Procerdure Room			$ -
60	14	Adult Urgent Care			$ -
60	16	Oncology Clinic			$ -
60	18	Medicine Clinic			$ -
60	24	Burn Clinic			$ -
60	28	Clinical Nutrition			$ -
60	30	OP Psych			$ -
60	32	Pediatric Clinic			$ -
60	34	Ortho Clinic			$ -
61		Emergency			$ -
61	1	Peds ER			$ -
61	2	Burn ER			$ -
62		Observation Beds (Non-DIS)			$ -
63	4	7th Ave FHC			$ -
63	6	Avondale FHC			$ -
63	8	Maryvale FHC			$ -
63	10	Glendale FHC			$ -
63	12	Mirage FHC			$ -
63	14	Mesa FHC			$ -
63	18	Chandler FHC			$ -
63	20	Guadalupe FHC			$ -
63	22	Sunnyslope FHC			$ -
63	24	Scottsdale FHC			$ -
63	26	South Central FHC			$ -
63	40	Dental Clinics			$ -
63	41	Patient Transfer			$ -
63	49	Psych Partial Hospital			$ -
63	50	RHC			$ -
63	60	FQHC			$ -
		Total Ancillaries		$ -	$ -

Adjustment for FQHC & Non Hospital Costs

Summation of Lines with FQHC Costs			$ -
Percent of Expense Excluded			0.3306
Non Hospital			$ -
Costs to be excluded			$ -

Maricopa Medical Center
OBRA Limit and CPE Schedule
SPY06 Unins BHS Sched of Costs

Schedule 1B: Determination of Unisured BHS Costs Hospital Fiscal Year 2 **Medicare Cost Report Ending 2007**

Line		Inpatient Routine Cost Centers		[1] Cost Center Per Diem Cost	[2] Uninsured Days	[3] Total Cost
25/5		Adults and Pediatrics				
26/6		Intensive Care Unit				
27/7		Coronary Care Unit				
28/8		Burn Intensive Care Unit				
29/9		Surgical Intensive Care Unit				
30/10		Other Specialty Unit <Specify>	PICU			
30/10	50	Other Specialty Unit <Specify>	NICU			
31/14		Hospital Subprovider <Specify>				
33/11		Nursery				
		TOTAL Inpatient Routine Costs				$ -

Line		Inpatient and Outpatient Ancillaries	[1] Ratio of Cost to Charges	[2] Uninsured Ancillary Charges	[3] Total Cost
37		Operating Room			$ -
38		Recovery Room			$ -
39		Delivery Room and Labor Room			$ -
40		Anesthesiology			$ -
41		Radiology Diagnostic			$ -
41	1	Cardiac Cath Lab			$ -
41	2	Cat Scan			$ -
41	3	Ultrasound			$ -
41	4	MRI			$ -
41	5	Nuclear Medicine			$ -
41	6	Angiography			$ -
41	7	Mammography			$ -
42		Radiology Therapeutic			$ -
43		Radioiscope			$ -
44		Laboratory			$ -
45		PBP Clinical Laboratory			$ -
46		Whole Blood & Packed Red Blood Cells			$ -
47		Blood Storing, Processing, & Trans			$ -
48		Intravenous Therapy			$ -
49		Respiratory Therapy			$ -
50		Physical Therapy			$ -
51		Occupational Therapy			$ -
52		Speech Pathology			$ -
53		Electrocardiology			$ -
53	1	Cardiology			$ -
54		Electroencephalography			$ -
55		Medical Supplies Charged			$ -
55	1	Medical Supplies Implants			$ -

Maricopa Medical Center
OBRA Limit and CPE Schedule
SPY06 Unins BHS Sched of Costs

