

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

To the extent necessary to relieve the State of the obligation to make eligible individuals who meet the statutory definition of this eligibility group because they are in an acute care hospital for greater than 30 days but who do not meet the level of care standard for long term care services.

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

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

To the extent necessary to permit the State to offer coverage through managed care organizations (MCOs) that provide additional or different benefits to enrollees, than those otherwise available other eligible individuals.

4. Disproportionate Share Hospital (DSH) Requirements **Section 1902(a)(13) insofar as it**
incorporates section 1923

To the extent necessary to relieve the State from the obligation to make DSH payments under the authority of a state plan amendment. DSH payments are authorized under the authority of the demonstration and its STCs. Beginning October 1, 2017 the state will make DSH payments under the authority of the Medicaid state plan.

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

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

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

To the extent necessary to enable the State to restrict freedom of choice of providers through mandatory enrollment of eligible individuals in managed care organizations that do not meet the requirements of section 1932 of the Act. No waiver of freedom of choice is authorized for family planning providers.

To the extent necessary to enable the State to impose a limitation on providers on charges associated with non-covered activities.

7. Drug Utilization Review

Section 1902(a) (54) insofar as it incorporates section 1927(g) (42 CFR 456.700 through 456.725 and 438.3(s) (4) and (5))

To the extent necessary to relieve the State from the requirements of section 1927(g) of the Act pertaining to drug use review.

8. Premiums

Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A

To the extent necessary to enable the state to require monthly premiums for individuals eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act, who have incomes above 100 up to and including 133 percent of the federal poverty level (FPL).

9. Comparability

Section 1902(a)(17)

To the extent necessary to enable the state to vary the premiums, cost-sharing and healthy behavior reduction options as described in these terms and conditions.

10. Retroactive Eligibility

Section 1902(a)(10) and (a)(34)

Effective no sooner than April 1, 2019, to the extent necessary to enable the state to not provide medical assistance for any month prior to the month in which a beneficiary's Medicaid application is filed. The waiver of retroactive eligibility does not apply to applicants who would have been eligible at any point within the three month period immediately preceding the month in which an application was received, as a pregnant woman (including during the 60-day period beginning on the last day of the pregnancy), an infant under age 1, or a child under age 19.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBERS: **11-W-00275/09**
 21-W-00064/9

TITLE: **Arizona Medicaid Section 1115 Demonstration AWARDEE:**
 Arizona Health Care Cost Containment System (AHCCCS)

Medicaid Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period beginning October 1, 2016, through September 30, 2021, unless otherwise specified, be regarded as matchable expenditures under the state's Medicaid state plan.

The expenditure authorities listed below promote the objectives of title XIX by: increasing overall coverage of low-income individuals in the state, improving health outcomes for Medicaid and other low-income populations in the state, and increasing access to, stabilizing, and strengthening the availability of provider and provider networks to serve Medicaid and low-income individuals in the state.

The following expenditure authorities shall enable Arizona to implement the AHCCCS section 1115 demonstration:

I. Expenditures Related to Administrative Simplification and Delivery Systems

1. Expenditures under contracts with managed care entities that do not meet the requirements in 1903(m)(2)(A) and 1932(a) of the Act in so far as they incorporate 42 CFC 438.52(a) to the extent necessary to allow the state to operate only one managed care plan in urban areas:
 - a) For AHCCCS Acute Care Program (AACP) members with a serious mental illness; and
 - b) Outside of Maricopa County to permit the state to limit choice of managed care plans to a single MCO for individuals enrolled in ALTCS and Comprehensive Medical and Dental Program (CMDP) programs, so long as enrollees in such plans have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). Notwithstanding this authority, the state must offer a choice of at least two MCOs to elderly and physically disabled individuals in Maricopa County.
2. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) of the Act specified below. AHCCCS's managed care plans participating in the demonstration will have to meet all the requirements of section 1903(m) except the following:

- a) Section 1903(m)(2)(A)(vi) of the Act insofar as it requires compliance with requirements in section 1932(a)(4) of the Act and 42 CFR 438.56(v)(2)(i) that enrollees be permitted an initial period after enrollment that would be longer than 30 days to disenroll without cause. Beginning October 1, 2017, the state must allow disenrollment without cause up to 90 days after enrollment into a managed care plan.
 - b) Section 1903(m)(2)(H) of the Act and 42 CFR 438.56(g), but only insofar as to allow the state to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan from which the individual was previously enrolled.
3. Expenditures under contracts with managed care entities that do not provide for payment for Indian health care providers as specified in section 1932(h) of the Act, when such services are not included within the scope of the managed care contract. Expenditures for direct payments made to IHS or Tribal 638 providers by the state, which are offset from the managed care capitation rate.
 4. Expenditures for outpatient drugs which are not otherwise allowable under section 1903(i)(10) of the Act that have not undergone a drug utilization review.
 5. Expenditures for direct payments to Critical Access Hospitals (CAH) for services provided to AHCCCS enrollees in the Acute Care and ALTCS managed care programs that are not consistent with the requirements of 42 CFR 438.60.
 6. Expenditures for items and services provided to AHCCCS fee-for-service beneficiaries that exceed the amounts allowable under section 1902(a)(30)(A) of the Act and the upper payment limitation and actual cost requirements of (42 CFR 447.250 through 447.280 (regarding payments for inpatient hospital and long-term care facility services), 447.300 through 447.321 (regarding payment methods for other institutional and non-institutional services) and 447.512 through 447.518(b) regarding payment for drugs) so long as those expenditures are in accordance with Special Term and Condition (STC) 88 entitled “Applicability of Fee-for-Service Upper Payment Limit.”
 7. Expenditures for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients but are not allowable under sections 1902(a)(13)(A) and 1923 of the Act, but are in accordance with the provisions for disproportionate share hospital (DSH) payments that are described in the STCs.
 8. Expenditures for medical assistance including Home and Community Based Services furnished through ALTCS for individuals over age 18 who reside in Alternative Residential Settings classified as residential Behavioral Health Facilities.

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

9. Expenditures related to:

- a) Medical assistance furnished to ALTCS enrollees who are eligible only as a result of the disregard from eligibility of income currently excluded under section 1612(b) of the Act, and medical assistance that would not be allowable for some of those enrollees but for the disregard of such income from post-eligibility calculations.
- b) Medical assistance furnished to ALTCS enrollees who are financially eligible with income equal to or less than 300 percent of the Federal Benefit Rate and who are eligible for ALTCS based on the functional, medical, nursing, and social needs of the individual.
- c) Medical assistance furnished to some dependent children or spouses who qualify for ALTCS based on a disregard of income and resources of legally responsible relatives or spouses during the month of separation from those relatives or spouses.
- d) Medical assistance furnished to individuals who are eligible as Qualified Medicare Beneficiary (QMB), Special Low Income Beneficiary (SLMB), Qualified Individuals-1(QI-1), or Supplemental Security Income Medical Assistance Only (SSI MAO) beneficiaries based only on a disregard of in-kind support and maintenance (ISM).
- e) Medical assistance furnished to individuals who are eligible based only on an alternate budget calculation for ALTCS and SSI-MAO income eligibility determinations when spousal impoverishment requirements of section 1924 of the Act do not apply or when the applicant/recipient is living with a minor dependent child.
- f) Medical assistance furnished to individuals who are eligible only based on the disregard of interest and dividend from resources, and are in the following eligibility groups:
 - i. The Pickle Amendment Group under 42 CFR 435.135;
 - ii. The Disabled Adult Child under section 1634(c) of the Act;
 - iii. Disabled Children under section 1902(a)(10)(A)(i)(II) of the Act; and
 - iv. The Disabled Widow/Widower group under section 1634(d) of the Act.
- g) Medical assistance furnished to ALTCS enrollees under the eligibility group described in section 1902(a)(10)(A)(ii)(V) of the Act that exceeds the amount that would be allowable except for a disregard of interest and dividend from the post-eligibility calculations.
- h) Medical assistance provided to individuals who would be eligible but for excess resources under the “Pickle Amendment,” section 503 of Public Law 94-566; section 1634(c) of the Act (disabled adult children); or section 1634(b) of the Act

(disabled widows and widowers).

- i) Medical assistance that would not be allowable but for the disregard of quarterly income totaling less than \$20 from the post-eligibility determination.
10. Expenditures to extend eligibility past the timeframes specific in 42 CFR §435.1003 for demonstration participants who lose SSI eligibility for a period of up to 2-months from the SSI termination effective date.
11. Expenditures to provide Medicare Part B premiums on behalf of individuals enrolled in ALTCS with income up to 300 percent of the FBR who are also eligible for Medicare, but do not qualify as a QMB, SLMB or QI; are eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO); are eligible for continued coverage under 42 CFR 435.1003; or are in the guaranteed enrollment period described in 42 CFR 435.212 and the State was paying their Part B premium before eligibility terminated.
12. Expenditures to extend ALTCS eligibility to individuals under the age of 65 who meet the applicable financial criteria but are not disabled, but who are found to be at risk of needing nursing facility services based on medical illness or intellectual disability on the preadmission screening instrument.
13. Expenditures associated with the provision of Home & Community-Based Services (HCBS) to individuals enrolled in the Arizona Long Term Care system with income levels up to 300 percent of the SSI income level, as well as individuals enrolled in the ALTCS Transitional program.
14. Expenditures for demonstration caregiver services provided by spouses of the demonstration participants.
15. Expenditures to provide certain dental services up to a cost of \$1,000 per person annually to individuals age 21 or older enrolled in the Arizona Long Term Care System.

