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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL CARE

INTRODUCTION

Attachment 4.19-A describes the inpatient hospital reimbursement methodology for fee-for-service (FFS) payments made by the Arizona Health Care Cost Containment System Administration (AHCCCSA) to hospitals under both the AHCCCS acute care and the Arizona Long Term Care System (ALTCS) programs. Because the AHCCCS and the ALTCS programs operate on a prepaid capitation basis, the majority of inpatient hospital services received by AHCCCS and ALTCS members are provided through and paid directly by contracting health plans or program contractors. However, inpatient hospital services provided to certain off-reservation Indian Health Services members, Emergency Services Only populations, and special cases are paid on a FFS basis.

Beginning with admission dates of October 1, 1999 and thereafter, FFS payments to hospitals will be made in accordance with a prospective, tiered per diem reimbursement system. For each day of care which meets medical necessity and other applicable authorization requirements, hospitals will receive one of seven per diem rates appropriate to the type of service rendered. The tiered per diem payment methodology does not apply to: organ transplants (with the exception of cornea transplants which are reimbursed under the tiered per diem methodology) and bone marrow transplants, other specialty services, out-of-state hospitals, and freestanding psychiatric hospitals. This submittal is organized into seven sections:

- Definitions
- General Description of the Tiered Per Diem Rate Structure
- Rate Setting Methodology
- Payment to New and Out-of-State Hospitals, and for New Programs
- Payment to Freestanding Psychiatric Hospitals
- Appeals Procedures
- Public Notice

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I. DEFINITIONS

A. AHCCCS Days of Care

Inpatient hospital days of care that are eligible for payment under this plan are defined as the admission day and each day of stay except the day of discharge, provided that all medical necessity and authorization requirements have been met. If a member who is an inpatient dies, the date of death (date of discharge) is paid provided all medical necessity and authorization requirements have been met. Except in the case of death, hospital stays where the day of admission and discharge are the same are called same day admit and discharge claims, and are paid as an outpatient hospital claim (including same day transfers). Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid the lesser of the maternity/nursery tier rate or the outpatient cost-to-charge ratio multiplied by covered ancillary and accommodation charges. A claim must be legible, error free, and have an accommodation revenue code and an allowable charge greater than zero to receive payment as an inpatient hospital day.

B. New Hospital

A new hospital is any hospital for which Medicare Cost Report data and AHCCCS claims and encounter data are not available from any owner or operator of the hospital for hospital rate development, during the rate-setting year.

C. Operating Costs

Operating costs are defined as allowable accommodation and ancillary department hospital costs, excluding capital and direct medical education.

D. Outlier

Outliers are hospital claims in which the operating costs per day are extraordinary. AHCCCS shall set the statewide outlier cost threshold for each tier at the greater of:

1) Three standard deviations from the statewide mean operating cost per day within the tier; or

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2) Two standard deviations from the statewide mean operating costs per day across all tiers.

The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers by multiplying the covered charges on a claim by the Medicare urban or rural cost-to-charge ratio. The Medicare urban or rural cost-to-charge ratio is defined as the sum of Medicare's urban or rural statewide average operating cost-to-charge ratio and Medicare's statewide average capital cost-to-charge ratio. If covered costs per day on a claim exceed the urban or rural cost threshold for a tier, the claim shall be considered an outlier. If there are two tiers on a claim or encounter, AHCCCS shall determine whether the claim or encounter is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying the threshold for each tier by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital.

Routine maternity stays shall be excluded from outlier reimbursement. A routine maternity is any one-day stay with a delivery of one or two babies. A routine maternity stay will be paid at tier.

The Medicare urban cost-to-charge ratio will be used for hospitals located in an Arizona county of 500,000 residents or more, and for out-of-state hospitals. The Medicare rural cost-to-charge ratio will be used for hospitals located in a county of fewer than 500,000 residents.

E. Peer Group

A peer group consists of hospitals which share a common and stable characteristic which significantly influences the cost of providing hospital services when measured statistically.

F. Prospective Rates

Prospective rates are inpatient hospital rates defined in advance of a payment period and represent payment in full for covered services excluding any quick-pay discounts, slow pay penalties, and third party payments regardless of billed charges or individual hospital costs.

G. Prospective Rate Year

The prospective rate year is the period from October 1 of each year to September 30 of the following year.

II. GENERAL DESCRIPTION OF THE TIERED PER DIEM RATE STRUCTURE FOR INPATIENT SERVICES

For admissions on and after October 1, 1999 AHCCCS will reimburse in-state acute care hospitals for each AHCCCS day of care with a prospective per diem rate representing payment for both ancillary and accommodation services. Each AHCCCS day of care is classified into one

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of seven service categories (tiers) and is paid the per diem rate corresponding to that category unless the claim is identified as an outlier claim, or is for a covered organ (with the exception of cornea transplants which are reimbursed under the tiered per diem methodology) or bone marrow transplant or other specialty services which may be paid under separate contract arrangements. This section describes the structure of the tiered per diem payment system.

A. Tiered Rate Structure

Medically necessary AHCCCS days of care that meet all medical review and authorization requirements are assigned to tiers based on information submitted on the claim. The classification logic examines revenue codes, diagnostic and procedure code information, and peer groups as applicable. Assignment to a tier follows the ordered, hierarchical processing described below. It is possible for some AHCCCS days of care on a claim to be classified into one tier and the remaining AHCCCS days of care on the claim to be classified to a different tier for payment purposes. A claim can never have AHCCCS days of care paid on the basis of more than two tiers. If a claim has no charges associated with an accommodation revenue code it is not considered an inpatient day for payment.

The following are the seven tiers:

1) **Maternity:** The maternity tier is identified by a primary diagnosis code within the range of 640.XX - 643.XX, 644.2X - 676.XX, V22.XX - V24.XX or V27.XX. If a claim has a primary diagnosis within one of these ranges, all the days on the claim are paid at the maternity tier rate.

2) **NICU:** The neonatal intensive care tier is identified by a revenue code of 174. For a hospital to qualify for the NICU per diem, the hospital must be classified as either a level II or level III perinatal center by the Arizona Perinatal Trust. All of the days on the claim with the NICU revenue code that meet the criteria for the NICU tier will be paid at the NICU per diem. Any remaining days on the claim are paid at the nursery tier rate.

3) **ICU:** The intensive care tier is identified by a revenue code in the range of 200-204, 207-212 or 219. All of the days on the claim with an ICU revenue code that meet the criteria for the ICU tier will be paid at the ICU rate. If there are days on the claim without an ICU revenue code, they may be paid at the surgery, psychiatric or routine tier rate.

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4) **Surgery:** The surgery tier is identified by a revenue code of 36X in combination with a valid surgical procedure code that is not on the AHCCCS excluded surgery procedure list. This excluded procedure list identifies minor procedures such as sutures which do not require the same hospital resources as other procedures. If these conditions are met, and the surgery was performed on a date after the person was determined AHCCCS eligible, any day that is not associated with an ICU revenue code is paid at the surgery tier rate.

5) **Psychiatric:** The psychiatric tier is identified in either of the following ways:

   a. A psychiatric revenue code within the range of 114, 124, 134, 144 or 154 and any psychiatric diagnosis in the range of 290.XX - 316.XX; or

   b. Any routine revenue code if all diagnosis codes on the claim are within the range of 290.XX - 316.XX.

   A claim with day(s) paid at the psychiatric tier rate, may also have day(s) paid at the ICU tier rate.

6) **Nursery:** A revenue code of 17X (excluding 174) is required to classify a day into this tier for payment at the nursery tier rate. A claim with day(s) paid at the nursery tier rate may also have day(s) paid at the NICU tier rate.

7) **Routine:** Other days associated with revenue codes within the following ranges that are not classified into one of the tiers listed above are paid at the routine per diem rate: 100-101, 110-113, 116-123, 126-133, 136-143, 146-153, 156-159, 16X, 206, 213 or 214.

Any day which does not group into a tier is pended for examination and may require additional information to be submitted before tier classification can occur.

B. Payment of Outliers, Transplants and Other Specialty Services

This section describes certain exceptions to the tiered payment rates for special cases in acute care hospitals.

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1) **Outliers**: Effective with dates of admission on and after October 1, 2007, AHCCCS shall reimburse hospitals for outlier claims by multiplying covered charges by the sum of Medicare's urban or rural statewide average operating cost-to-charge ratio (CCR) and Medicare's statewide average capital CCR, updated annually and phased in as described below. For rates effective on and after October 1, 2007, outlier cost thresholds shall be updated annually by the increase or decrease in the index published by the Global Insight hospital market basket index for prospective hospital reimbursement. For the rate year effective October 1, 2010, to September 30, 2011, AHCCCS will not apply the Global Insight hospital market basket index to adjust the outlier cost thresholds. For inpatient hospital admissions with begin dates of admission on and after October 1, 2011, AHCCCS will increase the outlier cost thresholds by 5% of the thresholds that were effective on September 30, 2011.

For calculations using the Medicare urban or rural CCRs, including outlier determination and threshold calculation, AHCCCS shall phase in the use of the Medicare urban or rural CCRs as follows: For outlier claims with dates of admission on or after October I, 2007 through September 30, 2008, AHCCCS shall adjust each hospital specific inpatient CCR in effect on September 30, 2007 by subtracting one-third of the difference between the hospital specific inpatient CCR and the sum of Medicare's urban or rural statewide average operating CCR and Medicare's statewide average capital CCR. For outlier claims with dates of admission on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust each hospital specific inpatient CCR in effect on September 30, 2007 by subtracting two-thirds of the difference between the hospital specific inpatient CCR and the sum of Medicare urban or rural statewide average operating CCR and Medicare's statewide average capital CCR.

For payment of outlier claims with dates of admission on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust the statewide inpatient hospital CCR in effect on September 30, 2007 by subtracting one-third of the difference between the statewide inpatient hospital CCR and the effective Medicare urban or rural CCR. For payment of outlier claims with dates of admission on or after October I, 2008 through September 30, 2009, AHCCCS shall adjust the statewide inpatient hospital CCR in effect on September 30, 2007 by subtracting two-thirds of the difference between the statewide inpatient hospital CCR and the effective Medicare urban or rural CCR.

For outlier claims with dates of admission on or after October 1, 2009, the full Medicare urban or rural CCR shall be utilized for all calculations. The three year phase-in does not apply to out of state or new hospitals.

For qualification and payment of outlier claims with begin dates of admission on or after April 1, 2011 through September 30, 2011, the CCR will be equal to 95% of the ratios in effect on October 1, 2010.

For qualification and payment of outlier claims with begin dates of admission on or after October 1, 2011, the CCR will be equal to 90.25% (95% of the previous 95% reduction = 95% x 95%) of the most recent published Urban or Rural Medicare CCR as of August of each year (e.g., 90.25% of the CCR published as of August 31, 2011 is used for the period of October 1, 2011 to September 30, 2012).

In addition, for qualification and payment of outlier claims with begin dates of admission on or after October 1, 2011 through September 30, 2012, AHCCCS will reduce the CCR for a hospital that filed a charge master with ADHS on or after April 1, 2011 by an additional percentage equal to the total percent increase reported on the charge master.

In addition, for qualification and payment of outlier claims with begin dates of admission on or after October 1, 2012, AHCCCS will reduce the CCR for a hospital that filed a charge master with ADHS on or after June 1 of the prior federal fiscal year, by an additional percentage equal to the total percent increase reported on the charge master.

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1) **Transplants**: AHCCCS shall negotiate contracts with hospitals qualified to perform covered organ and hematopoietic cell transplantation services. Reimbursement is based on a fixed price per type of transplant, by component, which may include stop-loss provisions. Component reimbursement is based on provider cost reports. At no time will payment for the entire case exceed a hospital's billed charges. Cornea transplants and bone graft transplantation are excluded from the component methodology and are reimbursed based on the tiered per diem rates.

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

III. RATE-SETTING METHODOLOGY

The final payment for each tier is the sum of two separate components: operating and capital. This section describes each component and how it is calculated. Five of the seven tiers are statewide. The NICU tier is peer grouped for NICU Level II versus NICU Level III, as certified by the Arizona Perinatal Trust. The Routine tier is peer grouped for rehabilitation hospital versus general acute care hospital.

A. Base Operating Component

The operating component of the rate represents the weighted average operating cost per day for treating AHCCCS patients in that tier across all acute care hospitals in Arizona with two exceptions:

Exception 1: For the Routine tier, the component represents the weighted average operating cost per day by peer group. The peer groups for the Routine tier are rehabilitation hospitals, and general acute care hospitals.

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Exception 2: For the NICU tier, the component represents the weighted average operating cost per day by peer group. The peer groups for the NICU tier are NICU Level III hospitals, and NICU Level II hospitals, as certified by the Arizona Perinatal Trust.

The computation of the operating component, and the application of inflation factors to the operating component, are described in the following paragraphs.

1) **Computation of Operating Cost:** Operating costs were computed based on a claim costing process involving cost report data and claims/encounter data for each hospital:

a. Hospital cost reports for fiscal years ending in 1996 served as the cost report data base. The cost report data provided ancillary department cost-to-charge ratios and accommodation costs per day. Cost-to-charge ratios were calculated for each hospital department. Cost-to-charge ratios were capped at 1.00 for each department. Because hospital cost report years are not standard, prior to calculating rates cost per diems were inflated to a common point in time, December 31, 1996, using the DRI inflation factor. Capital and medical education costs were excluded for computation of the operating cost component.

b. Hospital claims and encounters were pulled that matched each hospital's Medicare FYE96 dates of service for the claims and encounters data base. Only claims and encounters that were accepted and processed by AHCCCS at the time the extract file was developed were included. Claims/encounter data were also subjected to a series of data quality, data reasonableness, and data integrity edits. Claims/encounters that failed edits were excluded from the data base. Duplicate claims, claims with missing information necessary to group into a tier, and Medicare crossover claims, among others were excluded in this process.

c. The claim and cost data bases were then combined. Because revenue codes on claims and encounters do not match cost centers or departments on cost reports, a cross walk was developed for matching.

d. Operating costs were derived from the combined cost/claim data bases by applying departmental cost-to-charge ratios for a hospital to allowed ancillary charges on each claim. Ancillary charges were inflated to December 31, 1996, using the DRI

inflation factor. Accommodation costs were derived by multiplying the covered days on the claim/encounter times the accommodation cost per diems from the cost report.

e. Costed claims/encounters were then assigned to tiers using the logic specified above. For claims assigned to more than one tier, ancillary costs were allocated to the tiers in the same proportion as the accommodation costs.

f. All costs were reduced by an audit adjustment factor equal to four percent since cost reports were not audited.

2. Inflation Factor: For rates effective on and after October 1, 1999, AHCCCS shall inflate the operating component of the tiered per diem rates to the mid-point of the prospective rate year, using the DRI inflation factor. For rates effective on and after October 1, 2010, no inflation factor will be applied.

Length of Stay (LOS) Adjustment: For rates effective October 1, 1999 through September 30, 2000, the operating component of the Maternity and Nursery tiers shall be adjusted to reflect changes in LOS as required by the federal mandate that allows women at least 48 hours of inpatient care for a normal vaginal delivery, and at least 96 hours of inpatient care for a cesarean section delivery, effective for dates of service on and after January 1, 1998. There shall be no LOS updates for any tiers for rates effective on or after October 1, 2000.