Line		Inpatient and Outpatient Ancillaries	[1] Ratio of Cost to Charges	[2] Uninsured Ancillary Charges	[3] Total Cost
55	2	Medical Supplies Skin			$ -
56		Drugs Charged to Patients			$ -
57		Renal Dialysis			$ -
58	1	Endoscopy			$ -
58	2	Vascular Lab			$ -
60		Other Ancillary <Specify>			$ -
60		Clinic			$ -
60	1	Clinic			$ -
60	2	Clinic			$ -
60	3	Eye Clinic			$ -
60	4	Ent Clinic			$ -
60	5	Surgery Clinic			$ -
60	6	Audiology Clinic			$ -
60	7	Clinic			$ -
60	8	OP Procedure Room			$ -
60	9	Adult Urgent Care Clinic			$ -
60	10	Oncology Clinic			$ -
60	11	Attendant Care Clinic			$ -
60	12	Burn Clinic			$ -
60	13	Clinical Nutrition			$ -
60	14	OP Psych Clinic			$ -
60	15	Clinic			$ -
60	16	Ortho Clinic			$ -
60	17	Clinic			$ -
60	18	Antepartum Clinic			$ -
60	19	Clinic			$ -
60	20	Clinic			$ -
60	21	Telemedicine Clinic			$ -
60	22	7th Ave FHC Clinic			$ -
60	23	Avondale FHC Clinic			$ -
60	24	Maryvale FHC Clinic			$ -
60	25	Glendale FHC Clinic			$ -
60	26	Mirage FHC Clinic			$ -
60	27	Mesa FHC Clinic			$ -
60	28	Chandler FHC Clinic			$ -
60	29	Guadalupe FHC Clinic			$ -
60	30	Sunnyslope FHC Clinic			$ -
60	31	South Central FHC Clinic			$ -
60	32	McDowell FHC Clinic			$ -
60	33	CHC Women Center FHC Clinic			$ -
60	34	CHC Internal Medicine FHC Clinic			$ -
60	35	CHC Pediatric FHC Clinic			$ -
60	36	Urgent Care FHC Clinic			$ -
60	37	7th Ave FHC Dental Clinic			$ -
60	38	Avondale FHC Dental Clinic			$ -
60	39	Maryvale FHC Dental Clinic			$ -
60	40	Glendale FHC Dental Clinic			$ -

Maricopa Medical Center
OBRA Limit and CPE Schedule
SPY06 Unins BHS Sched of Costs

Line		Inpatient and Outpatient Ancillaries	[1] Ratio of Cost to Charges	[2] Uninsured Ancillary Charges	[3] Total Cost
60	41	Mirage FHC Dental Clinic			$ -
60	42	Mesa FCH Dental Clinic			$ -
60	43	Chandler FHC Dental Clinic			$ -
60	44	Guadalupe FHC Dental Clinic			$ -
60	45	Sunnyslope FHC Dental Clinic			$ -
60	46	South Central FHC Dental Clinic			$ -
60	47	McDowell FHC Dental Clinic			$ -
60	48	CHC Dental FHC Clinic			$ -
60	49	Clinic			$ -
61		Emergency			$ -
61	1	Peds ER			$ -
61	2	Burn ER			$ -
62		Observation Beds			$ -
		Total Ancillaries		$ -	$ -

Adjustment for FQHC & Non Hospital Costs

Summation of Lines with partial year FQHC Costs			$ -
Percent of Expense Excluded			0.0806
Summation of Lines with full year non hospital costs			$ -
Costs to be excluded			$ -

Maricopa Medical Center
OBRA Limit and CPE Schedule
SPY06 Unins BHS Sched of Costs

Summary of Uninsured BHS Costs	**HFY 2006**	**HFY 2007**
Total Uninsured BHS Inpatient Routine Costs	$ -	$ -
Total Uninsured BHS Ancillary Costs	$ -	$ -
Total Uninsured BHS Costs	**$ -**	$ -

Schedule 2: Schedule of Payments by Uninsured or Third Parties for Uninsured Hospital Services

Third party payments do not include state or local subsidies

Payments for Uninsured BHS Hospital Services During Fiscal Year	**HFY 2006**	**HFY 2007**
Made By Uninsured BHS Patients		
Made On Behalf of Uninsured BHS Patients		
Section 1011 Federal Reimbursements Emergency Health Services Furnished to		
Made By or On Behalf of Uninsured BHS Patients for non hospitals costs included above		
Total Payments for Uninsured BHS	**$ -**	**$ -**

Schedule 3: Uninsured BHS Shortfall Analysis

	HFY 2006	**HFY 2007**
Total Costs for Uninsured BHS	$ -	$ -
Total Payments for Uninsured BHS	$ -	$ -
Total Uninsured BHS Shortfall	$ -	$ -

Medicaid Estimates for SPY 2008

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 based on an estimate of the OBRA limit for the state plan year of the initial DSH payment. In certifying public expenditure estimates, 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 and then provide for adjustments to such OBRA limit. The adjustments must be supported by adequate explanation/justification.

This schedule is provided to permit governmentally-operated hospitals to report the estimated SPY 2008 Uninsured Shortfall. All figures shall be based on the Uninsured Shortfall reported for SPY 2006 with adjustments. All adjustments must be documented with appropriate supporting materials and submitted with thie PFIS OBRA Limit and CPE Schedule.