The following expenditure (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall be regarded as matchable expenditures under the state's Medicaid state plan:

16. Subject to the availability of and the overall cap on Safety Net Care Pool (SNCP) funds, expenditures for payments to Phoenix Children's Hospital reflecting uncompensated care costs incurred by Phoenix Children's Hospital for medical services that are within the scope of the definition of "medical assistance" under 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals and that exceed the amounts paid to the hospital pursuant to section 1923 of the Act. The state may claim federal financial participation (FFP) for these payments only if they reflect uncompensated care costs that are incurred by Phoenix Children's Hospital on or before December 31, 2017, and only in accordance with paragraph 32.

- 17.** Expenditures for all state plan and demonstration covered services for pregnant women during their hospital presumptive eligibility period.
- 18.** Expenditures for payments to participating IHS and tribal 638 facilities for categories of care that were previously covered under the State Medicaid plan, furnished in or by such facilities.
- 19.** Expenditures under contracts with managed care entities that pay incentive payments to providers that meet targets specified in the contract as described in the STCs. Total incentive payments will be limited to the amounts established in paragraph 48 and payments will be limited to those providers who participate in integrated care activities established under the Targeted Investments Program.
- 20.** Expenditures for the approved Designated State Health Programs (DSHP) specified in these STCs, not to exceed the amounts specified in paragraph 50. This expenditure authority will not be renewed or extended after September 30, 2021.

**SPECIAL TERMS AND CONDITIONS
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
(AHCCCS) MEDICAID SECTION 1115 DEMONSTRATION**

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

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

AWARDEE: Arizona Health Care Cost Containment System

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the “Arizona Health Care Cost Containment System (AHCCCS)” section 1115(a) Medicaid and CHIP demonstration (hereinafter “demonstration”) to enable Arizona (state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted the state waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs that are not otherwise matchable, and which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS related to this demonstration. The AHCCCS demonstration will be statewide, and is approved for a 5-year period, from October 1, 2016, through September 30, 2021, with implementation of the waiver of retroactive eligibility no sooner than April 1, 2019.

The STCs have been arranged into the following subject areas:

- I. Preface;
 - II. Program Overview and Historical Context;
 - III. General Program Requirements;
 - IV. Eligibility;
 - V. Demonstration Programs;
 - VI. Funding Pools and Payments under the Demonstration;
 - VII. Delivery Systems;
 - VIII. General Reporting Requirements;
 - IX. Targeted Investments Program;
 - X. Evaluation of the Demonstration;
 - XI. General Financial Requirements under Title XIX;
 - XII. General Financial Requirements under Title XXI; and
 - XIII. Monitoring Budget Neutrality
- Attachment A Developing the Evaluation Design
 - Attachment B Preparing the Evaluation Report
 - Attachment C AHCCCS Disproportionate Share Hospital Program (DSH)
 - Attachment D Reimbursement for Critical Access Hospitals
 - Attachment E Safety Net Care Pool Claiming Protocol

Attachment F	IHS and 638 Facilities Uncompensated Care Payment Methodology
Attachment G	AHCCCS CARE Operational Protocol
Attachment H	Targeted Investments Program DSHP Claiming Protocol
Attachment J	Monitoring Protocol
Attachment K	Approved Appendix K
Attachment J	Approved Evaluation Design

II. PROGRAM OVERVIEW AND HISTORICAL CONTEXT

Until 1982, Arizona was the only state that did not have a Medicaid program under title XIX of the Social Security Act. In October 1982, Arizona implemented the AHCCCS in the state's first section 1115 demonstration project. AHCCCS initially covered only acute care services, however, by 1989, the program was expanded to include the Arizona Long Term Care System (ALTCS), the state's capitated long term care program for the elderly and physically disabled (EPD) and the developmentally disabled (DD) populations. In 2000, the state also expanded coverage to adults without dependent children with family income up to and including 100 percent of the federal poverty level (FPL) as well as established the Medical Expense Deduction (MED) program for adults with income in excess of 100 percent of the FPL who have qualifying healthcare costs that reduce their income at or below 40 percent of the FPL. On March 31, 2011, Arizona requested to eliminate the MED program and implement an enrollment freeze on the adults without dependent children population. On April 30, 2011, and July 1, 2011, CMS approved the state's required phase-out plans for the MED program and the adults without dependent children population, respectively. Arizona amended its State Plan, effective January 1, 2014, to provide coverage under section 1902(a)(10)(A)(i)(VIII) for certain persons with income not exceeding 133 percent of the FPL.

The demonstration provides health care services through a prepaid, capitated managed care delivery model that operates statewide for both Medicaid state plan groups as well as demonstration expansion groups. It affects coverage for certain specified mandatory state plan eligibles by requiring enrollment in coordinated, cost effective, health care delivery systems. In this way, the demonstration will test the use of managed care entities to provide cost effective care coordination, including the effect of integrating behavioral and physical health services for most AHCCCS members. In addition, the demonstration will provide for payments to IHS and tribal 638 facilities to address the fiscal burden for certain services not covered under the state plan and provided in or by such facilities. This authority will enable the state to evaluate how this approach impacts the financial viability of IHS and 638 facilities and ensures the continued availability of a robust health care delivery network for current and future Medicaid beneficiaries. As part of the extension of the demonstration in 2016, based on CMS clarifying its policy for claiming 100 percent federal matching for services received through IHS and 638 facilities, the state can transition from the current uncompensated care reimbursement methodology to service-based claiming.

As part of the extension of the demonstration on October 1, 2016, beginning January 1, 2017 the state was approved to implement its AHCCCS Choice Accountability Responsibility Engagement (CARE) program. Beneficiaries in the new adult group with incomes above 100 percent of the FPL are required to participate in AHCCCS CARE and

will be required to make monthly contributions into AHCCCS CARE accounts. AHCCCS CARE will also provide certain incentives for timely payment of these monthly contributions and completion of “healthy targets” under the state’s Healthy Arizona program that will also be implemented with AHCCCS CARE.

On January 18, 2017, an amendment was approved which established the “Targeted Investments Program.” The state directs its managed care plans to make specific payments to certain providers pursuant to 42 CFR 438.6(c), with such payments incorporated into the actuarially sound capitation rates, to incentivize providers to improve performance. Specifically, providers are paid incentive payments for increasing physical and behavioral health care integration and coordination for individuals with behavioral health needs.

The Targeted Investments Program is expected to:

- Reduce fragmentation that occurs between acute care and behavioral health care,
- Increase efficiencies in service delivery for members with behavioral health needs, and
- Improve health outcomes for the affected populations.

On January 18, 2019, CMS approved two amendments for AHCCCS. Under the first amendment, beginning no sooner than April 1, 2019, Arizona will not provide retroactive eligibility for beneficiaries enrolled in AHCCCS (with exceptions for pregnant women, women who are 60 days or less postpartum, infants under age 1, and children under age 19).

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Laws.** The state must comply with applicable federal civil rights laws relating to non-discrimination in services and benefits in its programs and activities. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557).
- 2. Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs, expressed in federal law, regulation, and written policy, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3. Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in federal law, regulation, or written policy affecting the Medicaid and/or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit

an amendment to the demonstration under STC 7. CMS will notify the state 30 calendar days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

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

- a) To the extent that a change in federal law, regulation, or written policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration, as well as a modified CHIP allotment neutrality worksheet if applicable, to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
- b) If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under federal law, whichever is sooner.

5. State Plan Amendments. The state will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances, the Medicaid and CHIP state plans govern.

6. Changes Subject to the Amendment Process. If not otherwise specified in these STCs, changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to

submit required elements of a complete amendment request as described in this STC, and failure by the state to submit reports required in the approved STCs and other deliverables in a timely fashion according to the deadlines specified herein.

Amendment requests must include, but are not limited to, the following:

- a) A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;
- b) A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c) An up-to-date CHIP allotment neutrality worksheet, if necessary;
- d) An explanation of the public process used by the state consistent with the requirements of STC 13; and,
- e) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration. States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than twelve months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 CFR 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.

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

- a) Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration’s suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised

transition and phase-out plan.