B. Direct Medical Education Component

Direct medical education includes nursing school education, intern and resident salaries, fringes and program costs and paramedical education.

1) For the service period July 1, 2020 through June 30, 2021, the Administration shall distribute $46,106,085 as described in this paragraph to the following hospitals: Abrazo Central Campus, Banner Boswell Medical Center, Banner University Medical Center - Phoenix, Banner University Medical Center - Tucson, Phoenix Children's Hospital, Scottsdale Healthcare - Osborn, Scottsdale Healthcare - Shea, St. Joseph's Hospital – Phoenix, Tucson Medical Center, and Valleywise Health Medical Center. For dates of service on and after October 1, 1997 (FFY98), GME payment dollars will be separated from the tiered per diem rates to create an AHCCCS GME pool. For FFY98 and each year thereafter, the value of the GME pool will be based on the total GME payments made for claims and encounters in FFY96, inflated by the DRI inflation factor. On an annual basis GME pool funds will be distributed to each hospital with an approved GME program based on the percentage of the total FFY96 GME pool that each hospital's FFY96 GME payment represented. In

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essence, the percentage of the total FFY96 GME pool that a hospital received in FFY96 will be the percentage of the total FFY98 GME pool that a hospital receives in FFY98. New GME programs approved on or before October 1, 1999, but that did not receive a GME payment in FFY96, will receive a FFY98 GME payment based on the percentage of the total FFY96 GME pool that their FFY97 payment represented.

2) For the service period of January 1, 2007 to June 30, 2007, the AHCCCS Administration shall distribute up to $6 million for GME above the amount prescribed above in the following order or priority:

a) For the direct costs to support the expansion of GME programs established before July 1, 2006 at hospitals that do not receive payments pursuant to paragraph B(1). These programs must be approved by the AHCCCS Administration.
b) For the direct costs to support the expansion of GME programs established on or before October 1, 1999. These programs must be approved by the AHCCCS Administration.
c) For the direct costs of GME programs established on or after July 1, 2006. These programs must be approved by the AHCCCS Administration.

The Administration will allocate funds to eligible GME programs based on the number of filled resident positions in each program, weighted by Medicaid utilization, and a statewide average per-resident cost. The amount allocated to each program will be distributed to the eligible hospitals participating in that program based on each hospital's level of program participation.

For example:
IF: Program X Total Residents = 10; and
Participating Hospital A Rotation Share = 50%; and
Participating Hospital B Rotation Share = 30%; and
Participating Hospital C Rotation Share = 20%; and
Participating Hospital A Medicaid Load = 30%; and
Participating Hospital B Medicaid Load = 35%; and
Participating Hospital C Medicaid Load = 40%; and
Statewide Average Per Resident Amount = $95,000

THEN: Program X Medicaid-Weighted Residents = (10 x .50 x .30) + (10 x .30 x .35) + (10 x .20 x .40) = 3.35; Program X Allocation = 3.35 x $95,000 = $318,250; and

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Participating Hospital A Distribution = [(10 x .50 x .30)/3.35] x $318,250 = $142,500
Participating Hospital B Distribution = [(10 x .30 x .35)/3.35] x $318,250 = $ 99,750
Participating Hospital C Distribution = [(10 x .20 x .40)/3.35] x $318,250 = $ 76,000

For the service period January 1, 2007 to June 30, 2007, the number of residents for a program will be divided by two.

Medicaid utilization for each hospital will be determined using the most recent as-filed Medicare Cost Report on file with the Administration and the Administration's inpatient hospital Fee-For-Service claims and managed care encounter data for the time period corresponding to the MCR for each hospital. The Medicaid utilization percent for each hospital will be calculated as its total Medicaid inpatient days divided by total MCR inpatient days, rounded up to the nearest 5%. Total MCR inpatient days will be taken from Form 2552, Worksheet S-3, Part 1, Line 12, Column 6. The Medicaid utilization from the most recent as-filed Medicare cost reporting period is a proxy for the Medicaid utilization for the service period.

The statewide average per-resident cost will be determined using the most recent as-filed MCR on file with the Administration and resident counts reported by hospitals and GME programs. The average will be calculated by totaling all Intern/Resident direct costs for all hospitals reporting such costs on the MCR and dividing by the total number of residents at those hospitals. The direct I/R costs will be taken from Form 2552, Worksheet B, Part 1, Lines 22 & 23, Column 0.

A filled resident position is a GME program position for which a resident is enrolled and receiving a salary. The number of filled resident positions in a program will be derived by program reporting to the Administration.

A hospital's level of participation is defined by the hospital's share of resident rotations within the program. For example, if residents in Program X spend nine months of the year on rotation at hospital A and three months at hospital B, then hospital A's level of participation in Program X is 75% and hospital B's level of participation is 25%. The program rotation schedules will be derived by program and hospital reporting to the Administration.

For the service period of January 1, 2007 to June 30, 2007, all hospitals will be distributed the full amount as computed by the prescribed distribution formula for its qualifying GME programs.

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3) Beginning July 1, 2007, the AHCCCS Administration shall distribute monies appropriated for graduate medical education above the amount prescribed in paragraph B(1) in the following order of priority:

a) For the direct costs to support the expansion of GME programs established before July 1, 2006, at hospitals that do not receive payments pursuant to paragraph B(1). These programs must be approved by the AHCCCS Administration.
b) For the direct costs to support the expansion of GME programs established before July 1, 2006, at hospitals that receive payments pursuant to paragraph B(1). These programs must be approved by the AHCCCS Administration.

The Administration will allocate funds to eligible GME programs based on the number of filled resident positions in each program, weighted by Medicaid utilization, and a statewide average per-resident cost. The amount allocated to each program will be distributed to the eligible hospitals participating in that program based on each hospital's level of program participation.

For example:

IF: Program X Total Residents =10; and
Participating Hospital A Rotation Share =50%; and
Participating Hospital B Rotation Share =30%; and
Participating Hospital C Rotation Share =20%; and
Participating Hospital A Medicaid Load =30%; and
Participating Hospital B Medicaid Load =35%; and
Participating Hospital C Medicaid Load =40%; and
Statewide Average Per Resident Amount =$95,000

THEN: Program X Medicaid-Weighted Residents =(10 x .50 x .30) +(10 x .30 x .35) +(10 x .20 x .40) =3.35; Program X Allocation =3.35 x $95,000 =$318,250; and

Participating Hospital A Distribution =[(10 x .50 x .30)/3.35] x $318,250 =$142,500
Participating Hospital B Distribution =[(10 x .30 x .35)/3.35] x $318,250 =$ 99,750
Participating Hospital C Distribution =[(10 x .20 x .40)/3.35] x $318,250 =$ 76,000

For purposes of the allocation described above, resident positions that are funded under paragraph B(1) will be excluded. For example, Program X existed on October 1, 1999 with 5 filled resident positions as of October 1, 1999. On July 1, 2006 (the effective date of the statutory authority for expansion funding), Program X had 7 filled resident positions. It follows that program X has 5 resident positions that are funded by existing GME payments, and 2

resident positions that are eligible for expansion funding. The per-resident allocation to Program X will be based on the 2 resident positions.

Medicaid utilization for each hospital will be determined using the most recent as-filed Medicare Cost Report on file with the Administration and the Administration's inpatient hospital Fee-For-Service claims and managed care encounter data for the time period corresponding to the MCR for each hospital. The Medicaid utilization percent for each hospital will be calculated as its total Medicaid inpatient days divided by total MCR inpatient days, rounded up to the nearest 5%. Total MCR inpatient days will be taken from Form 2552, Worksheet S-3, Part 1, Lines 14 and 16 through 18, Column 8. The Medicaid utilization from the most recent as-filed Medicare cost reporting period is a proxy for the Medicaid utilization for the service period.

The statewide average per-resident cost will be determined using the most recent as-filed MCR on file with the Administration and resident counts reported by hospitals and GME programs. The average will be calculated by totaling all Intern/Resident direct costs for all hospitals reporting such costs on the MCR and dividing by the total number of residents at those hospitals. The direct I/R costs will be taken from Form 2552, Worksheet B, Part 1, Lines 21 & 22, Column 0.

A filled resident position is a GME program position for which a resident is enrolled and receiving a salary. The number of filled resident positions in a program will be derived by hospital and program reporting to the Administration.

A hospital's level of participation is defined by the hospital's share of resident rotations within the program. For example, if residents in Program X spend nine months of the year on rotation at hospital A and three months at hospital B, then hospital A's level of participation in Program X is 75% and hospital B's level of participation is 25%. The program rotation schedules will be derived by program and hospital reporting to the Administration.

For the service period of July 1, 2020, to June 30, 2021, the Administration shall distribute up to $38,529,921 under this paragraph to the following hospitals: Banner Boswell Medical Center, Banner University Medical Center - Phoenix, Banner University Medical Center - South, Banner University Medical Center - Tucson, John C. Lincoln Medical Center, Kingman Regional Medical Center, Mayo Hospital, Phoenix Children's Hospital, Scottsdale Healthcare - Osborn, Scottsdale Healthcare - Shea, Scottsdale Healthcare – Thompson Peak, St. Joseph's Hospital – Phoenix, Tucson Medical Center, and Valleywise Health Medical Center. If funds are insufficient to cover all calculated distributions within any priority group described in paragraphs B(3)(a) and (b), the Administration shall adjust the distributions proportionally within that priority group.

4) Beginning July 1, 2007 the AHCCCS Administration shall distribute monies appropriated for graduate medical education above the amounts prescribed in paragraphs B(1) and B(3) for the direct costs of graduate medical education programs established or expanded on or after July 1, 2006. These programs must be approved by the Administration.

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The Administration will allocate funds to eligible GME programs based on the number of filled resident positions in each program, weighted by Medicaid utilization, and a statewide average per-resident cost according to the methodology described in paragraph B(3).

For the service period of July 1, 2020, to June 30, 2021, the Administration shall distribute up $21,880,584 under this paragraph to the following hospitals: Abrazo Arrowhead Campus, Abrazo West Campus, Banner Boswell Medical Center, Banner Del Webb Medical Center, Banner University Medical Center - Phoenix, Banner University Medical Center - South, Banner University Medical Center - Tucson, Canyon Vista Medical Center, HonorHealth Rehabilitation Hospital, John C. Lincoln Medical Center, Mayo Hospital, Mountain Vista Medical Center, Phoenix Children's Hospital, Scottsdale Healthcare - Osborn, Scottsdale Healthcare - Shea, Scottsdale Healthcare - Thompson Peak, St. Joseph's Hospital – Phoenix, Tucson Medical Center, Valleywise Health Medical Center and Yuma Regional Medical Center. In addition to the above amount, this pool also includes the payment amounts listed on page 9(g)(i) for other teaching hospitals. If funds are insufficient to cover all calculated distributions, the Administration shall adjust the distributions proportionally.

C. New Hospitals
Payments made to new hospitals with GME programs will be calculated using a statewide average where necessary until hospital-specific data can be obtained

D. Indirect Medical Education Component
Beginning July 1, 2007, the AHCCCS Administration shall distribute monies appropriated for graduate medical education above the amounts prescribed in paragraphs B(1), B(3), and B(4) for a portion of additional indirect medical education costs at hospitals with GME programs with residency positions

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that include rotations in any county other than Maricopa or Pima whose population was less than five hundred thousand persons at the time the residency rotation was added to the academic year rotation schedule. These programs must be approved by the Administration.

The Administration will allocate funds for indirect costs to eligible GME programs based on the number of filled resident positions in each program that include rotations in qualifying counties, the number of months that a program's residents rotate to facilities in those counties, and a Medicaid-specific statewide average per-resident-per-month cost. The program allocation will be calculated as follows:

Program Allocation = (Total filled resident positions that include rotations in qualifying counties) x (Number of months per academic year that each resident will spend on such rotations) x (Medicaid-specific statewide average per-resident-per-month cost).

A filled resident position is a GME program position for which a resident is enrolled and receiving a salary. The number of filled resident positions in a program and the number of months that program residents rotate to facilities in qualifying counties will be derived by hospital and program reporting to the Administration.

The Medicaid-specific statewide average per-resident-per-month cost will be determined using the most recent as-filed Medicare cost reports on file with the Administration, and will be based on a calculated Medicaid IME cost for all hospitals that calculate a Medicare IME payment on the Medicare cost report and the total number of residents at those hospitals.

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The Medicaid-specific statewide average per-resident-per-month cost will be calculated by totaling the Medicaid IME costs for all hospitals that have such costs, dividing the result by the total number of residents at those hospitals, and dividing that result by 12. The Medicaid IME cost for each hospital is to be calculated as follows:

1. Calculate each hospital's Medicare share by dividing the Medicare inpatient discharges on the Medicare Cost Report (Worksheet S-3 Part I, Column 13, Line 14 plus Line 2) by the total inpatient hospital discharges on the Medicare Cost Report (Worksheet S-3 Part I, Column 15, Line 14).
2. Calculate the ratio of the residents to beds by dividing the number of filled resident positions for each hospital derived from reporting by the GME programs to the Administration as described in paragraph B(2) by the bed days available divided by the number of days in the cost reporting period from the Medicare Cost Report (Worksheet E Part A, Line 4, Column 1).
3. Calculate the indirect medical education adjustment factor by using the following formula: $1.35 \times \{[(1+r).405]-1\}$ where r is the ratio of residents to beds calculated above.
4. Calculate each hospital's total indirect medical education cost by adding the DRG amounts other than outlier payments from the Medicare cost report and the managed care simulated payments from the Medicare Cost Report (Worksheet E Part A, Lines 1, 1.01, 1.02, 1.03, 1.04 and 3, Column 1), multiplying the total by the indirect medical education adjustment factor and dividing the result by the Medicare share.
5. Calculate each hospital's Medicaid indirect medical education cost by multiplying the hospital's total indirect medical education by the Medicaid Utilization Percent used to determine the direct GME component.

The amount allocated to each program will be distributed to the program's sponsoring hospital or the program's base hospital if the sponsoring institution is not a hospital.
The total amount computed for a teaching hospital under this paragraph shall not exceed the greatest among the amounts described in paragraph F(1) through F(3).

A hospital that does not have any IME amount reported on the Medicare cost report, other than a children's hospital or a new teaching hospital whose latest available Medicare cost report used does not include the hospital's Medicare IME amount as a teaching hospital, will be ineligible for IME payment under this paragraph D.

For the service period of July 1, 2020, to June 30, 2021 the Administration shall distribute up to $7,794,474 under this paragraph to the following hospitals: Banner University Medical Center - South, Banner University Medical Center - Tucson, Canyon Vista Medical Center, Kingman Regional Medical Center, Tucson Medical Center, and Yuma Regional Medical Center. If funds are insufficient to cover all calculated distributions, the Administration shall adjust the distributions proportionally.

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E. Medical Education Funding Transfer Authority

Any remaining unallocated authority from paragraphs B(3), B(4) or D, may be redistributed among those pools if necessary to address insufficient funding levels in any of them.