ALL CELLS SHADED YELLOW ARE TO HAVE DATA PROVIDED BY THE HOSPITAL
ALL CELLS SHADED BLUE ARE AUTOMATICALLY CALCULATED OR POPULATED

Schedule 1: Schedule of Uninsured Costs for Uninsured Hospital Services

Summary of Uninsured Costs	**HFY 2007 Est**	**HFY 2008 Est**
Total Uninsured Inpatient Routine Costs	$ -	$ -
Total Uninsured Ancillary Costs	$ -	$ -
Total Uninsured Costs	**$ -**	$ -

Schedule 2: Schedule of Payments by Uninsured or Third Parties for Uninsured Hospital Services

Third party payments do not include state or local subsidies

Payments for Uninsured Hospital Services During Fiscal Year	**HFY 2007 Est**	**HFY 2008 Est**
Made By Uninsured Patients	$ -	$ -
Made On Behalf of Uninsured Patients	$ -	$ -
Section 1011 Federal Reimbursements Emergency Health Services Furnished to	$ -	$ -
Made By or On Behalf of Uninsured Patients for non hospitals costs included above	$ -	$ -
Total Payments for Uninsured	**$ -**	**$ -**

Schedule 3: Uninsured Shortfall Analysis

	HFY 2007 Est	**HFY 2008 Est**
Total Costs for Uninsured	$ -	$ -
Total Payments for Uninsured	$ -	$ -
Total Uninsured Shortfall	$ -	$ -

Maricopa Medical Center
OBRA Limit and CPE Schedule
Calculation of OBRA Limit and CPE

OBRA Limit SPY 2006

	HFY 2006	HFY 2007
Medicaid Shortfall from A.3	$ -	$ -
Uninsured Cost Shortfall from B.3	$ -	$ -
Uninsured BHS Cost Shortfall	$ -	$ -
HFY OBRA Limits	$ -	$ -

Apportionment of OBRA Limits to State Plan Year

HFY 2006	0.75	
HFY 2007		0.25

OBRA LIMIT FOR STATE PLAN YEAR 2006 **$ -**

ESTIMATED OBRA Limit SPY 2008

	HFY 2007 Est	HFY 2008 Est
Medicaid Shortfall	$ -	$ -
Uninsured Cost Shortfall	$ -	$ -
Uninsured BHS Cost Shortfall	$ -	$ -
HFY OBRA Limits	$ -	$ -

Apportionment of OBRA Limits to State Plan Year

HFY 2007 Est	0.75	
HFY 2008 Est		0.25

OBRA LIMIT FOR STATE PLAN YEAR 2008 **$ -**

Arizona State Hospital
Hospital OBRA Limit and CPE Schedule
SPY06 Uninsured Sched of Costs

Uninsured

The hospital should collect uninsured days and program data from the hospital's claims and auditable financial records for each of the hospital's fiscal years that encompass the state plan year

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 Medicare Cost Report

Governmentally-operated hospitals that are all-inclusive rate providers under Medicare must collect uninsured days and per diems on a cost center basis and use cost center-specific days and per diems from the Medicare Cost Report

Only hospital inpatient days and costs and program data for medical services that would otherwise be eligible for Medicaid should be included in the DSH calculation

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)

It is permissable 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

Payments made by state or local government are not considered a source of third party payment

ALL CELLS SHADED YELLOW ARE TO HAVE DATA PROVIDED BY THE HOSPITAL
ALL CELLS SHADED GREEN ARE TO HAVE DATA PROVIDED BY AHCCCS ENTERED BY THE HOSPITAL
ALL CELLS SHADED BLUE ARE AUTOMATICALLY CALCULATED OR POPULATED

Schedule 1	Schedule of Uninsured Costs Schedule 1A Uninsured Cost Hospital Fiscal Year 1 Schedule 1B Uninsured Cost Hospital Fiscal Year 2
Schedule 2	Schedule of Uninsured Payments
Schedule 3	Shortfall Analysis

Arizona State Hospital
Hospital OBRA Limit and CPE Schedule
SPY06 Uninsured Sched of Costs

Schedule 1A: Determination of Unisured Costs Hospital Fiscal Year 1 MCR 2006

Line	Inpatient Routine Cost Centers		[1] Cost Center Per Diem Cost	[2] Uninsured Days	[3] Total Cost
25/5	Adults and Pediatrics		$ -		$ -
26/6	Intensive Care Unit		$ -		$ -
27/7	Coronary Care Unit		$ -		$ -
28/8	Burn Intensive Care Unit		$ -		$ -
29/9	Surgical Intensive Care Unit		$ -		$ -
30/10	Other Specialty Unit	<specify>	$ -		$ -
30/10	Other Specialty Unit	<specify>	$ -		$ -
30/10	Other Specialty Unit	<specify>	$ -		$ -
31/14	Hospital Subprovider	<specify>	$ -		$ -
31/14	Hospital Subprovider	<specify>	$ -		$ -
33/11	Nursery		$ -		$ -
	TOTAL Inpatient Routine Costs				**$ -**