- b) Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.
- c) Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must begin no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
- d) Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).
- e) Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
- f) Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
- g) Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of

beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than six months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

- a) Expiration Requirements. The state must include, at a minimum, in its demonstration authority expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration authority for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities.
- b) Expiration Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).
- c) Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR 431.416 in order to solicit public input on the state's demonstration authority expiration plan. CMS will consider comments received during the 30-day period during its review of the state's demonstration authority expiration plan. The state must obtain CMS approval of the demonstration authority expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must begin no sooner than fourteen (14) calendar days after CMS approval of the demonstration authority expiration plan.
- d) Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the expiration of the demonstration authority including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

11. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to

withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX or title XXI. CMS must promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

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

13. Public Notice, Tribal Consultation, and Consultation with Interested Parties.

The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

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

14. Federal Financial Participation (FFP). No federal matching for state expenditures under this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

15. Common Rule Exemption. The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ELIGIBILITY

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

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

Description	Program	Social Security Act Cite	42 CFR Cite
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS Families and Children			
1931 (Title IV A program that was in place in July 1996) including: <ul style="list-style-type: none"> pregnant women with no other eligible children (coverage for third trimester) persons 18 years of age, if a full-time student family with unemployed parent 	AACP	1902(a)(10)(A)(i)(I)	435.110
Twelve months continued coverage (transitional medical assistance) 1931 ineligible due to increase in income from employment or work hours or loss of "income disregard."	AACP	1902(a)(52) 1902(e)(l) 1925(a)(b)(c)	435.112
1931 Extension-Extension of MA when child or spousal support collection results in 1931 ineligibility. (4 months continued coverage)	AACP	408(a)(11)(B) 1902 (a) (10) (A) (i) (I) 1931 (c)	435.115
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS Pregnant Women, Children, and Newborns			
Qualified pregnant women who: <ul style="list-style-type: none"> would be AFDC eligible if child were born and meet AFDC income & resource criteria 	AACP	1902(a)(10)(A)(i)III 1905(n)	435.116
"S.O.B.R.A. WOMEN & INFANTS" Pregnant women & infants under age 1 with incomes less than or equal to 133% FPL. (optional group extends coverage up to 140% FPL for infants under age 1)	AACP ALTCS	1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	
"S.O.B.R.A. CHILDREN" Children age 1+ but not yet 6 with incomes at or below 133% FPL.	AACP ALTCS	1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)	

"S.O.B.R.A. CHILDREN" Children age 6+ but not yet 19, born after 9-30-83, with income less than or equal to 133% FPL.	AACP ALTCS	1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)	
"DEEMED CATEGORICAL NEWBORNS" Children born to a woman who was eligible and received Medicaid on the date of the child's birth. Children living with their mothers are eligible for 1 year as long as mothers are eligible or would be eligible if pregnant.*	AACP	1902(e)(4)	435.117
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS Qualified Family Members			
Qualified members of family with unemployed principal wage earner (persons who would be eligible if state did not limit number of months AFDC-UP cash was available).	AACP	1902(a)(10)(A)(i) 1905(m)(l)	435.119
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS Aged, Blind, and Disabled			
All SSI cash recipients: aged, blind or disabled persons	AACP ALTCS	1902(a)(10)(A)(i)(II)	435.120
Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or state supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87	AACP	1902(a)(10)(A)(i)(II) 1905(q)	435.120
"DAC" Disabled adult child (age 18+) who lost SSI by becoming Old Age, Survivor and Disability Insurance (OASDI) eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits.	AACP	1634(c)	
SSI cash or state supplement ineligible for reasons prohibited by Title XIX.	AACP ALTCS		435.122
SSA Beneficiaries who lost SSI or state supplement cash benefits due to cost of living adjustment (COLA) increase in Title II benefits	AACP		435.135
Disabled widow/widower who lost SSI or state supplement due to 1984 increase in OASDI caused by elimination of reduction factor in PL 98-21. (person must apply for this by 7/88)	AACP	1634(b)	435.137
Disabled widow/widower (age 60-64 and ineligible for Medicare Part A) who lost SSI or state supplement due to early receipt of Social Security benefits.	AACP	1634(d)	435.138
"DC Children" Children under the age of 18 who were receiving SSI Cash on 8/26/96 and would continue to be eligible for SSI Cash if their disability met the childhood definition of disability that was in effect prior to 8/26/96.	AACP	1902(a)(10)(A)(i)(II)	
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS Adoption Assistance and Foster Care Children			
Children in adoption subsidy/foster care Title IV-E programs	AACP ALTCS	473(b)(l) 1902(a)(10)(A)(i)(I)	435.145
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS Special Groups			

"POSTPARTUM" Title XIX eligible women who apply on or before pregnancy ends, (continuous coverage through the month in which the 60th day postpartum period ends)	AACP	1902(e)(5) 1902(e)(6)	435.170
STATE PLAN MANDATORY TITLE XIX COVERAGE GROUPS New Adult Group			
Individuals age 19 through 64 with incomes at or below 133% FPL	AACP	1902(a)(10)(A)(i)(VIII)	435.119
STATE PLAN OPTIONAL TITLE XIX COVERAGE GROUPS			
"210 GROUP" Persons who meet AFDC, SSI or state supplement income & resource criteria.	AACP ALTCS Case Management	1902(a)(10)(A)(ii)(I)	435.210
"211 GROUP" Persons who would be eligible for cash assistance except for their institutional status.	ALTCS	1902(a)(10)(A)(ii)(IV)	435.211
"GUARANTEED ENROLLMENT" Continuous coverage for persons enrolled in AHCCCS Health Plans who lose categorical eligibility prior to 6 months from enrollment. (5 full months plus month of enrollment)	AACP	1902(e)(2)	435.212
"S.O.B.R.A. Infants" infants with incomes between the 133% FPL mandatory group maximum and a 140% FPL optional state maximum.	AACP ALTCS	1902(a)(10)(A)(ii)(IX)	
Pregnant women, including postpartum, who maintain eligibility without regard to changes in income.	AACP	1902(e)(6)	
"HCBS GROUP" Persons receiving HCBS under a waiver with incomes < or equal to 300% of the federal benefit rate (FBR).	ALTCS	1902(a)(10)(A)(ii)(VI)	435.217
"State Adoption Subsidy" Children who receive a state adoption subsidy payment.	AACP	1902(a)(10)(ii)(VIII)	435.227
"236 GROUP" Persons in medical institutions for 30 consecutive days who meet state-set income level of < or equal to 300% of FBR.	ALTCS	1902(a)(10)(A)(ii)(V)	435.236
"Freedom to Work" Basic Coverage Group – individuals aged 16-64 with a disability who would be eligible, except for earnings, for SSI up to and including 250% of FPL.	AACP ALTCS	1902(a)(10)(A)(ii)(XV)	
"Freedom to Work" Medical Improvement Group – employed individuals aged 16-64 with a medically improved disability up to and including 250% of FPL.	AACP ALTCS	1902(a)(10)(A)(ii)(XVI)	
Women under 65 who need treatment for breast or cervical cancer, and not otherwise eligible for Medicaid.	AACP	1902(a)(10)(A)(ii)(XVIII)	
Children who have aged out of foster care at 18 up to age 26	AACP	1902(a)(10)(A)(ii)(XVII)	
1931 Expansion-Income Greater than 36% FPL and less than or equal to 100% FPL.	AACP		
SSI-MAO Expansion (Optional 210 Group)- aged, blind, or disabled individuals with income greater than 100% FBR and less than or equal to 100% FPL.	AACP	Arizona State Plan	

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

17. Waiver of Retroactive Eligibility. The state will not provide medical assistance for any month prior to the month in which a beneficiary's Medicaid

application is filed, except for a pregnant woman (including during the 60-day period beginning on the last day of the pregnancy), an infant under age 1, or a child under age 19. The waiver of retroactive eligibility applies to all populations described in STC 16 who are not pregnant (including during the 60-day period beginning on the last day of the pregnancy), an infant under age 1, or a child under age 19, effective no sooner than April 1, 2019.

- a) The state assures that, through various methods, it will provide outreach and education regarding how to apply for and receive Medicaid coverage to the public and to Medicaid providers, particularly those who serve vulnerable populations that may be impacted by the retroactive eligibility waiver.

V. DEMONSTRATION PROGRAMS

18. Arizona Acute Care Program (AACP). Most AACP enrollees receive integrated physical and behavioral health care services through a single Managed Care Organization (MCO) called an AHCCCS Complete Care (ACC) Plan. AACP members determined to have a Serious Mental Illness (SMI) receive integrated physical and behavioral health services through a geographically designated Regional Behavioral Health Authority (RBHA).

- a) Enrollment. The Arizona DES processes applications and determines acute care Medicaid eligibility for children, pregnant women, families and non-disabled adults under the age of 65 years. The Social Security Administration (SSA) determines eligibility for the Supplemental Security Income (SSI) cash-related groups, and AHCCCS determines eligibility for the SSI-related aged and disabled groups, Medicare Savings Programs, women diagnosed with breast or cervical cancer, and Freedom to Work recipients. Individuals determined eligible must then select and enroll in a Health Plan, or they will be auto-assigned by the AHCCCS administration.
- b) Benefits. With the exception of the new adult group, benefits for AACP and the expansion population authorized by the 1115 demonstration will consist of all acute care benefits covered under the Medicaid state plan, unless otherwise noted within these STCs. The new adult group will receive benefits for AACP through the state's approved alternative benefit plan (ABP) state plan amendment (SPA).
 - i. Notice. The state must include the CMS Central Office when submitting a SPA to the CMS Regional Office that would impact the expansion population authorized by the 1115 demonstration inclusive of:
 - a. The proposed date of implementation;
 - b. The date the state plans to submit the SPA; and
 - c. Revised budget neutrality projections.

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

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

Table 2 – AACP Behavioral Management

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

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

19. The AHCCCS CARE Program. The AHCCCS CARE program is designed to engage Arizona’s new adult group expansion population with income over 100 percent FPL (hereinafter “Expansion Adults”) to prepare adults for successful transition to Marketplace or other coverage. AHCCCS CARE is also designed to build health literacy by promoting incentives around achieving identified health targets. The AHCCCS CARE program is comprised of: an AHCCCS CARE Account (the “Account”), meeting a Healthy Arizona Target. The AHCCCS CARE program will be administered by a third party AHCCCS contractor (“Vendor”) upon completion and award of a Request for Proposal by the state.