F. Indirect Medical Education – Second Payment Pool

Beginning July 1, 2007, the Administration establishes a second Indirect Medical Education payment pool. Those funds will be used for the purposes of reimbursing hospitals specified by the local, county, or tribal government for indirect program costs other than those reimbursed under paragraph D. Funds available under this subsection shall be distributed in accordance with paragraph D except that (a) reimbursement with such funds includes resident positions or rotations other than those in counties with populations of less than five hundred thousand persons, and (b) the hospitals eligible to receive the funds are participating hospitals that incur indirect medical education costs. The total amount computed for a teaching hospital under paragraphs D and F combined shall be equal to the greatest among the following amounts:

1. The hospital's Medicaid IME costs calculated under paragraph D;
2. The median of all such costs if the hospital does not have an IME payment calculated on its Medicare Cost Report because the hospital is a children's hospital or a new teaching hospital and the latest available Medicare cost report used does not include the hospital's Medicare IME amount as a teaching hospital; and
3. The hospital's program allocation amount, as calculated under paragraph D but for the qualifying rotations in both paragraphs D and F counted at the participating hospital (rather than only rural rotations counted for the sponsoring or base hospital).

The amount that a teaching hospital receives under paragraph D will be subtracted from the total amount computed above to determine the calculated IME payment amount under this paragraph F.

A hospital that does not have any IME amount reported on the Medicare cost report, other than a children's hospital or a new teaching hospital described above, will be ineligible for IME payment under paragraphs D and F.

For the service period of July 1, 2016 to June 30, 2017, the Administration shall distribute up to $203,930,886 in total funds under this paragraph to the following hospitals: Abrazo Central Campus , Banner University Medical Center - Phoenix, Banner University Medical Center - South, Banner University Medical Center - Tucson, John C. Lincoln Medical Center, Kingman Regional Medical Center, Maricopa County Medical Center, Mayo Hospital, Mountain Vista Medical Center, Phoenix Children's Hospital, Scottsdale Healthcare - Osborn, Scottsdale Healthcare - Shea, Scottsdale Healthcare - Thompson Peak, St. Joseph's Hospital - Phoenix, and Tucson Medical Center. Any unallocated authority remaining from paragraphs B(3), B(4) or D after any necessary redistribution under paragraph E may be distributed under this paragraph. If funds are insufficient to cover all calculated distributions, the Administration shall adjust the distributions proportionally.

All payments for GME and IME provided for in paragraphs B-F are payable annually at the end of the year.

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A hospital that does not have any IME amount reported on the Medicare cost report, other than a children's hospital or a new teaching hospital described above, will be ineligible for IME payment under paragraphs D and F.

For the service period of July 1, 2020 to June 30, 2021, the Administration shall distribute up to $258,693,294 in total funds under this paragraph to the following hospitals: Abrazo Central Campus, Abrazo Arrowhead Campus, Abrazo West Campus, Banner Boswell Medical Center, Banner Del Webb Medical Center, Banner University Medical Center - Phoenix, Banner University Medical Center - South, Banner University Medical Center - Tucson, Canyon Vista Medical Center, HonorHealth Rehabilitation Hospital, John C. Lincoln Medical Center, Mayo Hospital, Mountain Vista Medical Center, Phoenix Children's Hospital, Scottsdale Healthcare - Osborn, Scottsdale Healthcare - Shea, Scottsdale Healthcare - Thompson Peak, St. Joseph's Hospital - Phoenix, Tucson Medical Center, and Valleywise Health Medical Center. Any unallocated authority remaining from paragraphs B(3), B(4) or D after any necessary redistribution under paragraph E may be distributed under this paragraph. If funds are insufficient to cover all calculated distributions, the Administration shall adjust the distributions proportionally.

All payments for GME and IME provided for in paragraphs B-F are payable annually at the end of the year.

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ADDITIONAL POOL AMOUNTS

1. The methodology described in Paragraph B(1) applies to the following:

   For the service period July 1, 2010 through June 30, 2011, in addition to the payments in Paragraph B(1), the Administration shall distribute up to $4,036,624 as described in this paragraph to the following hospitals: Scottsdale Healthcare Osborn, Scottsdale Healthcare Shea, St. Joseph's Hospital and Tucson Medical Center.

2. The methodology described in Paragraph B(3) applies to the following:

   For the service period of July 1, 2010, to June 30, 2011, in addition to the payments in Paragraph B(3), the Administration shall distribute up to $2,586,973 under this paragraph to the following hospitals: Scottsdale Healthcare Osborn, Scottsdale Healthcare Shea, St. Joseph's Hospital and Tucson Medical Center. If funds are insufficient to cover all calculated distributions within any priority group described in paragraphs B(3)(a) and (b), the Administration shall adjust the distributions proportionally within that priority group.

3. The methodology described in Paragraph B(4) applies to the following:

   For the service period of July 1, 2010, to June 30, 2011, in addition to the payments in Paragraph B(4), the Administration shall distribute up to $784,416 under this paragraph to the following hospitals: Scottsdale Healthcare Osborn, Scottsdale Healthcare Shea, St. Joseph's Hospital and Tucson Medical Center. If funds are insufficient to cover all calculated distributions, the Administration shall adjust the distributions proportionally.

4. The methodology described in Paragraph F applies to the following:

   For the service period of July 1, 2010 to June 30, 2011, in addition to the payments in Paragraph F, the Administration shall distribute up to $31,720,017 in total funds under this paragraph to the following hospitals: Scottsdale Healthcare Osborn, Scottsdale Healthcare Shea, St. Joseph's Hospital and Tucson Medical Center. Any unallocated authority remaining from paragraphs B(3), B(4) or D after any necessary redistribution under paragraph E may be distributed under this paragraph.

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G. For the period of July 1, 2022 to June 30, 2023, the AHCCCS Administration shall distribute $16,374,987 for hospitals located in counties with populations of five hundred thousand or more residents for new graduate medical education programs that began on or after July 1, 2020 or for positions that were expanded on or after July 1, 2020 These distributions are supplementary to and do not supplant the payments described in paragraphs B, C, D, and F above, with priority of the supplementary monies based on the number of residents and fellows in graduate medical education in the following manner:

1) Each eligible resident and fellow is placed into a tier with the following priority order:
   a) Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this section for the previous academic year, and who is continuing in the same GME program.
   b) Residents and fellows that are not a returning resident or fellow but are in a GME program for:
      i) Family medicine
      ii) Internal medicine
      iii) General pediatrics
      iv) Obstetrics and gynecology
      v) Psychiatry, including subspecialties
      vi) General surgery
   c) Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this section in a prior year.
   d) All other residents and fellows.

2) Funds shall be allocated based on the priority of each tier. Distributions for eligible positions in a tier with a lower priority will not receive a distribution until distributions are allocated for the costs of all positions in a higher tier. If funding is insufficient to fully fund a tier, the remainder of funds will be prorated for eligible positions within that tier, based on the amount computed for each hospital that would have been reimbursable for that tier if full funding were available. Distribution is made for each tier, in priority order, before distribution to the next lower tier.

3) The amount of the distribution for each GME program for direct costs is calculated as the product of:
   a) The number of eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospitals; and
   b) The hospital's Arizona Medicaid utilization as determined in paragraph B(3) for the program year using the most recent as-filed Medicare cost report as proxy; and,
   c) The statewide average direct cost per resident determined in paragraph B(3)for the program year using the most recent as-filed Medicare cost reports as proxy.

4) If monies are still remaining after direct funding has been allocated, indirect funding shall be allocated based on the priority of each tier, consistent with (G)(2). The amount of the distribution for each GME program for indirect costs is calculated as the product of:
   a) The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital; and
   b) The Medicaid-specific statewide average indirect cost per resident per month calculated in paragraph D for the program year using the most recent as-filed Medicare cost reports as proxy; and
   c) Twelve months.

5) To ensure that the program receives accurate funding, residents/fellows which receive funding first in paragraph G may additionally receive funding through paragraphs B, C, D, and F, but total number of residents/fellows funded shall not be greater than 100% of the total FTEs in that program.

6) Payments are made to participating hospitals based on the FTEs who worked at their hospitals per academic year.

H. For the period of July 1, 2022 to June 30, 2023, the AHCCCS Administration shall distribute $2,685,716 for hospitals located in counties of less than five hundred thousand persons for graduate medical education for new programs that began or for positions that were expanded on or after July 1, 2020. These distributions are supplementary to and do not supplant the appropriated amounts prescribed in paragraphs B, C, D, and F and the supplementary distributions are to be made in the following order of priority based on the number of residents and fellows in graduate medical education in the following manner.

1) Each resident and fellow will be placed into a tier with the following priority order:

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a) Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this section for the previous year and who is continuing in the same GME program.
b) Residents and fellows that are not a returning resident or fellow but are in a GME program for Family Medicine, Internal Medicine, General Pediatrics, Obstetrics and Gynecology, Psychiatry including Subspecialties, and General Surgery.
c) Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this section in a prior year.
d) All other residents and fellows.

2) Residents and fellows in the tiers described in 1(a) through 1(d) are further divided into 4 sub-tiers with the following priority order based on the location of the participating hospital:
   a) Hospitals in a county designated by the Health Resource and Services Administration of the U.S. Department of Health & Human Services as a HPSA with a greater than 85% primary care shortage
   b) Hospitals in a county designated as a HPSA with a greater than 50% to 85% primary care shortage.
   c) Hospitals in a county designated as a HPSA with a 25-50% primary care shortage.
   d) Hospitals in a county designated as a HPSA with a less than 25% primary care shortage.

3) Funds shall be allocated based on the priority of each tier and sub-tier. Distributions for eligible positions in a sub-tier with a lower priority will not receive a distribution until distributions are allocated for the costs of all positions in a higher sub-tier. If funding is insufficient to fully fund a sub-tier, the remainder of funds will be pro-rated for eligible positions within that sub-tier, based on the amount computed for each hospital that would have been reimbursable for that sub-tier if full funding were available. Distribution is made for each sub-tier, in priority order, within a tier before distribution to the next lower tier.
   a) Distributions for eligible positions in a sub-tier with a lower priority will not receive a distribution until distributions are allocated for the direct and indirect costs of all positions in a higher sub-tier.
   b) Distributions are made for each sub-tier, in priority order, within a tier before distribution to the next lower tier.

4) For the specific purpose of the direct GME costs in this paragraph (H), each hospital will separately report actual direct costs per resident per academic year for the qualifying new programs and positions, following the same principles in the MCRs associated with existing graduate medical education programs. The recognized costs

will only be for the participating hospital's FTEs in the new programs and positions qualifying under paragraph (H). Such costs will be further apportioned to Medicaid using the actual Medicaid utilization ratio (Medicaid inpatient days divided by total inpatient days) for the program year. AHCCCS may adjust the reported costs to be consistent with applicable Medicare cost principles.

5) The amount of the distribution for each GME program for indirect costs is calculated as the product of:
   a) The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
   b) The Medicaid-specific statewide average indirect cost per resident per month calculated in paragraph D for the program year using the most recent as-filed Medicare cost reports as proxy; and
   c) Twelve months.

6) To ensure that the program receives accurate funding, residents/fellows who receive funding first in paragraph H may additionally receive funding through paragraphs B, C, D, and F, but total number of residents/fellows funded shall not be greater than 100% of the total FTEs in that program.

7) Payments are made to participating hospitals based on the FTEs who worked at their hospitals per academic year.

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I. Capital Component

Hospitals shall receive payment to compensate for capital costs associated with treating AHCCCS members. The capital component is a blend of hospital-specific and statewide costs, as defined below.

1) Calculation of Capital Costs: Capital costs for each hospital are identified through a claim costing process using accommodation cost per diems and cost-to-charge ratios in a manner similar to that described for operating costs. Costs identified using ratios and per diems which include only operating are subtracted from costs identified using ratios and per diems which include capital as well as operating. The result is capital cost per claim which is summed across claims for each hospital and divided by covered days. The statewide average is calculated based on capital costs across all claims divided by covered days across claims.

2) Blend Capital reimbursement represents a blend of statewide and individual hospital costs. For rates effective on and after October 1, 1999, the capital component shall be frozen at the 40% hospital-specific/60% statewide blend in effect on January 1, 1999.

PROSPECTIVE RATE YEAR		HOSPITAL SPECIFIC	STATEWIDE
1	(3/1/93-9/30/94)	90%	10%
2	(10/1/94-9/30/95)	80%	20%
3	(10/1/95-9/30/96)	70%	30%
4	(10/1/96-9/30/97)	60%	40%

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5 (10/1/97-9/30/98)	50%	50%
6 (10/1/98) and after	40%	60%

3) **Capital Payment by Tier**: Capital payments effective before September 30, 2000, shall be indexed to each tier by a relative weight factor, which is calculated by dividing each of the hospital's tiered operating rates by the weighted average of all the tiered operating rates for that hospital. For rates effective on and after October 1, 2000, this weighting of capital rates by tier will be frozen at the level in effect on September 30, 2000.

4) **Annual Update**: On an annual basis, AHCCCS shall adjust the capital component by the DRI inflation factor. For rates effective on and after October 1, 2010, no inflation factor will be applied.

H. Discounts and Penalties

AHCCCS shall subject all inpatient hospital admissions on and after March 1, 1993 to quick-pay discounts and slow-pay penalties in accordance with Arizona Revised Statute (A.R.S.) Title 36, Chapter 29, Article 1.

For dates of service or admissions on or after October 1, 1999, a quick pay discount of 1% is applied to claims paid within 30 days of the clean claim date.

Effective with dates of service or admissions on or after March 1, 1993, if a hospital's bill is paid after 30 days but within 60 days of the clean claim date, AHCCCS shall pay 100% of the rate. If a hospital's bill is paid any time after 60 days of the clean claim date, AHCCCS shall pay 100% of the rate plus a fee of 1% per month for each month or portion of a month following the 60th day of receipt of the bill until the date of payment.

IV. PAYMENT TO NEW HOSPITALS AND OUT-OF-STATE HOSPITALS, AND FOR NEW PROGRAMS

A. New Hospitals

New hospitals are assigned the statewide (or peer group) average operating cost and the statewide average capital amount for each tier, as appropriate. Capital reimbursement for new hospitals is indexed according to statewide relative weights per tier. A new hospital's statewide operating and capital components shall be updated annually by the DRI inflation factor. For rates effective on and after October 1, 2010, no inflation factor will be applied.

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B. Out-of-State Hospitals

Out-of-state hospitals providing covered services (excluding organ and transplantation services) to persons eligible for AHCCCS are paid by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio (CCR). The CCR is updated annually by AHCCCS, with an October 1 effective date, using the most current Medicare cost-to-charge ratios published or placed on display by CMS by August 31 of that year.

Out-of-state hospitals providing covered organ and transplantation services to persons eligible for AHCCCS are paid based upon a fixed price per type of transplant with stop-loss provisions. Reimbursement rates are negotiated using the out of state provider's home state Medicaid reimbursement as a benchmark. At no time will payment exceed the hospital's billed charges.