Line	Inpatient and Outpatient Ancillaries		[1] Per Diem Amount	[2] Uninsured Days	[3] Total Cost
37	Operating Room		$ -		$ -
38	Recovery Room		$ -		$ -
39	Delivery Room and Labor Room		$ -		$ -
40	Anesthesiology		$ -		$ -
41	Radiology Diagnostic		$ -		$ -
42	Radiology Therapeutic		$ -		$ -
43	Radioiscope		$ -		$ -
44	Laboratory		$ -		$ -
45	PBP Clinical Laboratory		$ -		$ -
46	Whole Blood & Packed Red Blood Cells		$ -		$ -
47	Blood Storing, Processing, & Trans		$ -		$ -
48	Intravenous Therapy		$ -		$ -
49	Respiratory Therapy		$ -		$ -
50	Physical Therapy		$ -		$ -
51	Occupational Therapy		$ -		$ -
52	Speech Pathology		$ -		$ -
53	Electrocardiology		$ -		$ -
54	Electroencephalography		$ -		$ -
55	Medical Supplies Charged to Patients		$ -		$ -
56	Drugs Charged to Patients		$ -		$ -
57	Renal Dialysis		$ -		$ -
58	ASC (Non-Distinct Part)		$ -		$ -
59	Other Ancillary		$ -		$ -
60	Clinic		$ -		$ -
61	Emergency		$ -		$ -
62	Observation Beds		$ -		$ -
63	Other Outpatient Services		$ -		$ -
	Total Ancillaries		$ -		**$ -**

Arizona State Hospital
Hospital OBRA Limit and CPE Schedule
SPY06 Uninsured Sched of Costs

Schedule 1B: Determination of Unisured Costs Hospital Fiscal Year 2 MCR 2007

Line	Inpatient Routine Cost Centers		[1] Cost Center Per Diem Cost	[2] Uninsured Days	[3] Total Cost
25/5	Adults and Pediatrics		$ -		$ -
26/6	Intensive Care Unit		$ -		$ -
27/7	Coronary Care Unit		$ -		$ -
28/8	Burn Intensive Care Unit		$ -		$ -
29/9	Surgical Intensive Care Unit		$ -		$ -
30/10	Other Specialty Unit	<specify>	$ -		$ -
30/10	Other Specialty Unit	<specify>	$ -		$ -
30/10	Other Specialty Unit	<specify>	$ -		$ -
31/14	Hospital Subprovider	<specify>	$ -		$ -
31/14	Hospital Subprovider	<specify>	$ -		$ -
33/11	Nursery		$ -		$ -
	TOTAL Inpatient Routine Costs				**$ -**

	Inpatient and Outpatient Ancillaries		[1] Per Diem Amount	[2] Uninsured Days	[3] Total Cost
37	Operating Room		$ -		$ -
38	Recovery Room		$ -		$ -
39	Delivery Room and Labor Room		$ -		$ -
40	Anesthesiology		$ -		$ -
41	Radiology Diagnostic		$ -		$ -
42	Radiology Therapeutic		$ -		$ -
43	Radioiscope		$ -		$ -
44	Laboratory		$ -		$ -
45	PBP Clinical Laboratory		$ -		$ -
46	Whole Blood & Packed Red Blood Cells		$ -		$ -
47	Blood Storing, Processing, & Trans		$ -		$ -
48	Intravenous Therapy		$ -		$ -
49	Respiratory Therapy		$ -		$ -
50	Physical Therapy		$ -		$ -
51	Occupational Therapy		$ -		$ -
52	Speech Pathology		$ -		$ -
53	Electrocardiology		$ -		$ -
54	Electroencephalography		$ -		$ -
55	Medical Supplies Charged to Patients		$ -		$ -
56	Drugs Charged to Patients		$ -		$ -
57	Renal Dialysis		$ -		$ -
58	ASC (Non-Distinct Part)		$ -		$ -
59	Other ancillary specify		$ -		$ -
60	Clinic		$ -		$ -
61	Emergency		$ -		$ -
62	Observation Beds		$ -		$ -
63	Other Outpatient Services		$ -		$ -