20. Participation in AHCCCS CARE.

a) Mandatory Participation. Expansion Adults – beneficiaries enrolled in the new adult group with incomes that exceed 100 percent of the FPL – are required to participate in AHCCCS CARE (hereinafter “AHCCCS CARE member(s)”). The following Expansion Adults are exempted from AHCCCS CARE

participation:

- i. Persons with serious mental illness;
 - ii. American Indian/Alaska Natives; and
 - iii. Persons considered “medically frail” as described in Attachment H.
- b) Hardship Exemptions. AHCCCS CARE members may be exempted from the program requirements for a period of one month if the member meets one of the following hardship exemption criteria during the prior month:
- i. A member of the household dies.
 - ii. The income group has one or more of the following expenses which exceed 10 percent of the countable gross income of the income group:
 - a. Medically necessary expenses for any member of the household that Medicaid or health insurance coverage did not pay for. Medically necessary means a covered service provided by a physician or other licensed practitioner to prevent disease, disability, or other adverse health conditions or their progression or prolong life;
 - b. Health insurance premiums for any member of the household;
 - c. Unexpected expenses for repairs to the home. Repairs include items such as fixing a leaky roof, replacing a non-working air conditioner, repairing plumbing, etc. Repairs do not include remodeling or redecorating; or
 - d. Expenses for repairs to an income group member’s transportation so the individual can get to work. This does not include routine maintenance, such as tune-ups, oil changes, etc.
 - iii. Reporting of a hardship exemption should be made by the AHCCCS CARE member directly to the Vendor. AHCCCS CARE members will be provided notice that will explain these hardship exemptions and give instructions for how to request an exemption.
 - iv. AHCCCS CARE members may seek a hardship exemption at any time. The member must provide supporting documentation of the permitted hardship, but there are no limits to the number or duration of hardship exemptions a member may receive during the course of the year.
- c) Voluntary Participation. Nothing in this demonstration shall preclude the state

from permitting all Expansion Adults exempted from AHCCCS CARE participation as outlined above as well as new adult group members at or below 100 percent of the FPL to choose to opt in to the AHCCCS CARE program. Opting in allows the member to open and maintain an AHCCCS CARE Account that will be funded by a third party, such as a charitable organization. In addition, members otherwise exempted from AHCCCS CARE may opt in and contribute their own funds. Such contributions would be voluntary with amounts and timing of contribution all at the discretion of the member. None of the other AHCCCS CARE program requirements will apply. Accordingly, members who opt in will not be:

- i. Required to pay premiums or Strategic Coinsurance based on Medicaid enrollment;
- ii. Disenrolled for failure to pay into the AHCCCS CARE Account; or
- iii. Required to participate in the Healthy Arizona program.

21. Beneficiary Contributions. AHCCCS CARE members must make two types of payments that in total shall not exceed 5 percent of household income, calculated quarterly: strategic coinsurance and premium payments.

a) Strategic Coinsurance. Strategic coinsurance will be applied retrospectively, rather than at the point of service. The strategic coinsurance payments are limited and targeted to support the medical home concept and steer members to the most appropriate care settings and types. Strategic coinsurance will not exceed 3 percent of household income and will be used to offset program costs. AHCCCS CARE members are responsible for making the following coinsurance payments:

- i. **\$4.00 for opioids prescriptions or refills.** This coinsurance requirement is part of a broader state effort to address the opioid epidemic. The only exceptions to this coinsurance requirement are for AHCCCS CARE members with a cancer diagnosis or terminal illness such that they have qualified for hospice care, or if the beneficiary's physician requests an exemption with supporting documentation as to medical necessity for the opioid prescription.
- ii. **\$8.00 for non-emergency use of the emergency room.** This strategic coinsurance requirement is designed to help steer members to lower levels of care that are more appropriate in non-emergency situations. The coinsurance requirement will be paid for the following ED visits: Level 1 Emergency Department Code 99281; and Level 2 Emergency Department Code 99282. The state will ensure that hospitals:
 - a. Conduct an appropriate medical screening under 42 CFR 489.24 subpart G to determine that the individual does not need emergency services;

- b. Inform the individual of the amount of his or her coinsurance obligation for non-emergency services provided in the emergency department;
 - c. Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;
 - d. Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
 - e. Provide a referral and coordinate scheduling for treatment by the alternative provider.
- iii. **\$5 or \$10 Specialist Services without a PCP Referral.** Because the state is emphasizing the medical home model as part of its managed care system, AHCCCS CARE members will pay a per visit coinsurance payment of \$5 for a specialist office visit (when AHCCCS pays \$50-\$99.99) or \$10 (when AHCCCS pays \$100 or more) if there is no referral from their primary care physician (PCP) for that specialist visit.
- iv. **\$4.00 Brand Name Drugs when Generic Available.** The brand name coinsurance payment will not apply if the physician determines that the generic drug is not as effective as the brand name drug.
- b) Calculation of Retrospective Strategic Coinsurance. AHCCCS CARE members will be responsible for coinsurance liability for the services outlined in (i) through (iv) of paragraph 21 based upon the most recent six months of utilization for which data is complete of the identified services used by the member. The utilization review will occur quarterly; accordingly the AHCCCS CARE member will have a coinsurance liability for a three month period. The amount owed for the quarter will be divided into three monthly payments. The amount owed for the quarter or for any month within that quarter shall not exceed 3 percent of household income.
- c) AHCCCS CARE Account Contributions or Premium Payments. AHCCCS CARE members will make a monthly premium payment that will serve as their AHCCCS CARE Account contribution. The payment is set at the lesser of 2 percent of household income or \$25. AHCCCS CARE members will make these payments to a Vendor, who will credit the amount of the payment to the beneficiary's established AHCCCS CARE Account. The AHCCCS CARE member will still access the full array of covered benefits as outlined in the state plan and 1115 demonstration.
- d) AHCCCS CARE Member Invoices Payments. AHCCCS CARE members will be sent a quarterly invoice by the state's Vendor that includes the following:

- i. Amount owed for strategic coinsurance for each month within that quarter that specified the basis for each included coinsurance charge, by the service for which the state charge applies, and explains to the member that the payment is connected to the services already received;
 - ii. Identifies the method by which the individual may dispute incorrect charges;
 - iii. Amount owed for premiums for each month within that quarter;
 - iv. Member's 5 percent threshold articulated in a dollar amount;
 - v. Account balance;
 - vi. Outstanding or past due liabilities.
- e) AHCCCS CARE Payments. AHCCCS CARE members make their payments directly to the Vendor. The amount of any payment including the premium, or strategic coinsurance will be credited on the CMS-64 against program expenditures claimed by the state for federal matching. No strategic coinsurance payments are made to health care providers; such payments also do not affect enrollment. Premium payments made by the AHCCCS CARE member are credited to the member's AHCCCS CARE Account that is recorded with the Vendor. (See Attachment H for example calculations of AHCCCS CARE payments.)
- f) Grace Period/Payment Period. AHCCCS CARE members will have two months from the date of the payment invoice to make the required monthly premium contribution.
- g) Disenrollment for Failure to Pay Premiums. AHCCCS CARE members will receive a notice of disenrollment for failure to make AHCCCS CARE premium payments. There is no lock out period. Anyone that has been disenrolled for failure to pay premiums may re-enroll in the Medicaid program at any time and does not have to pay any past-due liabilities. If re-enrollment occurs within 90 days, a new application is not needed.

22. AHCCCS CARE Contributions by Third Parties. Third parties such as employers or charitable organizations may make contributions on behalf of AHCCCS CARE members. Arrangements for billing the third party will be made on a case-by-case basis to accommodate the unique needs of the third party. Any such arrangement shall be reviewed and approved by CMS and incorporated into the state's AHCCCS CARE Operational Protocol. There are no limits on the amounts third parties can contribute to any AHCCCS CARE member's Account. Health care providers or provider-related entities making contributions on individual's behalf must have criteria for providing assistance that do not distinguish between individuals based on whether or not they receive or will receive services from the contributing provider(s) or class of providers.

Providers may not include the cost of such payments in the cost of care for purposes of Medicare and Medicaid cost reporting and cannot be included as part of a Medicaid shortfall or uncompensated care for any purpose.

23. Beneficiary Protections for AHCCCS CARE Account Contributions.

- a) Arizona and/or its vendor may attempt to collect unpaid premiums and the related debt from beneficiaries, but may not report the debt to credit reporting agencies, place a lien on an individual's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of the individual's earnings for enrollees at any income level. The state and/or its vendor may not "sell" the debt for collection by a third party.
- b) Beneficiaries described in 42 CFR 447.56(a) (including American Indians/Alaska Natives, as described therein) must be exempt from all coinsurance and premium contribution requirements, as applicable.
- c) Beneficiaries may not incur household cost sharing or premiums that exceeds 5 percent of the aggregate household income, following rules established in 42 CFR 447.56(f).
- d) Coinsurance amounts will not exceed Medicaid cost sharing permitted by federal law and regulation.
- e) The state may not pass along the cost of any surcharge associated with processing payments to the beneficiary. Any surcharges or other fees associated with payment processing must be considered an administrative expense by the state.
- f) The state will ensure that all payments from the beneficiary, or on behalf of the individual, are accurately and timely credited toward unpaid premiums and related debt, and will provide the beneficiary an opportunity to review and seek correction of the payment history.

24. The AHCCCS CARE Account. The Account is styled like a flexible spending arrangement. The Account is maintained by the Vendor and will be credited with member premium payments and/or any contributions made by employers or other entities. Beneficiaries can receive direct payments that reflect amounts credited to their AHCCCS CARE Accounts These payments shall be treated as a refund of contributions paid and shall be credited (for federal claiming purposes) as an expenditure in the quarter paid. The state may make the return of the premium conditioned upon incurred expenses for certain health-care related items; any list of such items must be approved by CMS. The AHCCCS CARE contractor will not credit the Account with strategic coinsurance payments.