V. PAYMENT TO FREESTANDING PSYCHIATRIC HOSPITALS

Psychiatric hospitals are paid a statewide per diem fee. AHCCCS rates were set as of October 1, 2015, and are effective for dates of admission on or after that date. AHCCCS rates for payments to freestanding psychiatric hospitals, including freestanding psychiatric hospitals that function solely as detoxification facilities, are published on the agency's website at

https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/behavioralhealthrates.html?id=Inpatient

VI. APPEALS PROCEDURES

Facilities may appeal rates within the limits of Arizona statute through the AHCCCS grievance and appeals process. Facilities may also informally request a rate review.

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VII. Temporary Rate Reduction

Notwithstanding the methods and rates as otherwise described in this attachment, for claims with dates of admission between April 1, 2011 and September 30, 2011, payments in the following categories will be reduced by 5% of the payments that would otherwise have been made under the methodology in effect as of October 1, 2010 as described in this attachment:

- Tiered per diem payments including tiered per diem payments to new hospitals,
- Cost to Charge ratios used to qualify and pay inpatient outliers.
- Payments to out-of-state hospitals

The following payments described in this attachment will not be subject to this 5% rate reduction:

- Transplant services,
- Specialty services,
- Direct Medical Education payments,
- Indirect Medical Education payments,
- Payments for services provided by the Indian Health Service or Tribal 638 Health facilities
- Payments to freestanding psychiatric hospitals

For claims with dates of admission effective from October 1, 2011 to September 30, 2014, the following payments will be at the payment rates in effect as of September 30, 2011, reduced by 5%:

- Tiered per diem payments including tiered per diem payments to new hospitals,
- Cost to Charge ratios used to qualify and pay inpatient outliers. For more information about Cost to Charge ratios, refer to page 6 of this Attachment.
- Payments to out-of-state hospitals
- Payments to freestanding psychiatric hospitals

The following payments described in this attachment will not be subject to this 5% rate reduction:

- Transplant services,
- Specialty services,
- Direct Medical Education payments,
- Indirect Medical Education payments,
- Payments for services provided by the Indian Health Service or Tribal 638 Health facilities

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The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 (A)

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below

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Adjustment of Inpatient Hospital Reimbursement to Account for Non-payment of HCACs and OPPCs

In accordance with 42 CFR 447.26(c), no reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider. AHCCCS will use the Point of Admission (POA) indicator, as used by Medicare, to identify when a condition was acquired in the hospital.

Reductions in provider payment are limited to the extent that the State can reasonably isolate for nonpayment, the portion of the payment directly related to treatment for, and related to, the provider preventable conditions that would otherwise result in an increase in payment.

For HCACs and OPPCs: AHCCCS reimburses hospitals on a per diem basis. AHCCCS will identify potential HCACs and OPPCs, and perform medical review to determine whether or not they resulted in a longer length of stay or higher level of care. If it is determined that a HCAC or OPPC resulted in a longer stay or higher level of care, reimbursement of the related claim will be reduced to an amount commensurate with a stay and level of care had there been no HCAC or OPPC. AHCCCS will not claim FFP for expenditures for HCACs or OPPCs.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 TRIBAL FACILITIES

Effective January 1, 2000, AHCCCS will reimburse the Indian Health Service (IHS) and 638 tribal facilities for Medicaid inpatient hospital services in accordance with the OMB all-inclusive rate most recently published in the Federal Register. Additionally, AHCCCS reimburses the IHS and 638 tribal facilities for inpatient professional services based on the AHCCCS' capped fee-for-service schedule.

The Navajo Nation and the Gila River Indian Community operate a nursing facility on-reservation and are reimbursed based on the established fee-for-service rate for long term care facilities in Attachment 4.19-D. All inpatient professional services will be reimbursed based on the AHCCCS capped fee-for-service schedule.

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VIII. INPATIENT HOSPITAL PAYMENTS EFFECTIVE OCTOBER 1, 2014

A. Applicability

Except as specified in this paragraph, the inpatient payment method applies to all inpatient stays in all acute care hospitals. It does not apply to the following:

1. Stays in Indian Health Services (IHS) hospitals, or hospitals operated as 638 facilities, which are paid the all-inclusive rate published annually by IHS.
2. Stays in rehabilitation hospitals and long term acute care hospitals which, for the period October 1, 2014 through September 30, 2015, are paid on a per diem basis using the per diem rates that were in effect for each hospital on September 30, 2014, and thereafter are paid in accordance with Att. 4.19-A, page 27, paragraphs X and IX respectively.
3. Stays in psychiatric hospitals, which are paid on a per diem basis in accordance with the methodology described in Att. 4.19-A, page 11, paragraph V.
4. Stays associated with organ transplant services that are paid under contract, which are paid in accordance with the contract between AHCCCS and the transplant hospital.
5. Stays where the principle diagnosis is a behavioral health diagnosis, which are covered by a Regional Behavioral Health or Tribal Regional Behavioral Health Authorities in accordance with state law and which are paid on a per diem basis in accordance with the methodology described in Att. 4.19-A, page 11, paragraph V.

B. APR-DRG Reimbursement

For dates of discharge on and after October 1, 2014, inpatient hospital services will be reimbursed using the diagnosis related group (DRG) payment methodology. Each claim for an inpatient hospital stay will be assigned a DRG code and a corresponding DRG relative weight based on the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. DRG payments made using this methodology shall be the sole reimbursement to the hospital for all inpatient hospital services and related supplies provided by the hospital. A hospital will not be reimbursed separately for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis, if the patient is admitted as an inpatient to the same hospital directly from the emergency room, observation or other outpatient department.

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C. DRG Relative Weights

The APR-DRG methodology classifies inpatient stays into categories based on similar clinical conditions and similar levels of hospital resources required for treatment. The categories are identified using diagnosis-related group codes, each of which is assigned a relative weight appropriate to the relative amount of hospital resources expected to be used to treat the patient. Each claim is assigned to a DRG based on the patient's diagnoses, surgical procedures performed, age, gender, birth weight, and discharge status. An APR-DRG payment is determined by multiplying the DRG base rate by the DRG relative weight and any applicable policy adjustors. The DRG relative weights are posted on the AHCCCS website as of October 1, 2022 at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGrates.html.

D. DRG Base Rate for Arizona Hospitals

The DRG base rate for each hospital other than those described in paragraphs 1 and 2 below is a statewide standardized amount adjusted by applying the hospital's wage index to the hospital's labor-related share. The hospital wage index and labor-related share are those published by Medicare on September 18, 2020 for the Medicare inpatient prospective payment system for the fiscal year October 1, 2020 through September 30, 2021, and will not be subject to annual updates. For the following described hospitals, the DRG base rate will be calculated in the same manner except that an alternative standardized amount will be used in place of the statewide standardized amount:

1. Hospitals that are licensed by the state of Arizona Department of Health Services as short-term hospitals, indicated by a license number beginning with the letters "SH." These hospitals typically practice in a limited, specialized field.

2. Hospitals that are located in a city with a population greater than one million, which on average have at least 15% of inpatient days for patients who reside outside of Arizona and at least 50% of discharges reimbursed by Medicare as reported on the hospital's Medicare Cost Report for the hospital's cost reporting period ending between January 1, 2011 and December 31, 2011.

If a hospital qualifies for D.1 or D.2, it is not eligible for the alternative standardized amounts outlined in D.3, D.4 or D.5.

The following described hospitals will have a DRG base rate calculated in the same manner as above except that a separate alternative standardized amount unique to each category below will be used in place of the statewide standardized amount starting January 1, 2023:

3. Hospitals that have one hundred or fewer inpatient beds, that is located in a county with a population of less than five hundred thousand persons and has greater than twenty percent of Medicaid inpatient reimbursement with a primary diagnosis of behavioral health in the prior federal fiscal year as of April 30th.

4. Hospitals with two separate Arizona Department of Health Services (ADHS) acute care hospital licenses, with one hospital that has one hundred or fewer beds, that is located in a county with a population of less than five hundred thousand persons and has one single AHCCCS registration for both ADHS licenses.

5. Unless in a qualifying group above, Hospitals that have one hundred or fewer inpatient beds, and that are located in a county with a population of less than five hundred thousand persons; or a hospital that is licensed as a critical access hospital.

The statewide standardized amount, the alternative standardized amount, and the DRG base rates for all hospitals are posted on the AHCCCS website as of January 1, 2023 at
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGrates.html.

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E. DRG Base Rate for Out-of-State Hospitals

The DRG base rate for high volume out-of-state hospitals will be calculated in the same manner as for Arizona hospitals, using the Arizona statewide standardized amount. A high volume out-of-state hospital is a hospital that is located in a county that borders the state of Arizona and had 500 or more AHCCCS-covered inpatient days for the fiscal year beginning October 1, 2015. The DRG base rate for all other out-of-state hospitals is posted on the AHCCCS website that is referenced in paragraph D.

F. Policy Adjustors

Where AHCCCS has determined that an adjustment to the base payment is appropriate to ensure access to quality care, a policy adjustor will be applied to the base payment. Firstly, AHCCCS will apply a provider policy adjustor of 1.110 times the base rate to all claims from hospitals that are high volume Medicaid providers. A high volume Medicaid provider is a hospital that had AHCCCS-covered inpatient days during the fiscal year beginning October 1, 2015 equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals, and had a Medicaid utilization rate greater than 30% as reported in the hospital's Medicare Cost Report for the hospital's cost reporting period ending between January 1, 2016 and December 31, 2016, and received less than $2 million in add-on payment for outliers for the fiscal year beginning October 1, 2015.These calculations include both Fee-For-Service and Managed Care Organization data. Secondly, and in addition to the provider policy adjustor if it applies, Effective October 1, 2022 AHCCCS will apply one of nine service policy adjustors where the claim meets certain conditions. The nine service policy adjustors, the conditions to which they apply, and the adjustment values are described below:

1. Normal newborn DRG codes: 1.70
2. Neonates DRG codes: 1.10
3. Obstetrics DRG codes: 1.55
4. Psychiatric DRG codes: 1.65
5. Rehabilitation DRG codes: 1.65
6. Burns DRG codes: 4.00
7. Claims for patients under age 19 assigned DRG codes other than those described in items 1 through 6 above and with severity of illness level 1 or 2: 1.25
8. Claims for patients under age 19 assigned DRG codes other than those described in items 1 through 6 above and with severity of illness level 3 or 4: 2.40
9. All Other Adjustor: 1.025

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G. DRG Initial Base Payment

A claim for an inpatient hospital stay will be assigned both a DRG code derived from all diagnosis and surgical procedure codes included on the claim and a DRG code derived by excluding diagnosis and surgical procedure codes associated with health care acquired conditions or other provider-preventable conditions listed in Att. 4.19-A, page 13. The DRG code with the lower relative weight will be used to process the claim. For each hospital stay, the DRG initial base payment equals the DRG base rate multiplied by the DRG relative weight and any applicable policy adjustors.
The DRG initial base payment may be subject to additional adjustments as described in the following paragraphs to produce a DRG final base payment.

H. Outlier Add-on Payments

Cases which are extraordinarily costly in relation to other cases within the same DRG due to the severity of illness or complicating conditions may qualify for an outlier add-on payment. A claim will qualify for an outlier add-on payment if the claim cost exceeds the outlier cost threshold. The claim cost is determined by multiplying the covered charges by the hospital's outlier cost-to-charge ratio. The outlier threshold is equal to the DRG base payment plus the fixed loss amount, where the DRG base payment for this purpose is the lesser of the DRG initial base payment determined under paragraph G and the DRG transfer payment determined under paragraph I. The fixed loss amounts for critical access hospitals and for all other hospitals are posted on the AHCCCS website as of October 1, 2022 at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGrates.html.

The outlier cost-to-charge ratios for all hospitals will be determined as follows:

1. For children's hospitals in Arizona, the outlier cost-to-charge ratio will be calculated by dividing the hospital's total costs by its total charges using the most recent Medicare Cost Report available as of September 1st each year.
2. For Critical Access Hospitals in Arizona, the outlier cost-to-charge ratio will be the sum of the statewide rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio contained in the Medicare inpatient prospective payment system data file available as of September 1st each year.

3. For all other Arizona hospitals and for high volume out-of-state hospitals, the outlier cost-to-charge ratio will be the sum of the operating cost-to-charge ratio and the capital cost-to-charge ratio established for the specific hospital and contained in the Medicare inpatient prospective payment system impact file available as of September 1st each year.
4. For all other out-of-state hospitals, the outlier cost-to-charge ratio will be the sum of the Arizona statewide urban default operating cost-to-charge ratio and the Arizona statewide capital cost-to-charge ratio contained in the Medicare inpatient prospective payment system data file available as of September 1st each year.

AHCCCS will update the cost-to-charge ratios annually on October 1st each year. AHCCCS will not adopt any Medicare updates that CMS publishes subsequently for that payment year. Where a claim qualifies for an outlier add-on payment, the payment is calculated by subtracting the outlier threshold from the claim cost and multiplying the result by the DRG marginal cost percentage. The DRG marginal cost percentage is 90% for claims assigned DRG codes associated with the treatment of burns and 80% for all other claims.

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I. Transfer Payments

A transfer payment adjustment applies when a patient is transferred from a hospital that is subject to DRG reimbursement to another hospital that is subject to DRG reimbursement for inpatient care. The transferring hospital will be reimbursed the lesser of the DRG initial base payment and the DRG transfer payment. The DRG transfer payment is equal to the DRG initial base payment divided by the DRG national average length of stay for the assigned DRG code, multiplied by the actual length of stay plus one day. The receiving hospital will not be impacted by the transfer payment adjustment unless it transfers the patient to another hospital.

J. Prorated Payments

When a patient has Medicaid coverage for fewer days than the actual length of stay, the DRG payment will be prorated. The proration factor is determined as follows:

1. Where the patient is ineligible for Medicaid on the first day of the inpatient stay but is eligible for subsequent days during the inpatient stay, the proration factor is equal to the number of Medicaid-eligible days divided by the DRG national average length of stay for the assigned DRG code.
2. Where the patient is eligible for Medicaid on the first day of the inpatient stay but is ineligible for one or more days prior to or on the date of discharge, the proration factor is equal to the number of Medicaid-eligible days plus one day divided by the DRG national average length of stay for the assigned DRG code.

If the calculated proration factor is greater than one, the proration factor used for the payment calculation will be one. The DRG prorated payment is equal to the DRG base payment multiplied by the proration factor, where the DRG base payment for this purpose is the lesser of the DRG initial base payment determined under paragraph G and the DRG transfer payment determined under paragraph I. The DRG prorated outlier add-on payment is equal to the outlier add-on payment determined under paragraph H multiplied by the proration factor. Notwithstanding paragraph K, for the purpose of paragraphs J.1 and J.2 above, the day of discharge is included in determining the number of Medicaid-eligible days during an inpatient stay.

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K. Length of Stay Defined

For purposes of inpatient hospital reimbursement, the length of stay is equal to the total number of calendar days of an inpatient stay beginning with the date of admission and ending with the date of discharge or transfer, but not including the date of discharge or transfer unless the patient expires. A claim for inpatient services with an admission date and discharge date that are the same calendar date will be processed and reimbursed as an outpatient claim, unless the patient expired on the date of discharge.