Arizona State Hospital
Hospital OBRA Limit and CPE Schedule
SPY06 Uninsured Sched of Costs

Total Ancillaries	$ -		**$ -**

Arizona State Hospital
Hospital OBRA Limit and CPE Schedule
SPY06 Uninsured Sched of Costs

Summary of Uninsured Costs	Year 1 Uninsured Costs	Year 2 Uninsured Costs
Total Uninsured Inpatient Routine Costs	$ -	$ -
Total Uninsured Ancillary Costs	$ -	$ -
Total Uninsured Costs	**$ -**	$ -

Schedule 2: Schedule of Payments by Uninsured or Third Parties for Uninsured Hospital Services

Third party payments do not include state or local subsidies

Payments for Uninsured Hospital Services During Fiscal Year	Year 1 Uninsured Payments	Year 2 Uninsured Payments
Made By Uninsured Patients	$ -	$ -
Made On Behalf of Uninsured Patients		
Section 1011 Federal Reimbursements Emergency Health Services Furnished to Undoc.		
Total Payments for Uninsured	**$ -**	**$ -**

Schedule 3: Uninsured Shortfall Analysis

	Year 1 Uninsured Shortfall	Year 2 Uninsured Shortfall
Total Costs for Uninsured	$ -	$ -
Total Payments for Uninsured	$ -	$ -
Total Uninsured Shortfall	$ -	$ -

Arizona State Hospital
OBRA Limit and CPE Schedule
SPY08 ESTIMATED Uninsured Sched of Costs

Medicaid Estimates for SPY 2008

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 based on an estimate of the OBRA limit for the state plan year of the initial DSH payment. In certifying public expenditure estimates, 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 and then provide for adjustments to such OBRA limit. The adjustments must be supported by adequate explanation/justification.

This schedule is provided to permit governmentally-operated hospitals to report the estimated SPY 2008 Uninsured Shortfall. All figures shall be based on the Uninsured Shortfall reported for SPY 2006 with adjustments. All adjustments must be documented with appropriate supporting materials and submitted with thie PFIS OBRA Limit and CPE Schedule.

ALL CELLS SHADED YELLOW ARE TO HAVE DATA PROVIDED BY THE HOSPITAL
ALL CELLS SHADED BLUE ARE AUTOMATICALLY CALCULATED OR POPULATED

Schedule 1: Schedule of Uninsured Costs for Uninsured Hospital Services

Summary of Uninsured Costs	**HFY 2007 Est**	**HFY 2008 Est**
Total Uninsured Inpatient Routine Costs		
Total Uninsured Ancillary Costs		
Total Uninsured Costs	**$ -**	$ -

Schedule 2: Schedule of Payments by Uninsured or Third Parties for Uninsured Hospital Services

Third party payments do not include state or local subsidies

Payments for Uninsured Hospital Services During Fiscal Year	**HFY 2007 Est**	**HFY 2008 Est**
Made By Uninsured Patients		
Made On Behalf of Uninsured Patients		
Section 1011 Federal Reimbursements Emergency Health Services Furnished to		
Made By or On Behalf of Uninsured Patients for non hospitals costs included above		
Total Payments for Uninsured	**$ -**	**$ -**

Schedule 3: Uninsured Shortfall Analysis

	HFY 2007 Est	**HFY 2008 Est**
Total Costs for Uninsured	$ -	$ -
Total Payments for Uninsured	$ -	$ -
Total Uninsured Shortfall	$ -	$ -

Arizona State Hospital
OBRA Limit and CPE Schedule
Calculation of OBRA Limit and CPE

OBRA Limit SPY 2006

	Year 1 OBRA Limit	Year 2 OBRA Liimit
Medicaid Shortfall from A.3	$ -	$ -
Uninsured Cost Shortfall from B.3	$ -	$ -
HFY OBRA Limits	$ -	$ -

Apportionment of OBRA Limits to State Plan Year

Hospital Fiscal Year	2006	0.75	
Hospital Fiscal Year	2007		0.25

OBRA LIMIT FOR STATE PLAN YEAR 2006 **$ -**

ESTIMATED OBRA Limit SPY 2008

	HFY 2007 Est	HFY 2008 Est
Medicaid Shortfall	$ -	$ -
Uninsured Cost Shortfall	$ -	$ -
HFY OBRA Limits	$ -	$ -

Apportionment of OBRA Limits to State Plan Year

	HFY 2007 Est	0.75	
	HFY 2008 Est		0.25

OBRA LIMIT FOR STATE PLAN YEAR **2008** **$ -**