- a) Accessing Funds in the AHCCCS CARE Account. The state will establish in the Operational Protocol described in STC 25 how AHCCCS CARE members in good standing may withdraw funds credited to their Accounts.

- b) Good Standing Requirements. To be in good standing, the AHCCCS CARE member must:
- i. Make timely payments into the AHCCCS CARE Account for premiums and coinsurance liabilities.
 - ii. Meet at least one Healthy Arizona Target.
- c) Accrual of Monies. AHCCCS CARE members do not have to expend funds within the year. Members may choose to roll funds over from year to year but only if they are in good standing. Interest will not accrue to the Account. Fund balances in the Account will not be treated as income or assets of the beneficiary.
- d) Healthy Arizona. Healthy Arizona is a small set of health targets that unlock the AHCCCS CARE member's ability to access funds in the AHCCCS CARE Account.
- i. **Healthy Arizona Targets**. The Healthy Arizona targets include:
 - a. **Preventive Health Targets:**
 1. Annual well exam
 2. Flu shot
 3. Mammogram
 4. Glucose screening
 - b. **Managing Chronic Disease**
 1. Tobacco cessation defined as having quit smoking or use of tobacco for at least 6 months.
 2. Diabetes management, which requires that the AHCCCS CARE member has developed a care management plan with their PCP that includes exercise, steps to help follow a proper diet, maintaining blood sugar levels, adherence to medication and managing blood pressure.
 3. Asthma management, which includes that the AHCCCS CARE member establish an asthma action plan with their PCP that includes guidance on taking medicines properly, avoiding asthma triggers and tracking level of asthma control.
 4. Substance use disorder management, which requires

establishing and following a care plan with their primary behavioral health provider that also includes access to peer supports, medication management, individual or group counseling and any other modalities needed by the member.

ii. **Member Reporting.** AHCCCS CARE members will report having met one of more of these targets to the Vendor. Reporting will be through self-attestation. AHCCCS CARE members can choose to submit documentation or other proof of completion of the Healthy Arizona target to the Vendor, but proof of completion is not required. The Vendor will allow for reporting through the AHCCCS CARE Account online or by phone.

iii. **Benefits of Meeting the Healthy Arizona Targets.**

- a. Accessing AHCCCS CARE Account funds. AHCCCS CARE members may not withdraw funds if they have not completed one of the Healthy Arizona Targets.
- b. Rolling unused AHCCCS CARE Account funds over into next benefit year.
- c. Reducing AHCCCS CARE Payments. Meeting one of the Preventive Health Targets or the Chronic Disease Management targets excuses the AHCCCS CARE member from any premium or coinsurance liabilities for a period of six months. The AHCCCS CARE member may choose the quarter to which he or she would like exemption to begin.

25. AHCCCS CARE Operational Protocol. The state must submit a draft Operational Protocol to CMS for review and approval prior to implementing the AHCCCS CARE program. The state's submission must be no later than 90 days prior to the planned implementation. The state may not implement beneficiary contributions and the Healthy Arizona Targets program until 30 days following CMS approval of the protocol pertaining to the program. The protocol will be incorporated into these STCs as Attachment H. The protocol must include, at a minimum, the following items:

a) Contributions and Accounts and Payments Infrastructure.

- i. The coinsurance liability and premium payments strategy and implementation plan, including an approach to implementation for beneficiaries beginning three months after enrollment that allows for milestones related to successful accounting for funds, data collection for review of incentives, member education and other critical operations to be met prior to inclusion of all AHCCCS CARE members into the payment and reward program. The plan must clearly explain when beneficiaries are responsible for payments and how beneficiaries will be

engaged in the payment process, including when and under what circumstances payments will be required.

- ii. A description of how third parties – i.e. the beneficiary’s employer, charitable or other organizations -- may contribute on the beneficiary’s behalf, including how this is operationalized, and how the contributions will be treated in so far as ensuring such funds are not considered beneficiary income or resources.
- iii. The strategy, operational and implementation plan to ensure that the beneficiary will not be charged a coinsurance amount by a Medicaid healthcare provider when covered benefits are provided.
- iv. A description of how AHCCCS CARE Account funds may be disbursed by the Vendor for use by the beneficiary and an assurance that the funds are not used to supplant payment for Medicaid covered services.
- v. The strategy and the description of the operational processes to define how and to provide assurances that ensure the AHCCCS CARE Account debits and credits will be accurately tracked, as well as quarterly and annual statements that will be provided to the beneficiary. The purpose of this requirement is to promote beneficiary awareness and understanding of the interaction between health care utilization and potential future coinsurance obligations or reductions due to healthy behaviors.
- vi. A description, strategy and implementation plan of the beneficiary education and assistance process including copies of beneficiary notices, a description of beneficiaries’ rights and responsibilities, appeal rights and processes and instructions for beneficiaries about how to interact with the Vendor as well as state officials for discrepancies or other issues that arise regarding the beneficiaries’ AHCCCS CARE Account.
- vii. Assurance that the AHCCCS CARE Account balances will not be counted as assets for the beneficiary and that funds returned to the beneficiary will not be treated as income.
- viii. A strategy for educating beneficiaries on how to use the statements, and understand that their health care expenditures will be covered.
- ix. For beneficiaries determined to be no longer eligible for the demonstration, a method for the remaining balance of the Account to be paid to the beneficiary.

b) Healthy Arizona Targets.

- i. Preventive Health Targets. The state will provide a list of approved utilization codes for applicable healthy targets when documenting self-attested healthy targets completed by AHCCCS CARE members.
- ii. Chronic Disease Management. The state will describe the standards for achieving chronic disease management for each of the targeted conditions listed in paragraph 24 subparagraph (d)(i)(b). Members must be provided the details of these requirements for purposes of self-attestation.
- iii. An ongoing strategy of education and outreach post implementation regarding the Healthy Arizona program including strategies related to the ongoing engagement of stakeholders.
- iv. A description for how beneficiaries will attest to completion of a healthy behavior target.
- v. A description of the educational opportunities or copies of educational materials that are provided to members that explain the Healthy Arizona program.
- vi. A method for conducting annual random audits to ensure appropriate documentation of utilization codes and healthy targets reporting.
- vii. The methodology for describing how healthy behavior incentives will be applied to reduce premiums or coinsurance.
- viii. A description of how the state will ensure that adjustments to premiums or average utilization coinsurance contributions are accurate and accounted for based upon the success in achieving healthy behaviors.

26. Children in Foster Care. Services for Arizona’s children in foster care are provided through an MCO contract between AHCCCS and the Arizona Department of Child Safety (DCS) called the Comprehensive Medical and Dental Program (CMDP). Children in foster care who receive acute care services will be enrolled in CMDP instead of other Health Plans. Children in foster care who are eligible for or receive ALTCS will be enrolled or remain with the Program Contractor. Case Management services provided and reimbursed through this contractual relationship must be provided consistent with federal policy, regulations and law. Children in foster care receive behavioral health services through RBHAs.

- a) FFP. FFP will not be available for:
 - i. Duplicate payments made to public agencies or private entities under other program authorities for case management services or other Medicaid services for the same purpose; or
 - ii. Activities integral to the administration of the foster care program excluding any health care related activities.

27. Children Rehabilitative Services (CRS). Children with qualifying conditions receive CRS specialty care. Most individuals receive care for their CRS conditions as well as behavioral health care and physical health care through an ACC plan. Children enrolled in ALTCS/DCS/DDD who also have a CRS condition receive care for their CRS and behavioral health conditions through the CRS contractor and treatment for physical health conditions through an ALTCS/DES/DDD subcontractor. Children with a CRS condition who are enrolled in CMDP receive treatment for their CRS and physical health care conditions through CMDP and treatment for behavioral health care conditions through a RBHA..

- a) Transition of Care. When individuals transition to the CRS contractor from an AACP health plan, children in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a CRS non-participating provider shall be allowed to continue receiving treatment from the non-participating provider through the duration of their prescribed treatment.
- b) Choice of Primary Care Physician (PCP). The CRS contractor is required to assure that members have a choice of PCPs. Specifically, beneficiaries will have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). In addition, the CRS contractor will offer contracts to primary and specialist physicians who have established relationships with beneficiaries including specialists who may also serve as PCPs to encourage continuity of provider. For children who have an established relationship with a PCP that does not participate in the CRS contractor's provider network, the CRS contractor will provide, at a minimum, a 90-day transition period in which the child may continue to seek care from their established PCP while the child and child's parents and/or guardian, the CRS contractor, and/or case manager finds an alternative PCP within the CRS contractor's provider network.
- c) Readiness Review of Health Plan. The state will submit to CMS for review a copy of its readiness review report of the health plan selected to provide the integrated services to the CRS population to ensure the selected health plan's provider network, both in terms of primary and specialty care providers, is adequate and would not result in access to care issues for the affected population.

28. Individuals with Serious Mental Illness (SMI). Individuals who are AACP members and who are diagnosed with a serious mental illness will receive integrated physical and behavioral health care services through a separate MCO called a RBHA.

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

through the duration of their prescribed treatment.