M. DRG Final Payment

The DRG final base payment is the lesser of the DRG initial base payment determined under paragraph G and the DRG transfer payment determined under paragraph I, and multiplied by a proration factor if applicable. The DRG final outlier add-on payment is the outlier add-on payment determined under paragraph H, and multiplied by a proration factor if applicable. The DRG final payment amount is equal to the DRG final base payment amount plus the DRG final outlier add-on payment amount.

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N. Interim Payments

For an inpatient stay with a length of stay greater than 29 days, the hospital may submit interim claims for each 30 day period during the inpatient stay. In this case, the hospital will be reimbursed for interim claims at a per diem rate of $500 per day. Following discharge of the patient, the hospital must void all interim claims and AHCCCS will recoup the interim payments. Final payment will be determined under the DRG payment methodology.

O. New Hospitals

The DRG base rate for a new hospital is calculated in the same manner as other Arizona hospitals if the hospital's wage index and labor-related share are available in the Medicare inpatient prospective payment system; otherwise, the DRG base rate is the statewide standardized amount adjusted by applying the wage index and labor-related share appropriate to the physical location of the hospital. Likewise, the outlier cost-to-charge ratio for a new hospital is determined in the same manner as other Arizona hospitals if the hospital's operating cost-to-charge ratio is contained in the Medicare inpatient prospective payment system impact file; otherwise, the Arizona statewide urban or rural default operating cost-to-charge ratio, whichever is appropriate to the physical location of the hospital, will be added to the Arizona statewide capital cost-to-charge ratio to derive the outlier cost-to-charge ratio.

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P. Administrative Days and Readmissions

1. Administrative days are days of a hospital stay in which a patient does not meet the criteria for an acute inpatient stay, but is not discharged because an appropriate placement outside the hospital is not available or the patient cannot be safely discharged or transferred. Administrative days are reimbursed at the rate the claim would have paid had the services not been provided in an inpatient hospital setting but had been provided at the appropriate placement. In certain circumstances, a member has unique medical or behavioral health needs, and the cost of the care for those unique needs is not factored into the rate otherwise established for the appropriate non-hospital inpatient placement. In such circumstances, AHCCCS negotiates with the hospital for a rate no less than the rate for the appropriate non-hospital inpatient placement and no more than the rate that would otherwise be paid for a hospital inpatient stay, taking into consideration the comparable fee for service rate for the unique services.

2. If a patient is readmitted, without prior authorization, to the same hospital that the patient was discharged from within 72 hours and the DRG code assigned to the claim for the prior admission has the same first three digits as the DRG code assigned to the claim for the readmission, then payment for the claim for the readmission will be disallowed if a medical review determines the readmission could have been prevented by the hospital.

IX. PAYMENT TO LONG-TERM ACUTE CARE HOSPITALS

Effective October 1, 2015, long-term acute care hospitals are paid a per diem rate which will be an intensive care unit (ICU) rate, a surgery rate, or a routine rate. A hospital is eligible to receive an ICU rate or a surgery rate if the hospital is licensed by the Arizona Department of Health Services to provide ICU or surgical services.

The ICU rate applies to inpatient days associated on the claim with revenue codes in the ranges 200-204, 207-212, and 219. The surgery rate applies to inpatient days associated on the claim with revenue codes 360-369 in combination with valid procedure codes that are not on the AHCCCS excluded surgery procedures list. The routine rate applies to all other inpatient days.

An outlier is a hospital claim on which the covered charges exceed the outlier threshold, which will be an ICU threshold, a surgery threshold, or a routine threshold. The outlier thresholds for long-term acute care hospitals are the thresholds that were in effect for those hospitals on September 30, 2014. Outliers shall be reimbursed by multiplying covered charges by the outlier cost-to-charge ratio. The outlier ratios will be the Final Statewide Average Total Cost-to-Charge Ratios for LTCHs in the data file published by CMS as part of the Medicare Long-Term Care Hospital Prospective Payment System for the prior fiscal year. The urban cost-to-charge ratio applies to hospitals located in Maricopa County or Pima County, and to out-of-state hospitals. The rural cost-to-charge ratio applies to all other hospitals.

AHCCCS rates were set as of October 1, 2022, and are effective for dates of admission on and after that date. AHCCCS rates and outlier thresholds for payments to long-term acute care hospitals are published on the agency's website at: https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/LTACrehab.html

X. PAYMENT TO REHABILITATION HOSPITALS

Effective October 1, 2015, rehabilitation hospitals are paid a statewide per diem rate.

An outlier is a hospital claim on which the covered charges exceed the outlier threshold. The outlier threshold for rehabilitation hospitals is the threshold that was in effect for those hospitals on September 30, 2014. Outliers shall be reimbursed by multiplying covered charges by the outlier cost-to-charge ratio. The outlier cost-to-charge ratios will be the Final Statewide Average Total Cost-to-Charge Ratios for LTCHs in the data file published by CMS as part of the Medicare Long-Term Care Hospital Prospective Payment System for the prior fiscal year. The urban cost-to-charge ratio applies to hospitals located in Maricopa County or Pima County, and to out-of-state hospitals. The rural cost-to-charge ratio applies to all other hospitals.

AHCCCS rates were set as of October 1, 2022, and are effective for dates of admission on and after that date. AHCCCS rates and outlier thresholds for payments to rehabilitation hospitals are published on the agency's website at https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/LTACrehab.html

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A. **OVERVIEW**

As of October 1, 2022, through September 30, 2023 (Contract Year Ending (CYE) 2023), AHCCCS registered Arizona hospitals (other than the facilities described in section C. below) which meet Agency established value-based performance metrics requirements in section B. below will receive a Differential Adjusted Payment described in section D. below. The Differential Adjusted Payment Schedule represents a positive adjustment to the AHCCCS Fee-For-Service reimbursement rates. These payment adjustments will occur for all dates of discharge in CYE 2023 (October 1, 2022 through September 30, 2023) only. The purpose of the Differential Adjusted Payment is to distinguish facilities which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth.

B. Applicability

To qualify for the Inpatient Differential Adjusted Payment (DAP), a hospital providing inpatient hospital services must meet one of the following criteria:

1. Hospitals (provider type 02) receiving APR-DRG reimbursement are eligible for DAP increases under the following criteria (Up to 3.25%)

Domain / % Increase	Description
a. Health Information Exchange Participation (Up to 2.0%)	Hospitals that meet the following milestones and performance criteria are eligible to participate in this DAP initiative and earn up to a 2.0% DAP increase for inpatient services. In order to qualify, by April 1, 2022 the hospital must have submitted a Letter of Intent (LOI) to AHCCCS and the Health Information Exchange (HIE), in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved: i. Milestone #1: No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved. ii. Milestone #2: No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable: 1. Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system.

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	2. Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system. 3. Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system. iii. Milestone #3: No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf. iv. Milestone #4: No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. v. Milestone #5: No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate connectivity and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization. vi. Milestone #6: No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization. vii. Milestone #7: No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW as agreed to in Milestone #6. viii. Milestone #8: No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW as agreed to in Milestone #6. In addition to the submission of the LOI agreeing to the above milestones, the hospital must meet these following performance criteria:

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ix. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below in B.1.a.x.

1. Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2020 data, to the final data quality profile, based on March 2022 data.
2. Meet a minimum performance standard of at least 60% based on March 2022 data.
3. If performance meets or exceeds an upper threshold of 90% based on March 2021 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

x. DAP HIE Data Quality Standards CYE 2023Measure Categories: Hospitals that meet the standards, as defined in Section C., qualify for a DAP increase for each category of the five measure categories, for a total potential increase of 2.0% if criteria are met for all categories.

1. Data source and data site information must be submitted on all ADT transactions. (1.0%)
2. Race must be submitted on all ADT transactions (0.5%)
3. Ethnicity must be submitted on all ADT transactions (0.5%)

For any milestone that includes electronic submission of patient information, the information transferred to the qualifying HIE must be actual patient data; the transfer of test data does not fulfill these requirements. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2.

In order to receive up to a 2.0% DAP increase for HIE performance a hospital must submit a LOI to the HIE by April 1, 2022, to the following email address: DAP@healthcurrent.org.

If a hospital has already achieved one or more of the CYE 2023 milestones as of April 1, 2022, the LOI must include a commitment by the hospital to maintain its participation in those milestone activities for the period April 1, 2022 through September 30, 2023.

If a hospital receives up to a 2.0% DAP increase for CYE 2023but fails to achieve one or more of the milestones in the LOI by the specified date or fails to maintain its participation in the milestone activities, that hospital will be ineligible to receive the HIE DAP for dates of service from October 1, 2023 through September 30, 2024 (CYE 2024) if a DAP is available at that time.

AHCCCS anticipates that HIE Data Quality Standards, minimum performance standards, and upper thresholds will continue to be monitored and evaluated during

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	the CYE 2023 period in order to ensure that performance improvements are maintained.
b. Social Determinants of Health Closed Loop Referral Platform (0.5%)	Hospitals that meet the following milestones are eligible to participate in this DAP initiative and earn a 0.5% DAP increase for inpatient services. In relation to this DAP initiative only, the qualifying HIE organization is designated as Contexture, the umbrella organization for Health Current, in alignment with AHCCCS' Whole Person Care Initiative. To qualify by April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates: i. Milestone #1: No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization. ii. Milestone #2: No later than April 1, 2022: 1. For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform. 2. For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform. The deadline for these hospitals to achieve this milestone is November 1, 2022. iii. Milestone #3: No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements. In order to receive a 0.5% DAP increase for SDOH Closed-Loop Referral Platform participation, hospitals must complete a registration form found on the website of the qualifying HIE organization and submit the form to the HIE by April 1, 2022 to the following email address: DAP@healthcurrent.org The registration form will include a commitment by the hospital to maintain its participation in any milestone activities already achieved as of April 1, 2022, for the period April 1, 2022, through September 30, 2023. Additionally, if a hospital submits

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	a registration form and receives the 0.5% DAP increase for CYE 2023 but fails to achieve one or more of the milestones by the specified date or fails to maintain its participation in the milestone activities, that hospital will be ineligible to receive the SDOH DAP for dates of service from October 1, 2023, through September 30, 2024 (CYE 2024) if a DAP is available at that time. The DAP will apply to all claims for covered AHCCCS services. The registration form must list each facility that the hospital requests to participate in this DAP initiative and must include the AHCCCS IDs for each listed facility.
c. Enter into a Care Coordination Agreement with an IHS/Tribal 638 Facility (0.5%)	Hospitals will be eligible for a 0.5% DAP increase by participating in a Care Coordination Agreement (CCA) with an IHS/Tribal 638 facility. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with an IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities: i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance- SHO #16-002. ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be provided by the non-IHS/Tribal 638 facility. iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA. iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2021. v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022, through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS. vi. Existing facilities with a CCA established in CYE 2022 must have submitted a minimum of 5 CCA claims to AHCCCS by March 15, 2022 and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.

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	In order to meet the DAP criteria for CCA participation the facility must submit a LOI to AHCCCS by March 15, 2022 (or a fully signed CCA in lieu of a LOI) and submit a fully signed CCA no later than April 30, 2022, to AHCCCS to both of the following email addresses: tribalcarecoordination_fmap@azahcccs.gov, and AHCCCSDAP@azahcccs.gov If a facility participated in the CCA DAP in prior years and the CCA is still current, the facility may submit a letter acknowledging participation for CYE 2023, rather than submitting the CCA agreement. If a facility receives the 0.5% DAP increase for CYE 2023 but fails to submit a minimum of one CCA claim by September 1, 2022, and fails to submit an average of 5 CCA claims per month to AHCCCS throughout CYE 2023, the facility will be ineligible to receive a care coordination agreement DAP for dates of service from October 1, 2023 through September 30, 2024 (CYE 2024) if a DAP is available at that time.
d. Hospital Capacity Reporting (0.25%)	Hospitals that commit to ongoing capacity reporting will qualify for a 0.25% DAP increase for inpatient services. In order to qualify, upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS: i. Number of ICU beds in use ii. Number of ICU beds available for use iii. Number of Medical-Surgical beds in use iv. Number of Medical-Surgical beds available for use v. Number of Telemetry beds in use vi. Number of Telemetry beds available for use In order to receive a 0.25% DAP increase for capacity reporting, a hospital must submit a LOI to AHCCCS within one calendar week of the declaration of the end of the State of Arizona PHE to the following email address: AHCCCSDAP@azahcccs.gov If a hospital submits a LOI but fails to comply with the weekly reporting requirement, the hospital will be ineligible to receive the hospital capacity reporting DAP for dates of service from October 1, 2023 to September 30, 2024 (CYE 2024) if a DAP is available at that time.

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2. Other Hospitals and Inpatient Facilities (Up to 5.0%)

Psychiatric Hospitals, with the exception of public hospitals, Provider Type 71; Subacute Facilities (1-16 Beds), Provider Type B5; Subacute Facilities (17+ beds), Provider Type B6; Rehabilitation Hospitals, Provider Type C4; Long Term Acute Care Hospitals, Provider Type C4 are eligible for DAP increases under the following criteria. For purposes of Section 2, other inpatient facilities will be referred to as hospitals.