- b) Choice of Primary Care Physician (PCP). The RBHA is required to assure that members have a choice of PCPs. Specifically, beneficiaries will have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). In addition, the RBHA, will offer contracts to primary and specialist physicians who have established relationships with beneficiaries including specialists who may also serve as PCPs to encourage continuity of provider. For individuals who have an established relationship with a PCP that does not participate in the /RBHA's provider network, the RBHA will provide, at a minimum, a 6-month transition period in which the individual may continue to seek care from their established PCP while the individual, the RBHA and/or case manager finds an alternative PCP within the /RBHA's provider network.
- c) Opt out for Cause. Individuals with SMI will have the option to opt-out of the RBHA for acute care services and be transferred to a Health Plan plan under the following conditions only:
- i. Either the beneficiary, beneficiary's guardian, or beneficiary's physician successfully dispute the beneficiary's diagnosis as SMI;
 - ii. Network limitations and restrictions, e.g. if a beneficiary's preferred provider is not contracted with a RHBA or there is only one provider in a service area and the provider is not contracted with a RBHA;
 - iii. Physician or provider course of care recommendation and subsequent review by the RBHA and the state;
 - iv. The member established that due to the enrollment and affiliation with the RBHA as a person with a SMI, and in contrast to persons enrolled with an acute care provider, there is demonstrable evidence to establish actual harm or the potential for discriminatory or disparate treatment in:
 - a. The access to, continuity or availability of acute care covered services;
 - b. Exercising client choice;
 - c. Privacy rights;
 - d. Quality of services provided; or
 - e. Client rights under Arizona Administrative Code, Title 9, Chapter 21.
- d) Under paragraph 28 subparagraph (c)(iv), a beneficiary must either

demonstrate that the discriminatory or disparate treatment has already occurred, or establish the plausible potential of such treatment. It is insufficient for a member to establish actual harm or the potential for discriminatory or disparate treatment solely on the basis that they are enrolled in the RBHA.

e) A transfer requested under paragraph 28 subparagraph (c)(iv) will be clearly documented in the enrollee handbook and any other relevant enrollee notices, and will be processed as follows:

i) The RBHA will take the following actions:

- a. Responsibility for reducing to writing the member's assertions of the actual or perceived disparate treatment of individuals as a result of their enrollment in the integrated plan.
- b. Responsibility for completing AHCCCS transfer of a RBHA member to an approved Acute Care Contractor Form.
- c. Confirmation and documentation that the member is enrolled in SMI RBHA program.
- d. Providing documentation of efforts to investigate and resolve member's concern.
- e. Inclusion of any evidence provided by the member of actual or reasonable likelihood of discriminatory or disparate treatment.
- f. Making a recommendation to approve or decision to deny the request:
 - 1) For making recommendations to approve, forward completed packet to AHCCCS for a determination decision within 7 days of request.
 - 2) For decision to deny, complete packet and provide member with a written denial notice within 10 calendar days of request that includes the reasons for the denial and appeal/hearing rights.

ii) AHCCCS will take the following actions:

- a. For recommendations made by the RBHA to approve, review the completed request packets and make a final decision to approve or deny the request.

- b. For denials, provide member written notice of the denial within 10 calendar days of the request that includes the reasons for the denial and appeal/hearing rights.
 - c. If a hearing is requested, the request for hearing will be forwarded to the AHCCCS Administration which will then schedule the matter for hearing with OAH;
 - d. The AHCCCS Administration will issue a Director's Decision within 30 calendar days of receipt of the ALJ Decision.
- f) The state will track the Opt-out for Cause requests detailed in paragraph 28, subparagraph (c) including the number of each type of request; the county of each request; and the final result of the request. This information shall be provided to CMS in the quarterly reports.
- g) **Care Coordination for Integrated SMI Program.** The State shall submit to CMS their procedures for ensuring that the integrated RBHAs have sufficient resources and training available to provide the full range of care coordination for individuals with disabilities, multiple and chronic conditions, and individuals who are aging. Care coordination capacity should reflect demonstrated knowledge and capacity to address the unique needs (medical, support and communication) of individuals in the SMI population. The needs may be identified through a risk assessment process. Care shall be coordinated across all settings including services outside the provider network.

29. Arizona Long Term Care System (ALTCS). The ALTCS program is for individuals who are age 65 and over, blind, disabled, or who need ongoing services at a nursing facility or ICF/IDD level of care. ALTCS enrollees do not have to reside in a nursing home and may live in their own homes or an alternative residential setting and receive needed in-home services. The ALTCS package also includes all medical care covered under AACP inclusive of doctor's office visits, hospitalization, prescriptions, lab work, behavioral health services, and rehabilitative services. Rehabilitative services may only be eligible for FFP if these services reduce disability or restore the program enrollee to the best possible level of functionality. Additionally, ALTCS participants age 21 or older receive dental services up to \$1,000 per person annually for therapeutic and preventative care, including but not limited to: basic diagnostic services, preventative services, restorative services, periodontics, prosthetic services and oral surgery.

- a) **ALTCS Eligibility Groups.** Individuals as defined in Table 1 requiring health care services at a nursing facility or ICF/IID level of care.
- b) **ALTCS Financial Eligibility.** Individuals must be financially eligible for ALTCS with income equal to or less than 300 percent of the Federal Benefit Rate (FBR), as used by SSA to determine eligibility for SSI.

- i. The state may disregard income in excess of the FBR for persons with AHCCCS approved income-only trusts.
 - ii. The resource (cash, bank accounts, stocks, bonds, etc.) limit is \$2,000 for a single individual. Resources, such as a person's home, vehicle, and irrevocable burial plan are not counted toward the resource limit.
 - iii. When the applicant has a spouse who resides in the community, the spouse can retain one-half of the couple's resources, up to the federal maximum as specified in section 1924(f)(2) of the Act. Resources, such as a person's home, vehicle, and irrevocable burial plan are not counted toward the resource limit.
 - iv. The total gross income for a married couple is combined and divided by 2. The resulting income may not exceed 300 percent of the single FBR. If the resulting income exceeds 300 percent of the single FBR, the income of the applicant only (name on check) is compared to 300 percent of the single FBR.
- c) **Pre-Admission Screening (PAS).** Once financial eligibility has been established, a PAS will be conducted by a registered nurse or social worker to determine if the individual is at immediate risk of institutionalization in either a nursing facility or an ICF/IID. The PAS must be used to determine if the applicant is eligible for ALTCS based on functional, medical, nursing, and social needs of the individual.
- d) **Written Plan of Care.** An individual written plan of care will be developed by qualified providers for ALTCS enrollees under this demonstration. This plan of care will describe the medical and other services to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the review of AHCCCS.
- e) **FFP.** FFP will not be claimed for demonstration services furnished prior to the development of the plan of care. FFP will not be claimed for demonstration services which are not included in the individual written plan of care.
- f) **ALTCS Safeguards.** AHCCCS will take the following necessary safeguards to protect the health and welfare of persons receiving HCBS services under the ALTCS program. Those safeguards include:
- i. Adequate standards for all types of providers that furnish services under the ALTCS program;
 - ii. Assurance that the standards of any state licensure or certification requirements are met for services or for individuals furnishing services that are provided under the ALTCS program. The state assures that these requirements will be met on the date that the services are furnished; and
 - iii. Assurance that all facilities covered by section 1616 (e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable state standards that meet the requirement of 45 CFR Part 1397 for board and care facilities.
 - iv. A formal quality control system which monitors the health and welfare

of members served in the ALTCS program.

- a. Monitoring will ensure that all provider standards and health and welfare assurances are continually met, and that plans of care are periodically reviewed to ensure that the services furnished are reasonably consistent with the identified needs of the individuals.
- b. The state further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

g) ALTCS Benefits and Services

- i. **ALTCS Acute Care.** Enrollees receive the same acute services as defined in paragraph 18(b).
- ii. **ALTCS Behavioral Health Care.** Enrollees receive behavioral health care services as defined in paragraph 18(b)(iii).
- iii. **ALTCS Limited Dental Benefits.** ALTCS participants age 21 or older receive certain dental services up to \$1,000 per person annually.
- iv. **Home and Community-Based Services (HCBS).** ALTCS will provide a comprehensive HCBS package to eligible enrollees in the enrollee's home or in an ALTCS approved Alternative Residential Setting.
 - a. **Alternative Residential Settings include:**
 - 1) Adult foster care, assisted living homes, assisted living centers, adult developmental homes, child developmental homes and group homes, hospices, group homes for traumatic brain injured members, and rural substance abuse transitional agencies.

Behavioral Health Facilities that are licensed to provide behavioral health services in a structured setting with 24-hour supervision. ALTCS covers services, except room and board, that are provided to ALTCS members who have a behavioral health disorder and are residing in one of the following behavioral health facilities:

- A. Level II behavioral health facility – Licensed by AHCCCS. A residential behavioral health treatment setting for individuals who do not require the intensity of services or onsite medical services found in a Level I facility.
- B. Level III behavioral health facility - Licensed by AHCCCS. A residential behavioral health treatment setting with 24-hour supervision and supportive, protective oversight. These services are excluded for individuals involuntarily living in the secure custody of law enforcement, judicial, or penal systems.

- 2) **HCBS and HCBS-like Services.** Services provided to ALTCS enrollees receiving HCBS and HCBS-like services are enumerated in Table 3.

Table 3 – ALTCS HCBS

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

*As Defined in State Medicaid Director Letter #02-008

- 3) **HCBS Expenditures.** Expenditures for individual members are limited to an amount that does not exceed the cost of providing care to the eligible individual in an institutional setting. Exceptions are permitted including when the need for additional services is due to a change in condition that is not expected to last more than 6 months.

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

- a. Services provided by the Spouse as Paid Caregiver must meet

the definition of a “service/support” for personal care or similar services that are rendered by a Paid Caregiver when such services are deemed extraordinary care.

- 1) Personal care or similar services – Is defined as assistance with the Activities of Daily Living (ADLs), or Instrumental Activities of Daily Living (IADLs), whether furnished in the home or the community, including personal assistance, attendant care, and closely related services such as home health aide, homemaker, chore, and companion services which may include improving and maintaining mobility and physical functioning, promoting health and personal safety, preparation with meals and snacks, accessing and using transportation, and participating in community experiences and activities.
 - 2) Extraordinary care - Is defined as care that exceeds the range of activities that a spouse would ordinarily perform in the household on behalf of the recipient spouse, if he/she did not have a disability or chronic illness, and which are necessary to assure the health and welfare of the beneficiary, and avoid institutionalization.
- b. The Spouse as Paid Caregiver must be a service/support that is specified in a plan of care prepared on behalf of the enrollee.
 - c. The enrollee who selects the Spouse as Paid Caregiver is not eligible to receive like services from another attendant caregiver.

The enrollee will remain eligible to receive other HCBS such as skilled/professional type services, home modifications, respite care, and other services that are not within the scope of the personal/attendant care services prescribed in the provider’s plan of care.

- d. The services must be provided by a Spouse as Paid Caregiver who meets specified provider qualifications and training standards prepared by the state for a Paid Caregiver.
- e. The Spouse as Paid Caregiver must be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the state Medicaid Agency (SMA) for the payment of personal care/attendant services; and
- f. The Spouse as Paid Caregiver will comply with the following conditions:
 - 1) A Spouse as Paid Caregiver may not be paid for more than 40 hours of services in a 7-day period;
 - 2) The Spouse as Paid Caregiver must maintain and submit time sheets and other required documentation for hours

- worked/paid;
- 3) The Spouse as Paid Caregiver may only submit claims for services that have been authorized by the Program Contractor or ALTCS FFS case manager;
 - 4) The ALTCS enrollee must be offered a choice of providers, other than his/her spouse. The enrollee's choice of a Paid Caregiver Spouse as provider must be recorded in his/her plan of care, at least annually.

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

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

h) Other ALTCS Requirements

- i. The state of Arizona will continue to provide access to ALTCS services to American Indians on the reservation as it does to other citizens of the state.
- ii. The state will not deny acute care Medicaid eligibility for any potentially disabled individual based on using PAS criteria in lieu of the SSI-disability determination. Prior to rendering a final decision of ineligibility for acute care services based on disability, the state will use the SSI criteria as required under section 1902(a)(10) as interpreted through Federal regulations at sections 435.120 and 435.601.
- iii. In the absence of a limit, AHCCCS will report annually on current placements and ongoing activities for expanding HCB services and settings. The report will be due by March 31 of each year.
- iv. The DES/DDD will comply with all contractual and reporting requirements as specified in the contract between AHCCCS and

DES/DDD and in any subsequent amendments. DES/DDD will be sanctioned as specified in the contract if DES/DDD fails to comply with the stated contractual and reporting requirements.

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

If determined eligible for the ALTCS Transitional Program, AHCCCS will transfer the member to the ALTCS Transitional Program which limits institutional services to 90 days per admission and provides the member with medically necessary acute care services, HCBS, behavioral health services and case management services as prescribed in paragraph 29.

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

VI. FUNDING POOLS AND PAYMENTS UNDER THE DEMONSTRATION.

- 32. Safety Net Care Pool (SNCP).** Payments from this pool will assist Phoenix Children’s Hospital (PCH), which has high levels of uncompensated care related to medical assistance provided to Medicaid eligibles or to individuals who have no source of third party coverage. For PCH, payments from the SNCP will be distributed to PCH based on its uncompensated care (based on prior period data). Payments to PCH for each CY will be subject to a limit computed in accordance with Attachment F, based on PCH’s uncompensated care costs incurred up to December 31, 2017. Specifically, the SNCP for PCH is \$110,000,000 for payments based on uncompensated care costs incurred in calendar year 2016; and \$90,000,000 for payments based on uncompensated care costs incurred in calendar year 2017. Any unspent cap amount cannot be used to pay for costs incurred in any following CY and will not be available for payments beyond the demonstration period ending September 30, 2021.

- a) **SNCP Payments.** Funds may be used to assist PCH with high levels of uncompensated care related to medical services that meet the definition of “medical assistance” contained in section 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals incurred by PCH. Expenditures must be claimed in accordance with CMS-approved claiming protocols in Attachment F. For any provider receiving SNCP payments, the total Medicaid payments,

Disproportionate Share Hospital (DSH) payments, SNCP payments, and any other payments for medical services furnished to Medicaid eligible and uninsured individuals cannot exceed the actual cost of providing services to Medicaid eligibles and the uninsured as defined in the claiming protocol. SNCP payments will be made directly from the state to Phoenix Children's Hospital for its incurred uncompensated care costs.

- b) **Prohibited Use of SNCP Funds.** SNCP funds cannot be used to pay for costs associated with non-emergency services provided to non-qualified aliens. The state must develop a methodology as part of the claiming protocol to exclude such costs from eligible uncompensated care costs.
- c) **Uncompensated Care Cost Limit.** For the calendar year 2016, up to \$110,000,000 total computable payments to PCH can be paid from the SNCP that are based on uncompensated care costs incurred by PCH in calendar year 2016. For payments based on uncompensated care costs incurred by PCH in calendar year 2017, up to \$90,000,000 total computable may be paid from the SNCP. The SNCP payment distributed to each individual provider will not exceed its uncompensated care costs for providing section 1905(a) medical services to Medicaid eligible and uninsured individuals for the applicable period.

To the extent that a provider's cost reporting period does not coincide with the DY (or partial DY or calendar year), the cost protocol will provide for an allocation of uncompensated care costs to the DY (or partial DY or calendar year).

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

- d) **Eligible Providers.** Phoenix Children's Hospital, for the uncompensated care costs it incurs from January 1, 2014 through December 31, 2017.
- e) **DSH and SNCP.** All applicable inpatient hospital and outpatient hospital SNCP payments received by a hospital provider must be included as offsetting revenue in the state's annual DSH audit reports. Hospitals cannot receive total payments, including DSH and SNCP payments, related to inpatient and outpatient hospital services furnished to Medicaid eligible and uninsured individuals that exceed the hospital's total eligible inpatient hospital and outpatient hospital uncompensated care costs.
- f) **Intergovernmental Transfers (IGTs).** The non-federal share of the SNCP payments for PCH will be funded by contributions from eligible governmental entities through IGTs. The state will submit to CMS for review and approval all IGT agreements to ensure compliance with Section 1903(w)(6)(A) of the Act and Part XI of these STCs. Such agreements should specify the source and use of the IGT money. The agreements shall ensure that the IGT is not derived from an impermissible source, including recycled Medicaid payments, federal money

precluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. The agreements shall also ensure that providers will retain the SNCP payments.

- g) **Annual Reporting Requirements for SNCP Payments.** The state will submit to CMS an annual report specifically related to the amount of payments made from the SNCP per DY. The reporting requirements are as follows:

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

- 1) Actual SNCP payments to each provider for each DY, including the interim payments and any overpayments resulting from the recomputations of the uncompensated care cost limits in accordance with the protocol in Attachment F;
- 2) The uncompensated care cost limit computed for each provider for each DY, including the projected uncompensated care costs used for interim payment purposes, the uncompensated care costs based on the as-filed cost reports, and the uncompensated care costs based on the finalized cost reports.
- 3) To the extent that the SNCP limits in paragraph 32(c) are stated for a period other than a DY, the state should allocate the SNCP payments to each DY proportionately based on the number of months in each DY that the payments cover.

33. Payments to IHS and 638 Facilities. The state is authorized through to make payments to IHS and tribal 638 facilities that take in to account furnishing specified types of care furnished by IHS and tribal 638 facilities to Medicaid-eligible individuals. Facilities must use the methodology discussed in Attachment G.

VII. DELIVERY SYSTEMS

34. Arizona Acute Care Program (AACP). The AACP is a statewide, managed care system, which delivers acute care services through contracts with Managed Care Organizations (MCOs) that AHCCCS calls “Health Plans.” Most AACP enrollees receive integrated physical and behavioral health care services through a single ACC Plan, and most individuals with CRS conditions also receive treatment for those conditions through an ACC Plan. AACP members determined to have a SMI receive integrated physical and behavioral health services through a geographically designated RBHA. Physical health care services for Arizona’s children in foster care are provided through the CMDP while behavioral health services are provided through RBHAs. Most Health Plan contracts are awarded by Geographic Service Area (GSA), which is a specific county or defined grouping of counties designated by AHCCCS within which a Health Plan provides covered health care services to members enrolled with that Health Plan.

35. Arizona Long Term Care System (ALTCS). ALTCS is administered through a statewide, managed care system which delivers physical, behavioral, long-term care services and supports (including home-and-community based services), and treatment for CRS conditions through contractors with MCOs that AHCCCS calls “Program Contractors.” ALTCS members in the Elderly and Physically Disabled (EPD) population, including those determined to have a SMI, receive integrated care through ALTCS/EPD Program Contractors. ALTCS members with a developmental disability (DD) receive physical health care through a MCO subcontracted with the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD), behavioral health care through a RBHA, and long-term services and supports through DES/DDD.