Domain / % Increase	Description
a. Health Information Exchange Participation (Up to 2.0%)	Hospitals that meet the following milestones and performance criteria are eligible to participate in this DAP initiative and earn up to a 2.0% DAP increase for inpatient services. In order to qualify, by April 1, 2022 the hospital must have submitted a Letter of Intent (LOI) to AHCCCS and the Health Information Exchange (HIE), in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved: i. Milestone #1: No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved. ii. Milestone #2: No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable: 1. Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system. 2. Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system. 3. Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system. iii. Milestone #3: No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the

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	external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf. iv. Milestone #4: No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. v. Milestone #5: No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization. vi. Milestone #6: No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization. vii. Milestone #7: No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW as agreed to in Milestone #6. viii. Milestone #8: No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW as agreed to in Milestone #6. In addition to the submission of the LOI agreeing to the above milestones, the hospital must meet these following performance criteria: ix. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below in B.2.a.x. 1. Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2021 data, to the final data quality profile, based on March 2022 data. 2. Meet a minimum performance standard of at least 60% based on March 2022 data. 3. If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

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	x. DAP HIE Data Quality Standards CYE 2023Measure Categories: Hospitals that meet the standards, as defined in Section C, qualify for a total potential increase of 2.0%if criteria are met for all categories. 1. Data source and data site information must be submitted on all ADT transactions. (1.0%) 2. Race must be submitted on all ADT transactions (0.5%) 3. Ethnicity must be submitted on all ADT transactions (0.5%) For any milestone that includes electronic submission of patient information, the information transferred to the qualifying HIE must be actual patient data; the transfer of test data does not fulfill these requirements. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2. If a hospital has already achieved one or more of the CYE 2023 milestones as of April 1, 2022, the LOI must include a commitment by the hospital to maintain its participation in those milestone activities for the period April 1, 2022 through September 30, 2023. In order to receive up to a 2.0% DAP increase for HIE performance a hospital must submit a LOI to the HIE by April 1, 2022 to the following email address: DAP@healthcurrent.org. If a hospital receives up to a 2.0% DAP increase for CYE 2023 but fails to achieve one or more of the milestones in the LOI by the specified date or fails to maintain its participation in the milestone activities, that hospital will be ineligible to receive the HIE DAP for dates of service from October 1, 2023 through September 30, 2024 (CYE 2024) if a DAP is available at that time. AHCCCS anticipates that HIE Data Quality Standards, minimum performance standards, and upper thresholds will continue to be monitored and evaluated during the CYE 2023 period in order to ensure that performance improvements are maintained.
b. Social Determinants of Health Closed Loop Referral Platform (0.5%)	Hospitals that meet the following milestones are eligible to participate in this DAP initiative and earn a 0.5% DAP increase. In relation to this DAP initiative only, the qualifying HIE organization is designated as Contexture, the umbrella organization for Health Current, in alignment with AHCCCS' Whole Person Care Initiative. To qualify by April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates:

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	i. Milestone #1: No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization. ii. Milestone #2: No later than April 1, 2022: 1. For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform. 2. For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform. The deadline for these hospitals to achieve this milestone is November 1, 2022. iii. Milestone #3: No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements. In order to receive a 0.5% DAP increase for SDOH Closed-Loop Referral Platform participation, hospitals must complete a registration form found on the website of the qualifying HIE organization and submit the form to the HIE by April 1, 2022 to the following email address: DAP@healthcurrent.org The registration form will include a commitment by the hospital to maintain its participation in any milestone activities already achieved as of April 1, 2022, for the period April 1, 2022, through September 30, 2023. Additionally, if a hospital submits a registration form and receives the 0.5% DAP increase for CYE 2023 but fails to achieve one or more of the milestones by the specified date or fails to maintain its participation in the milestone activities, that hospital will be ineligible to receive the SDOH DAP for dates of service from October 1, 2023, through September 30, 2024 (CYE 2024) if a DAP is available at that time. The DAP will apply to all claims for covered AHCCCS services. The registration form must list each facility that the hospital requests to participate in this DAP initiative and must include the AHCCCS IDs for each listed facility.
c. Enter into a Care	Hospitals will be eligible for a 0.5% DAP increase by participating in a CCA with an IHS/Tribal 638 facility. By March 15, 2021, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable).

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Coordination Agreement with an IHS/Tribal 638 Facility (0.5%)	By April 30, 2021, the facility must have entered into a CCA with an IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities: i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance- SHO #16-002. ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility. iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA. iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed-upon claims operation process with AHCCCS for the review of medical records by May 31, 2022. v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022, through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS. vi. Existing facilities with a CCA established in CYE 2022 must have submitted a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022. In order to meet the DAP criteria for CCA participation the facility must submit a LOI to AHCCCS by March 15, 2022 (or a fully signed CCA in lieu of a LOI) and submit a fully signed CCA no later than April 30, 2022 to AHCCCS to both of the following email addresses: tribalcarecoordination_fmap@azahcccs.gov, and AHCCCSDAP@azahcccs.gov. If a facility participated in the CCA DAP in prior years and the CCA is still current, the facility may submit a letter acknowledging participation for CYE 2023, rather than submitting the CCA agreement. If a facility receives the 0.5% DAP increase for CYE 2023 but fails to submit an average of 5 CCA claims per month to AHCCCS throughout CYE 2023, the facility will be ineligible to receive a care coordination agreement DAP for dates of service from

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	October 1, 2023, through September 30, 2024 (CYE 2024) if a DAP is available at that time.
d. Inpatient Psychiatric Facility Quality Reporting Program (2.0%)	Hospitals that meet the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) performance measure will qualify for a DAP increase. On March 15, 2022, AHCCCS will download the most current data from the QualityNet.org website to identify Medicare's Annual Payment Update (APU) recipients. APU recipients are those facilities that satisfactorily met the requirements for the IPFQR program, which includes multiple clinical quality measures. Facilities identified as APU recipients will qualify for the DAP increase.
e. Long-term Care Hospital Pressure Ulcers Performance Measure (2.0%)	Hospitals that meet or fall below the national average for the pressure ulcers performance measure will qualify for a 2.0% DAP increase. On March 15, 2022, AHCCCS will download the most current data from the Medicare Provider Data Catalog website for the rate of changes in skin integrity post-acute care: Pressure Ulcer/Injury. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.
f. Inpatient Rehabilitation Pressure Ulcers Performance Measure (2.0%)	Hospitals that meet or fall below the national average for the pressure ulcers performance measure will qualify for a 2.0% DAP increase. On March 15, 2022, AHCCCS will download the most current data from the Medicare Provider Data Catalog website for the rate of changes in skin integrity post-acute care: Pressure Ulcer/Injury. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.

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3. **Critical Access Hospitals (up to 10.75%)**
Hospitals designated as a Critical Access Hospital (CAH) by March 15,2022 are eligible for up to a maximum 10.75% DAP increase under the following criteria.

Domain / % Increase	Description
a. Health Information Exchange Participation (Up to 8.0%)	Hospitals that meet the following milestones and performance criteria are eligible to participate in this DAP initiative and earn up to an 8.0% DAP increase for inpatient services. In order to qualify, by April 1, 2022 the hospital must have submitted a Letter of Intent (LOI) to AHCCCS and the Health Information Exchange (HIE), in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved: i. Milestone #1: No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved. ii. Milestone #2: No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable: 1. Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system. 2. Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system. 3. Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system. iii. Milestone #3: No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf. iv. Milestone #4: No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the

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	production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. v. Milestone #5: No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate connectivity and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization. vi. Milestone #6: No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization. vii. Milestone #7: No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW as agreed to in Milestone #6. viii. Milestone #8: No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW as agreed to in Milestone #6. In addition to the submission of the LOI agreeing to the above milestones, the hospital must meet these following performance criteria: ix. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below in B.3.x. 1. Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2021 data, to the final data quality profile, based on March 2022 data. 2. Meet a minimum performance standard of at least 60% based on March 2022 data. 3. If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements. x. DAP HIE Data Quality Standards CYE 2023 Measure Categories: Hospitals that meet the standards, as defined in Section C., qualify for a total potential increase of 8.0% if criteria are met for all categories. 1. Data source and data site information must be submitted on all ADT transactions. (3.0%)

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	2. Event type must be properly coded on all ADT transactions. (1.0%) 3. Race must be submitted on all ADT transactions (2.0%) 4. Ethnicity must be submitted on all ADT transactions (2.0%) For any milestone that includes electronic submission of patient information, the information transferred to the qualifying HIE must be actual patient data; the transfer of test data does not fulfill these requirements. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2. In order to receive up to an 8.0% DAP increase for HIE performance a hospital must submit a LOI to the HIE by April 1, 2022, to the following email address: DAP@healthcurrent.org If a hospital has already achieved one or more of the CYE 2023 milestones as of April 1, 2022, the LOI must include a commitment by the hospital to maintain its participation in those milestone activities for the period April 1, 2022 through September 30, 2023. If a hospital receives up to an 8.0% DAP increase for CYE 2023 but fails to achieve one or more of the milestones in the LOI by the specified date or fails to maintain its participation in the milestone activities, that hospital will be ineligible to receive an HIE DAP for dates of service from October 1, 2023 through September 30, 2024 (CYE 2024) if a DAP is available at that time. AHCCCS anticipates that HIE Data Quality Standards, minimum performance standards, and upper thresholds will continue to be monitored and evaluated during the CYE 2023 period in order to ensure that performance improvements are maintained.
b. Social Determinants of Health Closed Loop Referral Platform (2.0%)	Hospitals that meet the following milestones are eligible to participate in this DAP initiative and earn a 2.0% DAP increase. In relation to this DAP initiative only, the qualifying HIE organization is designated as Contexture, the umbrella organization for Health Current, in alignment with AHCCCS' Whole Person Care Initiative. To qualify by April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates: i. Milestone #1: No later than April 1, 2022, submit registration form(s) for participation using the forms found on the website of the qualifying HIE organization. ii. Milestone #2: No later than April 1, 2022:

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	a. For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform. b. For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform. The deadline for this milestone is November 1, 2022. iii. Milestone #3: No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements. In order to receive a 2.0% DAP increase for SDOH Closed-Loop Referral Platform participation, hospitals must complete a registration form found on the website of the qualifying HIE organization and submit the form to the HIE by April 1, 2022 to the following email address: DAP@healthcurrent.org. The registration form will include a commitment by the hospital to maintain its participation in any milestone activities already achieved as of April 1, 2022, for the period April 1, 2022, through September 30, 2023. Additionally, if a hospital submits a registration form and receives the 2.0% DAP increase for CYE 2023 but fails to achieve one or more of the milestones by the specified date or fails to maintain its participation in the milestone activities, that hospital will be ineligible to receive the SDOH DAP for dates of service from October 1, 2023, through September 30, 2024 (CYE 2024) if a DAP is available at that time. The DAP will apply to all claims for covered AHCCCS services. The registration form must list each facility that the hospital requests to participate in this DAP initiative and must include the AHCCCS IDs for each listed facility.
b. Enter into a Care Coordination Agreement with	Hospitals will be eligible for a 0.5% DAP increase by participating in a CCA with an IHS/Tribal 638 facility. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and

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an IHS/638 Facility (0.5%)	maintain participation in the following activities: i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance- SHO #16-002. ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA. iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA. iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022. v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS. vi. Existing facilities with a CCA established in CYE 2022 must have submitted a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022. In order to meet the DAP criteria for CCA participation the facility must submit a LOI to AHCCCS by March 15, 2022 (or a fully signed CCA in lieu of a LOI) and submit a fully signed CCA no later than April 30, 2022 to AHCCCS to both of the following email addresses: tribalcarecoordination_fmap@azahcccs.gov, and AHCCCSDAP@azahcccs.gov. If a facility participated in the CCA DAP in prior years and the CCA is still current, the facility may submit a letter acknowledging participation for CYE 2023, rather than submitting the CCA agreement. If a facility receives the 0.5% DAP increase for CYE 2023 but fails to submit an average of 5 CCA claims per month to AHCCCS throughout CYE 2023, the facility will be ineligible to receive a care coordination agreement DAP for dates of service from October 1, 2023 through September 30, 2024 (CYE 2024) if a DAP is available at that time.

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d. Hospital Capacity Reporting (0.25%)	Hospitals that commit to ongoing capacity reporting will qualify for a 0.25% DAP increase for inpatient services. In order to qualify, upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS: 1. Number of ICU beds in use 2. Number of ICU beds available for use 3. Number of Medical-Surgical beds in use 4. Number of Medical-Surgical beds available for use 5. Number of Telemetry beds in use 6. Number of Telemetry beds available for use In order to receive a 0.25% DAP increase for capacity reporting, a hospital must submit a LOI to AHCCCS within one calendar week of the declaration of the end of the State of Arizona PHE to the following email address: AHCCCSDAP@azahcccs.gov If a hospital submits a LOI but fails to comply with the weekly reporting requirement, the hospital will be ineligible to receive a hospital capacity reporting DAP for dates of service from October 1, 2023 to September 30, 2024 (CYE 2024) if a DAP is available at that time.

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4. **Rehabilitation and Long Term Acute Care Hospitals (0.25%)**
Rehabilitation Hospitals, Provider Type C4 and Long-Term Acute Care Hospitals, Provider Type C4 are eligible for DAP increases under the following criteria.

Domain / % Increase	Description
a. Hospital Capacity Reporting (0.25%)	Hospitals that commit to ongoing capacity reporting will qualify for a 0.25% DAP increase for inpatient services. In order to qualify, upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS: 1. Number of ICU beds in use 2. Number of ICU beds available for use 3. Number of Medical-Surgical beds in use 4. Number of Medical-Surgical beds available for use 5. Number of Telemetry beds in use 6. Number of Telemetry beds available for use In order to receive a 0.25% DAP increase for capacity reporting, a hospital must submit a LOI to AHCCCS within one calendar week of the declaration of the end of the State of Arizona PHE to the following email address: AHCCCSDAP@azahcccs.gov If a hospital submits a LOI but fails to comply with the weekly reporting requirement, the hospital will be ineligible to receive a hospital capacity reporting DAP for dates of service from October 1, 2023 to September 30, 2024 (CYE 2024) if a DAP is available at that time.

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C. HIE Data Quality Standards

The following data quality standards apply to Provider Types 02, CAH, 71, B1, B3, B5, B6 and C4:

1. Measure 1: Data source and data site information must be submitted on all ADT transactions.
    i. Standards: HL7
    ii. Inclusions: MSH.4 and PV1.3.4
    iii. Exclusions: None
    iv. Additional Notes: The source information can be derived from the MSH.4 segment, and the site information from one of the other inclusions. If both source and site information are sent in MSH.4, the sending organization must provide the required mapping details to Contexture.

2. Measure 2: Event type must be properly coded on all ADT transactions.
    i. Standards: HL7
    ii. Inclusions: EVN.1, MSH.9.1, MSH.9.2
    iii. Exclusions: None

3. Measure 3: Patient class must be properly coded on all appropriate ADT transactions.
    i. Standards: HL7
    ii. Inclusions: PV1.2 (associated with completed EVN., MSH.9 with A01, A02, A03, A04)
    iii. Exclusions: None

4. Measure 4: Patient demographic information must be submitted on all ADT transactions.
    i. Standards: HL7
    ii. Inclusions: PID.1.1, PID.3.1, PID.5.1, PID.5.2, PID.7.1, PID.8.1, PID.10.1 PID.11.1, PID.11.3, PID.11.4, PID,11.5
    iii. Exclusions: None
    iv. Additional Notes: The patient demographic elements that will be evaluated for this measure are first name, last name, date of birth, gender, and address (street address, city, state, and zip). The patient demographic elements that have been removed from previous iterations of this measure include middle name, address type, county, and country.

5. Measure 5: Race
    i. Standards: HL7 or CCD
    ii. Inclusions: PID.10.1 and PID.10.2
    iii. Exclusions: None
    iv. Additional Notes: HL7 standard code sets will be used for race items outside of HL7 will be mapped, when possible, to one of the HL7 excepted code sets. The following link will

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provide code set details https://www.hl7.org/fhir/v2/0005/index.html

6. Measure 6: Ethnicity
   i. Standards: HL7 or CCDi
   ii. Inclusions: PID.22.1 and PID.22.2
   iii. Exclusions: None
   iv. Additional Notes: HL7 standard code sets will be used for ethnicity, items outside of HL7 will be mapped, when possible, to one of the HL7 excepted code sets. The following link will provide code set details https://www.hl7.org/fhir/v2/0189/index.html

7. Measure 7: Discharge Diagnosis
   i. Standards: HL7
   ii. Inclusions: DG1.3.1, DG1.3.2, DG1.3.3, DG1.5.1, DG1.6.1
   iii. Exclusions: Admission, transfers
   iv. Additional Notes: initial quality measure will only include diagnosis upon discharge A03

8. Measure 8: Overall completeness
   i. Standards: HL7
   ii. Inclusions: MSH.4 and PV.1.3.4; MSH.4, EVN.1, MSH.9.1, MSH.9.2; PV1.2 (associated with completed EVN., MSH.9 with A01, A02, A03, A04), PID.1.1, PID.3.1, PID.5.1, PID.5.2, PID.7.1, PID.8.1, PID.11.1, PID.11.3, PID.11.4, PID,11.5; PID.10.1 and PID.10.2; PID.22.1 and PID.22.2; DG1.3.1, DG1.3.2, DG1.3.3, DG1.5.1, DG1.6.1
   iii. Exclusions: None

D. IHS/638 Facilities: DAP for IHS and 638 tribally owned and/or operated hospitals is described on page 28(v).

E. Payment Methodology

For hospitals receiving APR-DRG reimbursement (described in Section B.1 above), fee-for-service reimbursement rates may be increased up to a maximum of 3.25%. Reimbursement rates for inpatient services will be increased by 2.0% if they meet the HIE requirements, by 0.5% if they meet the SDOH closed loop referral platform requirements, by 0.5% if they meet the CCA requirements, and 0.25% if they meet the hospital capacity reporting requirements. These increases do not apply to supplemental payments.

For other hospitals and inpatient facilities (described in Section B.2 above), fee-for-service reimbursement rates may be increased up to a maximum of 5.0%. Payment rates for inpatient services will be increased by 2.0% if they meet the HIE requirements detailed in B.2.a., by 0.5% if they meet the SDOH closed loop referral platform requirements in B.2.b, and by 0.5% if they meet the CCA requirements detailed in B.2.c.

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For inpatient psychiatric facilities, payment rates for services will be increased by 2.0% if they meet the Quality Reporting requirements detailed in B.2.d. For Long-Term Care Hospitals, payment rates for services will be increased by 2.0% if they meet the Pressure Ulcers Performance requirements detailed in B.2.e. For Inpatient Rehabilitation Hospitals, payment rates for services will be increased by 2.0% if they meet the Pressure Ulcers Performance requirements detailed in B.2.f. These increases do not apply to supplemental payments.

Additionally, for Long-Term Care Hospitals, payment rates for services will be increased by 0.25% if they meet the hospital capacity reporting requirements detailed in B.4.a. For Inpatient Rehabilitation Hospitals, payment rates for services will be increased by 0.25% if they meet the hospital capacity reporting requirements detailed in B.4.a. These increases do not apply to supplemental payments.

For critical access hospitals (described in Section B.3 above), fee-for-service reimbursement rates may be increased up to a maximum of 10.75%. Reimbursement rates for inpatient services will be increased by 8.0% if they meet the HIE requirements, by 2.0% if they meet the SDOH closed loop referral platform requirements, by 0.5% if they meet the CCA requirements, and by 0.25% if they meet the hospital capacity reporting requirements. These increases do not apply to supplemental payments.

Hospitals which submitted an LOI and received an increase for CYE 2022 but failed to achieve one or more milestones in the LOI or failed to maintain its participation in the milestone activities are ineligible to receive the respective DAP in CYE 2023.

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The following is a description of methods and standards for determining Differential Adjusted Payments for IHS/638 Tribally owned and/or operated facilities. The purpose of the Differential Adjusted Payment is to distinguish facilities which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. The Differential Adjusted Payment Schedule represents a positive adjustment to the AHCCCS rates. These payment adjustments will occur for all dates of service in Contract Year Ending (CYE) 2023 (October 1, 2022 through September 30, 2023) only.

1. IHS and 638 Tribally Owned and/or Operated Facilities (Up to 3.25%)

A. Applicability

Hospitals, provider type 02, owned and/or operated by Indian Health Services (IHS) or owned and/or operated by Tribal authority by March 15,2022 are eligible for a DAP increase under the following criteria:

Domain / % Increase	Description
a. Health Information Exchange Participation (Up to 2.5%)	Hospitals that meet the following milestones are eligible to participate in this DAP initiative and a 2.5% DAP increase for inpatient services. In order to qualify, by April 1, 2022 the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved: i. Milestone #1: No later than April 1, 2022 the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved. ii. Milestone #2: No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable: 1. Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system. 2. Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system. 3. Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to

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	the qualifying HIE organization to ensure proper processing of immunizations within the HIE system. iii. Milestone #3: No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf. iv. Milestone #4: No later than May 1, 2022 the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the facility has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If the hospital has ambulatory and/or behavioral health practices, then the facility must submit the following actual patient identifiable information to the production environment of a qualifying HIE: registration, encounter summary, and SMI data elements as defined by the qualifying HIE organization. For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022. v. Milestone #5: No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization. vi. Milestone #6: No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW as agreed to in Milestone #5. vii. Milestone #7: No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW as agreed to in Milestone #5. In addition to the submission of the LOI agreeing to the above milestones, the hospital must meet these following performance criteria: viii. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below in 1.A.a.ix:

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1. Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
2. Meet a minimum performance standard of at least 60% based on March 2022 data.
3. If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

ix. DAP HIE Data Quality Standards CYE 2023 Measure Categories: Hospitals that meet the standards, as defined in Section C., qualify for a 0.5% DAP percentage increase for each Data Quality Measure for a total potential increase of 2.5% if criteria are met for all categories

1. Data source and data site information must be submitted on all ADT transactions. (0.5%)
2. Event type must be properly coded on all ADT transactions. (0.5%)
3. Patient class must be properly coded on all appropriate ADT transactions. (0.5%)
4. Patient demographic information must be submitted on all ADT transactions. (0.5%)
5. Overall completeness of the ADT message. (0.5%)

For any milestone that includes electronic submission of patient information, the information transferred to the qualifying HIE must be actual patient data; the transfer of test data does not fulfill these requirements. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2.

In order to receive up to a 2.5% DAP increase for HIE participation a hospital must submit a LOI to the HIE by April 1, 2022 to the following email address: DAP@healthcurrent.org.

If a facility has already achieved one or more of the CYE 2023 milestones as of April 1, 2022 the LOI must include a commitment by the facility to maintain its participation in those milestone activities for the period April 1, 2022 through September 30, 2023. The LOI must list each facility that the hospital requests to participate in this DAP initiative and must include the AHCCCS IDs for each listed facility. In all cases, the hospital must submit the AHCCCS IDs for each listed facility as part of the LOI or must email the associated AHCCCS IDs to the email addresses noted.

If a facility submits a LOI and receives the 2.5% DAP increase for CYE 2023 but fails to achieve one or more of the milestones by the specified date or fails to maintain

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	its participation in the milestone activities, that facility will be ineligible to receive the HIE DAP for dates of service from October 1, 2023 through September 30, 2024 (CYE 2024) if a DAP is available at that time.
b. Care Coordination Agreement with Non-IHS/Tribal 638 Facilities (up to 0.5%)	IHS/Tribal 638 facilities will be eligible for a 0.5% DAP increase by participating in a CCA with a non-IHS/638 facility. By March 15, 2022, the facility must submit a LOI to enter into a CCA with a non-IHS/638 facility (a fully signed copy of a CCA with a non-IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with a non-IHS/Tribal 638 facility for inpatient services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities: i. The IHS/Tribal 638 facility will have a valid referral template in place for requesting services to be performed by the non-IHS/Tribal 638 facility. ii. The IHS/Tribal 638 facility will continue to assume responsibility of the referred member, maintaining records and release of information protocol including clinical documentation of services provided by the non-IHS/Tribal 638 facility. iii. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the IHS/Tribal 638 facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022 iv. The IHS/638 facility will submit a minimum of one referral and any supporting medical documentation to the non-IHS/Tribal 638 facility by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA referrals per month to the non-IHS/Tribal 638 20 facility v. Existing facilities with a CCA established in CYE 2022 must have submitted a minimum of 5 CCA referrals to the non-IHS/Tribal 638 facility by March 15, 2022, and must have submitted an average of 5 CCA referrals per month by May 31, 2022. In order to meet the DAP criteria for CCA participation an IHS/Tribal 638 facility must submit a LOI to AHCCCS by March 15, 2022 and a submit a signed CCA by April 30, 2022 to AHCCCS to both of the following email addresses: tribalcarecoordinationfmap@azahcccs.gov, and AHCCCSDAP@azahcccs.gov If a facility participated in the CCA DAP in prior years and the CCA is still current, the facility may submit a letter acknowledging participation for CYE 2023, rather than submitting the CCA agreement.

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	If a facility receives the 0.5% DAP increase for CYE 2023 but fails to submit an average of 5 CCA referrals per month to the non-IHS/Tribal 638 facility throughout CYE 2023, the facility will be ineligible to receive a Care Coordination Agreement DAP for dates of service from October 1, 2023 through September 30, 2024 (CYE 2024) if a DAP is available at that time.
c. Hospital Capacity Reporting (0.25%)	Hospitals that commit to ongoing capacity reporting will qualify for a 0.25% DAP increase for inpatient services. In order to qualify, upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS: 1. Number of ICU beds in use 2. Number of ICU beds available for use 3. Number of Medical-Surgical beds in use 4. Number of Medical-Surgical beds available for use 5. Number of Telemetry beds in use 6. Number of Telemetry beds available for use In order to receive a 0.25% DAP increase for capacity reporting, a hospital must submit a LOI to AHCCCS within one calendar week of the declaration of the end of the State of Arizona PHE to the following email address: AHCCCSDAP@azahcccs.gov If a hospital submits a LOI but fails to comply with the weekly reporting requirement, the hospital will be ineligible to receive a hospital capacity reporting DAP for dates of service from October 1, 2023 to September 30, 2024 (CYE 2024) if a DAP is available at that time.

B. **Payment Methodology**

All payments may be increased up to a maximum of 3.25%. Payments will be increased by 2.5% if the IHS/Tribal 638 facility meets the HIE requirements, by 0.5% if it meets the CCA requirements and by 0.25% if it meets the hospital capacity reporting requirements. The proposed DAP for IHS/638 facilities would be applicable to the All- inclusive Rate (AIR). The DAP is not applicable to supplemental payments.

IHS/Tribal 638 facility which submitted an LOI and received a DAP increase for CYE 2023 but failed to achieve one or more milestone in the LOI or failed to maintain its participation in the milestone activities are ineligible to receive DAP in CYE 2024.

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Disproportionate Share Hospital Program

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 section sets forth the criteria by which Arizona defines DSH hospitals and the methodology through which DSH payments are calculated and distributed. The section 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 and 1A eligibility)
- Low Income Utilization Rate (LIUR) calculation (Group 2 and 2A eligibility)
- Governmentally-operated hospitals (Group 4 eligibility)
- Obstetrician Requirements
- Payment
- Group 5 Eligibility Determination
- Aggregate Limits
- Reconciliations
- Certified Public Expenditures (CPEs)
- Grievances and appeals
- Other provisions

Hospital 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	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	The hospital has an MIUR of at least 1 percent

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receiving a Medicaid payment in the state and is an IHS facility, tribally owned and/or operated facility, or an other federally owned or operated facility ("Group 1") 1.A. The hospital has a MIUR which is at least one standard deviation above the mean MIUR for all hospitals receiving a Medicaid payment in the state 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% and is an IHS facility, tribally owned and/or operated facility, or an other federally owned or operated facility ("Group 2") 2.A. The hospital has a LIUR that exceeds 25% and is a privately owned or privately operated hospital licensed by the state of Arizona ("Group 2A")	patients 2. The hospital is located in a rural area, defined in accordance with Section 1923(d)(2)(B) of the Social Security Act, 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	

3. The hospital is a governmentally- operated hospital and is not an IHS facility, tribally owned and/or operated facility, or an other federally owned or operated facility. ("Group 4")		

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 Year. The State Plan Year (or State Plan Rate 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. When data is not available based on a State Plan Year, the calculations to determine eligibility for, and the amount of, DSH payments, will be performed separately for each hospital's fiscal year which encompass the SPY and these results will be prorated based on the distribution of months from each of the two years. For example, for SPY 2019(10/1/18 to 9/30/19), 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 from the 2552 Report will be derived by summing:

1. $9/12^{th}$ of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/19, and
2. $3/12^{th}$ of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/20.

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 that have submitted the information required by this document and/or as otherwise requested by AHCCCS during the application process. In order to be considered "submitted during the application process," 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. This does not preclude AHCCCS from using other information available to AHCCCS to verify or supplement the information submitted by the hospitals. The calculations will be performed with the information submitted by hospitals, 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 year of the initial DSH payment. To determine initial eligibility, AHCCCS will:
    a. Extract from PMMIS all inpatient and outpatient hospital claims and encounters from the state plan year two years prior
    b. to the state plan year of the initial DSH payment. 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%. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above. 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
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 using the same steps above except that the data will be from the actual state plan year for which the DSH payment is made.

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.

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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:

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

The calculation will be performed based on the state plan year. AHCCCS will perform this calculation twice. The first calculation will be performed using data for the state plan year two years prior to the year of the initial DSH payment. The second calculation will be performed using data for the state plan year of the initial DSH payment. The CMS 2552 form(s) to be used is/are the most recent available cost report(s) that encompass the relevant state plan years.

AHCCCS may apply trending factors for the initial calculation to account for changes in utilization and/or population (e.g., due to changes in Medicaid eligibility criteria). 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.

If a hospital has a MIUR of at least 1%, and the obstetrical criteria of Column B above are satisfied, it will meet the overall eligibility criteria. If a hospital has a MIUR which is at least one standard deviation above the mean MIUR for all Arizona hospitals receiving a Medicaid payment in that State Plan Year, it will meet the eligibility for Group 1 or 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. AHCCCS will extract claims and encounter data for "Medicaid Inpatient Days" from PMMIS. The data extraction will be performed using dates of service as specified in the earlier section titled "Timing of Eligibility Determination," found in both step 1(a) and step 2.

    "Medicaid Inpatient Days" includes all adjudicated inpatient days for Title XIX beneficiaries, including days paid by Medicare.

3. For "Total number of inpatient days" data should be taken from hospital cost reports. The specific figures to be used are found on Worksheet S-3, Lines 1 and 8 through 13, Column 8 plus Line 16 through 18, Column 8 for hospital subprovider days.

Calculation of the mean MIUR and the Standard Deviation

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

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LIUR Calculation (Group 2 and 2 A 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:

$$\text{LIUR} = \left| \frac{\text{Total Medicaid Patient Services Charges + Total State and Local Cash Subsidies for Patient Services}}{\text{Total Charges for Patient Services}} \right| + \left| \frac{\text{Total Inpatient Charges Attributable to Charity Care-Cash Subsidies Portion Attributable to Inpatient}}{\text{Total Inpatient Charges}} \right|$$

The calculation will be performed based on the state plan year.

If a hospital has a LIUR that exceeds 25% it will meet the eligibility for Group 2 or 2A. AHCCCS will perform this calculation twice. The first calculation will be performed using data for the state plan year two years prior to the year of the initial DSH payment. The second calculation will use data for the state plan year of the initial DSH payment. The CMS 2552 form(s) to be used is/are the most recent available report(s) that encompass the relevant state plan year.

AHCCCS may apply trending factors for the initial calculation to account for changes in utilization, population (e.g., due to changes in Medicaid eligibility criteria), supplemental payments, and/or Medicaid payments and rates. The adjustments may increase or decrease the days, costs, charges, or payments reflected on the cost reports, Medicaid data and/or uninsured information. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior.

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) extracted from PMMIS.

2. "Total Medicaid Patient Services Charges" does not include DSH payments or payments made for GME, Critical Access Hospitals, Rural Hospital Inpatient Payments or any other Title XIX 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. These payments include, but are not limited to
    a. Payments made for:
        i. Non-Title XIX and Non-Title XXI enrollees in the Comprehensive Medical and Dental Program (CMDP), this information is provided to AHCCCS from CMDP
        ii. Non-Title XIX and Non-Title XXI enrollees in the Behavioral Health Services Program
        iii. The support of trauma centers and emergency departments
    b. Payments reported by hospitals to AHCCCS which are 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) from hospital cost report(s). The specific figures to be used are found on Worksheet C Part I, Column 8 Line 200 less Lines 44 to 46, less Lines 88 to 89, less Lines 94 to 101, less Lines 105 to 112, and less Lines 115 to 117. If charges for Rural Health Clinics or Federally Qualified Health Centers appear anywhere other than on Lines 88 to 89, these charge amounts should also be deducted from Line 200.

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. This data is taken from the hospital claims and financial records submitted with information requested by AHCCCS during the application process.

7. "Total Inpatient Charges Attributable to Charity Care" does not include bad debt expense or contract allowances and discounts offered to third party payers 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. Data should be taken from the hospital claims and financial records submitted with information requested by AHCCCS during the application process. 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.

9. "Total Inpatient Charges" includes total inpatient and hospital subprovider charges without any deductions for contract allowances or discounts offered to third party payers or self pay patients. Data should be taken from hospital cost report(s). The specific figures to be used are found in Worksheet C, Part I, Column 6 Line 200 less Lines 44 to 46, less Lines 88 to 89, less Lines 94 to 101, less Lines 105 to 112, and less Lines 115 to 117. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 88 to 89, these charge amounts should also be deducted from Line 200.

Governmentally-Operated Hospitals (Group 4 Eligibility)

Because the state has designated all governmentally-operated hospitals (represented in Group 4) as DSH hospitals, no eligibility calculations are required other than the minimum qualifications in columns B and C.

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 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 year of the initial DSH payment from the start of the state plan 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. With the exception of Group 5, each of the pools correlates to one of the hospital eligibility Groups. The amounts of funding for the pools for the current state plan year are contained in Exhibit 3.

When determining the payment amounts, hospitals in Group 1 and 2 will be calculated concurrently, and if a hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment. When determining the payment amounts, hospitals in Group 1A and 2A will be calculated concurrently, and if a hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment.

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 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 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 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 non-governmental 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. AHCCCS may set aside monies from the initial payment to make these minimum payments. AHCCCS may use monies which were set aside for hospitals which did not qualify for the initial determination but qualified in subsequent determinations. In the event that monies set aside are insufficient to provide the minimum payments, 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.

The payment amount to each governmentally-operated hospital will be determined during the state plan 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.

Recoupment of Pool 5 payments for any of the above instances, however, would not be redistributed

Determination of Payment Amounts

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 qualify for Group 1, 1A, 2, or 2A

There are ten steps to determining the DSH payment amount for hospitals that qualify for Group 1, 1A, 2, 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. These steps will need to be performed separately: once for Groups 1 and 2 and once for Groups 1A and 2A.

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 charges. 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 hospital that qualifies for Group 1, 1A, 2, 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 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 total funding amount for the current state plan year for Group 4 is contained in Exhibit 3. The funding amount for the IMD hospital in Group 4 is the IMD DSH limit for Arizona. The funding amount for the other governmentally-operated hospital in Group 4 is the remainder of the Group 4 pool amount, including any amount unclaimed by the IMD hospital.

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:

Uncompensated Care Costs Incurred Serving Medicaid Recipients
+
Uncompensated Care Costs Incurred Servicing the Uninsured

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 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 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 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 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 year of the initial DSH payment is finalized

The steps to computing the OBRA limit are:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). Each hospital must complete the cost report to determine cost center-specific per diems (for inpatient routine services) and ratios of cost to charges (RCC) (for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.

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

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

The Medicaid Shortfall

The data used to calculate the Medicaid shortfall is extracted from the cost report(s) as well as from the AHCCCS PMMIS and other AHCCCS financial reporting systems.

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

1. The number of Medicaid fee for service (FFS) inpatient hospital days for each inpatient routine service cost center on the cost report
2. The number of Medicaid managed care inpatient hospital days for each inpatient routine service cost center on the cost report
3. The Medicaid inpatient and outpatient hospital FFS charges for each ancillary cost center on the cost report
4. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital FFS services
5. The amounts of Medicaid payments made by AHCCCS for inpatient and outpatient hospital FFS services
6. The Medicaid inpatient and outpatient hospital managed care charges for each ancillary cost center on the cost report
7. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services for health plans and program contractors
8. The amounts of Medicaid payments made by managed care organizations for inpatient and outpatient hospital services

9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan year under review (e.g. GME, CAH, etc.)
10. AHCCCS may apply trending factors for the initial payment to account for changes in utilization (e.g., due to changes in Medicaid eligibility criteria), supplemental payments, and Medicaid payments and rates. The adjustments may increase or decrease the days, costs, charges, or payments reflected on the cost reports, Medicaid and/or uninsured information. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior.

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

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

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 24, Line 30 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 8, Line 1 should have added the amount appearing on Line 28 (observation bed days).

The ancillary RCCs will be calculated by dividing:

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

Costs will be offset by the payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services as well as payments made by AHCCCS including FFS payments and payments by managed care

organizations, made for the state plan year. Amounts for supplemental payments (such as GME, Rural Hospital Inpatient Payment and CAH) will be those made for the SPY. During the initial calculation, AHCCCS may use actual data if available as opposed to two years prior payments.

Uninsured Costs

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

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

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (under either Title XIX or Title XXI) 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 payer types that are included in the uninsured data compilation, and

- An electronic file that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted during the application process to the financial records of the hospital

The uninsured costs will be calculated for each hospital. The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (this will be accumulated for each inpatient routine service cost center on the cost report)
2. The uninsured inpatient and outpatient hospital ancillary charges (this will be accumulated for each ancillary cost center on the cost report)
3. The amounts of payments received during the state plan year 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 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)
4. AHCCCS may apply trending factors for the initial payment to account for changes in utilization (e.g., due to changes in Medicaid eligibility criteria), supplemental payments, and Medicaid payments and rates. The adjustments may increase or decrease the days, costs, charges, or payments reflected on the cost reports, Medicaid and/or uninsured information. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior.

For each hospital the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report (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 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

The Administration will make additional payments, as specified in Exhibit 3, for hospitals that qualify for funding in Groups 1, 1A, 2, 2A, or 4. Group 5 DSH payments are in addition to the Groups 1, 1A, 2, 2A, and 4 DSH payments, but no individual hospital will receive aggregate DSH payments that exceed its OBRA limit. 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 = $50,000,000, MIUR = 0.3500, LIUR = 0.3000
Group 5 LOM score for Hospital A = $50,000,000 x 0.3500 x 0.3000 = $5,250,000

For the first round of distributions, each participating hospital's percentage of the total LOM score will be calculated using the hospital's LOM score as the numerator and the total of all participating hospitals' LOM scores as the denominator. Allocations will initially be provided to qualifying hospitals located outside of the Phoenix and Tucson metropolitan statistical areas.

The total amount of DSH available for Group 5, as specified in Exhibit 3 to Attachment C, will be multiplied by each hospital's LOM percentage of this first round. If the allocation is higher than a hospital's OBRA limit (remaining after Group 1, 1A, 2, 2A, and 4 DSH distributions) or higher than the maximum amount allocated for the hospital in Exhibit 3 in Attachment C, the lower of those three limits will be recorded as the allocation for round one.

For subsequent rounds which will be also open to qualifying hospitals located in the Phoenix and Tucson metropolitan statistical areas, only the hospitals that have not hit their OBRA limit or the maximum amount allocated for the hospital in Exhibit 3 in Attachment C will be considered. The LOM score for 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, as specified in Exhibit 3 in Attachment C, 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 remaining total computable matching funds for that hospital or the maximum amount allocated for the hospital in Exhibit 3 in Attachment C, the lower of those three limits will be recorded as the allocation for that round. Distribution rounds will continue until all Group 5 DSH funds for the hospitals are distributed, or all hospitals have reached their individual OBRA limits or the maximum amount allocated for the hospital in Exhibit 3 in Attachment C, whichever comes first.

The Administration will specify the hospitals which may be eligible for Group 5 and the amount of funding in Exhibit 3 to Attachment C. The Administration may include multiple pools within Group 5, to be specified in Exhibit 3.

Any Group 5 payment made to a hospital which qualifies for Group 4 will be accounted for as an offset in the CPE computation under Group 4.

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.

Reconciliations

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 under Pool 4 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.

AHCCCS Disproportionate Share Hospital (DSH) Payments
Exceptions

An exception to the use of the Medicare Cost Report (Form CMS 2552-10) 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 2552-10 (Medicare Cost Report), and
- Receive an acceptance letter from the CMS fiscal intermediary for the portion of the CMS 2552-10 (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 2552-10 (Medicare Cost Report) as provided in this Attachment C.

The method of extracting and compiling the data from the hospital's financial records shall conform to the instructions for the Form CMS 2552-10. All other non-Medicare Cost Report data and documentation as described in this Attachment C shall be required from such hospitals.

II. Indian Health Service (IHS) Hospitals and tribally-operated 638 hospitals who do not file a full Form CMS 2552-10 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 aswell 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 2552-10. All other non-Medicare Cost Report data and documentation as described on the PFIS cover sheet will be required by such hospitals.

DSH Exhibit 1:
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.

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

The Medicaid Shortfall

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

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

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report and the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services.

The per diem amounts will be calculated by dividing:

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

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 24, Line 30 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 8, Line 1 should have added the amount appearing on Line 28 (observation bed days).

The ancillary RCCs will be calculated by dividing:

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

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

1. The governmentally-operated hospital specific Medicaid inpatient and outpatient cost data,
2. The payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services,
3. The Medicaid inpatient and outpatient net cost data,
4. Payments made by AHCCCS including FFS and payments by health plans and program contractors
5. The amount of supplemental Medicaid payments related to inpatient and outpatient hospital services (e.g., GME and CAH, etc.)
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 and submit to the state uninsured days and charges and program data for 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 (under either Title XIX or Title XXI) 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 payer types that are included in the uninsured data compilation, and

- An electronic file that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted during the application process 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 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 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 outpatient 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 year of the initial DSH payment is calculated as described below under "Reconciliation".

Reconciliation

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

DSH Exhibit 2:
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 during the application process, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan year(s) under review.

The Medicaid Shortfall

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

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

ASH will use a single total per diem calculated from the cost report and the inpatient days extracted from PMMIS to determine the cost of providing inpatient Medicaid services. The single total per diem amount will be calculated by summing the inpatient per diem amount and the ancillary per diem amount.

The inpatient per diem amount will be found by dividing the amounts from Worksheet B, Part I Column 24, Line 30 by the day total on Line 1 from Worksheet S-3, Part I Column 8. Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 24, Line 30 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part

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

The ancillary per diem amount will be calculated by:

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

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

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

Uninsured Costs

ASH will collect and submit to AHCCCS uninsured days and program data for the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient days and program data for medical services that would otherwise be eligible for Medicaid should be included in the calculation. Inpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days and program information provided to 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 (under either Title XIX or Title XXI) 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 the state plan year.
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 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 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 outpatient 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 year of the initial DSH payment will be computed for ASH three times:

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

DSH Exhibit 3:
AHCCCS
Disproportionate Share Hospital Payment
Methodology Pool Funding Amount

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

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

Pools 1, 1A, 2, 2A, and 3 - Non-governmentally-operated hospitals

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

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

- For SPY 2018, the funding for pools 1, 2, 1A, and 2A will be $884,800.
- For SPY 2019, the funding for pools 1, 2, 1A, and 2A will be $884,800.
- For SPY 2020, the funding for pools 1, 2, 1A, and 2A will be $884,800.
- For SPY 2021, the funding for pools 1, 2, 1A, and 2A will be $884,800.
- For SPY 2022, the funding for pools 1, 2, 1A, and 2A will be $884,800.
- For SPY 2023, the funding for pools 1, 2, 1A, and 2A will be $884,800

Pool 4 – Governmentally-operated hospitals

The funding for pool 4 is the amount authorized by the Legislature for governmentally operated hospitals.

- For SPY 2018, the funding for pool 4 is $142,293,400.
- For SPY 2019, the funding for pool 4 is $142,293,400.
- For SPY 2020, the funding for pool 4 is $142,293,400.
- For SPY 2021, the funding for pool 4 is $142,293,400.
- For SPY 2022, the funding for pool 4 is $142,293,400.
- For SPY 2023, the funding for pool 4 is $142,293,400

Pool 5 - The funding for pool 5 is specified below.

- For SPY 2018, the funding for Pool 5 is the FY 2018 Arizona DSH allotment total computable amount minus $143,178,200.
- For SPY 2019, the funding for Pool 5 is the FY 2019 Arizona DSH allotment total computable amount minus $143,178,200.
- For SPY 2020, the funding for Pool 5 is the FY 2020 Arizona DSH allotment total computable amount minus $143,178,200.

For SPY 2018, the pool 5 hospitals are:

- Benson Hospital
- Holy Cross Hospital
- Kingman Regional Medical Center
- Little Colorado Medical Center
- Mt. Graham Regional Medical Center
- Northern Cochise Community Hospital
- Page Hospital
- Yuma Regional Medical Center
- Canyon Vista Medical Center
- Banner Payson Medical Center

For SPY 2019, the pool 5 hospitals are:

- Benson Hospital
- Holy Cross Hospital
- Kingman Regional Medical Center
- Little Colorado Medical Center
- Mt. Graham Regional Medical Center
- Northern Cochise Community Hospital
- Page Hospital
- Yuma Regional Medical Center
- Canyon Vista Medical Center
- Banner Payson Medical Center

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For SPY 2020, the pool 5 hospitals are:

- BENSON HOSPITAL
- KINGMAN REGIONAL MEDICAL CENTER
- LITTLE COLORADO MED CTR
- MT. GRAHAM REGIONAL MEDICAL CENTER
- NORTHERN COCHISE HOSPITAL
- PAGE HOSPITAL
- YUMA REGIONAL MEDICAL CENTER

Upon reconciliation, Pool 5 funds will be recouped due to changes in hospital qualification or payment limits; Pool 5 overpayments are not redistributed to other hospitals.

For SPY 2020, excess pool 4 funding not allocated due to OBRA limits will be reallocated to Pool 5 by December 31, 2021 or soon after the SPA is approved. The reallocation will be based proportionately according to the hospital's LOM scores, subject to each hospital's remaining OBRA limit. The amount to be reallocated to DSH pool 5 is $18,122,533.

The participating Pool 5 hospitals that will receive the pool 4 funding reallocation are:

- Yuma Regional Medical Center