ALTCS/EPD contracts are awarded in the same geographic service areas as the ACC Plans. ALTCS/EPD enrollees in Maricopa and Pima Counties have a choice of Program Contractors, but ALTCS/EPD enrollees in the rest of the state enroll in the Program Contractor for their GSA. The ALTCS contract with the Arizona DES/DDD provides coverage on a statewide basis of the full ALTCS benefit package to all eligible individuals with developmental disabilities. Under state law, A.R.S. 36-2940, AHCCCS is required to enter into an intergovernmental agreement (IGA) with DES/DDD to serve as the Program Contractor for individuals with developmental disabilities. The DES/DDD ALTCS contract is an at-risk MCO contract that complies with 42 C.F.R. Part 438 and as such is reviewed and approved by CMS. Payments to DES/DDD under the ALTCS contract shall not include any payments other than payments that meet the requirements of 42 CFR 438.3(c) and 438.4 through 438.8 including the requirement that all payments and risk-sharing mechanisms in the contract are actuarially sound. State law, A.R.S. 36-2953, requires DES/DDD to maintain a separate fund to account for all revenues and expenditures under the ALTCS contract and limits use of the fund for the administration of the ALTCS contract.

36. Children Rehabilitative Services (CRS). Most AHCCCS members with a qualifying CRS condition receive integrated care for physical, behavioral, and CRS conditions through an ACC plan. Children in foster care with a qualifying CRS condition receive treatment for CRS and physical health care conditions through the CMDP and treatment for behavioral conditions through a RBHA. ALTCS/DD members with a qualifying CRS condition receive treatment for CRS and behavioral health conditions through the CRS Contractor, treatment for physical conditions through a MCO subcontracted with the DES/DDD, and long-term services and support through DES/DDD.

37. Regional Behavioral Health Authorities (RBHAs). Individuals who are AACP members and who are diagnosed with a serious mental illness will receive their acute care services and behavioral health services through separate MCOs called RBHAs. RBHAs serve as subcontractors of AHCCCS. RBHAs also serve children in foster care and ALTCS/DES/DDD members. All other AACP members will receive their behavioral health services through the RBHA.

38. American Indians/Alaska Natives (AI/AN). Medicaid-eligible AI/AN may opt to receive Medicaid benefits through managed care or through Medicaid fee-for-service. AI/AN members electing to receive benefits through fee-for-service are otherwise included in the demonstration.

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

VIII. GENERAL REPORTING REQUIREMENTS

40. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of \$5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or are found to be inconsistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

In the event that either (1) the state has not submitted a written request to CMS for approval of an extension, as described below, within thirty (30) days after a deliverable was due, or (2) the state has not submitted a revised submission or a plan for corrective action to CMS within thirty days after CMS has notified the state in writing that a deliverable was not accepted for being inconsistent with the requirements of this agreement including the information needed to bring the deliverable into alignment with CMS requirements; the following process is triggered:

- a) CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submission of required deliverable(s). For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state’s anticipated date of submission. Should CMS agree to the state’s request, a corresponding extension of the deferral process can be provided.
- b) CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state’s written extension request.
- c) If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System

(MBES/CBES) following a written deferral notification to the state.

- d) If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

41. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

42. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

- a) Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
- b) Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
- c) Submit deliverables to the appropriate system as directed by CMS.

43. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than 210 calendar days after approval of the demonstration. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment J.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS' template. Any proposed deviations from CMS' template should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as described in STC 44(b) below), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis covering the key policies being tested under this demonstration, including but not limited to the waiver of retroactive eligibility. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g., operational updates as described in STC 44(a) below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

44. Monitoring Reports. The state must submit three (3) Quarterly Reports and one

(1) Annual Report each DY. The fourth-quarter information that would ordinarily be provided in a separate quarterly report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.

- a) Operational Updates. The operational updates will focus on progress towards meeting the milestones identified in CMS' framework. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
- b) Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the milestones identified in CMS' framework which includes the following key policies under this demonstration - the AHCCCS CARE program (including the AHCCCS CARE Account), ALTCS, funding pools, and the waiver of retroactive eligibility. The performance metrics will also reflect all other components of the state's demonstration, including the managed care programs. For example, these metrics will cover enrollment, disenrollment or suspension by specific demographics and reason, access to care, and health outcomes.

Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the CMS framework provided by CMS to support federal tracking and analysis.

- c) Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the

demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

- d) Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

45. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

46. Close Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

- a) The draft report must comply with the most current guidance from CMS.
- b) The state will present to and participate in a discussion with CMS on the Close-Out report.
- c) The state must take into consideration CMS' comments for incorporation into the final Close Out Report.
- d) The final Close Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.
- e) A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 47.

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

- a) The Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) performs on its subcontracting MCOs.
- b) The state will also forward summaries of the financial and operational reviews that AHCCCS completes on the Children's Rehabilitative Services Program (CRS) contractor; and the Comprehensive Medical and Dental Program (CMDP) at the Arizona DCS.

53. Contractor Quality. AHCCCS will require the same level of quality reporting for DCS/DDD and DCS/CMDP as for Health Plans and Program Contractors, which include RBHAs, subject to the same time lines and penalties.

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

55. Monitoring Calls. CMS will convene periodic conference calls with the state.

- a) The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, and progress on evaluation activities.
- b) CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
- c) The state and CMS will jointly develop the agenda for the calls.

56. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time, and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

IX. TARGETED INVESTMENTS PROGRAM

57. Description. Arizona will include directed lump sum payments in its capitation rates paid to managed care entities pursuant to 42 CFR 438.6(c). The managed care entities will be directed to use the funding to make specific incentive payments to certain providers to improve performance and increase physical and behavioral health care integration and coordination for individuals with behavioral health needs. The Targeted Investments Program will:

- a) Reduce fragmentation that occurs between acute care and behavioral health care,
- b) Create efficiencies in service delivery for members with behavioral health needs, and
- c) Improve health outcomes for the affected populations.

58. Funding Limit. Pursuant to 42 CFR 438.6(c), AHCCCS may include in the actuarially sound capitation rates paid to managed care entities up to \$300 million total for the period of January 18, 2017, through September 30, 2021, in directed incentive payments to physical and behavioral health care providers that provide integrated services and care to Medicaid beneficiaries and achieve AHCCCS defined targets for performance improvement. In accordance with paragraph 74(f), the actual payment to the managed care entities may occur after September 30, 2021. The lump sum payments for the Targeted Investments Program will be paid to the managed care entities after the close of the contract period based on provider performance. The final amounts of the targeted payment amounts paid for the contract period must retrospectively be cost allocated across rate cells in an actuarially sound and justified manner and in alignment with the described payment adjustment in the approved template for payments made under 438.6(c). Additionally, the total of all payments under the contract must be actuarially sound and in compliance with part 438. These capitation rates, including the directed incentive payments and any associated taxes and managed care entity administration costs, are eligible for federal financial participation at the state’s FMAP for individual rate cells affected by the incentive payments.

Of the total \$300 million, the state may expend up to \$15 million to support the administration, including state level reporting and evaluation of the Targeted Investments Program. These administrative expenses will be eligible for federal financial participation at the administrative match rate of 50 percent.

Pursuant to 42 CFR 438.6(c), AHCCCS will direct payment of the incentive payments to be distributed annually to physical and behavioral health providers based on demonstrated performance improvement and increased integration and coordination of physical and behavioral health across three focus populations: (i) adults, (ii) children, and (iii) adults who have transitioned from a criminal justice facility. Payment of these directed incentive payments will be tied to performance improvement targets (including project milestones).

Table 4 – Estimated Annual Funding Distribution for the Targeted Investments Program

Programs	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
Targeted Investments	\$19 m.	\$66.5 m.	\$85.5 m.	\$66.5 m.	\$47.5 m.	\$285 m.
Administration	\$1m.	\$3.5 m.	\$4.5 m.	\$3.5 m.	\$2.5 m.	\$15 m.
Totals	\$20 m.	\$70 m.	\$90 m.	\$70 m.	\$50 m.	\$300 m.

59. Provider Payment Criteria. The state shall ensure that the contracts with managed care entities for provider performance payments adhere to the requirements in 42 CFR 438.6 (81 FR 27859-61) and sub-regulatory guidance unless otherwise explicitly modified by these STCs.

60. Designated State Health Programs (DSHP). Federal funding of DSHPs is to ensure the continuation of vital health care and provider support programs while the state devotes increased state resources during the period of this demonstration for Targeted Investments Program that will positively impact the Medicaid program, and result in savings to the federal government that will exceed the federal financial participation in DSHP funding.

- a) To the extent that the state increases its Medicaid expenditures through its Targeted Investments Program, and achieves the measures that are a condition for DSHP payment, the state may claim federal matching funding for certain DSHP expenditures to support the initial investment costs of the Targeted Investments Program. The expectation, which will be addressed in the demonstration evaluation, is that long-term savings achieved through the targeted investment will offset the amount of time-limited federal DSHP funding, and that the state will be able to continue the Targeted Investments Program on a self-sustaining basis after the initial demonstration approval period. DSHP expenditures cannot exceed the amount spent on the Targeted Investments Program and DSHP funding will also be subject to the annual and total DSHP spending limits in Table 5 and the reductions described in paragraph 56 and Table 6. DSHP funding is at-risk at the statewide level based on the state’s ability to meet system transformation targets, as described in Table 7. DSHP funding will be phased down over the demonstration period. No payments will be available for DSHP expenditures that are claimed under Medicaid or are reimbursed by third parties. DSHP expenditures may be claimed following procedures and subject to limits as described in the Table 5 below.
- b) FFP may be claimed for expenditures made for services provided by the following two state programs beginning January 18, 2017 through September 30, 2021:
 - i. Division of Developmental Disabilities (DDD), Arizona Early Intervention program (AZEIP)
 - ii. Services to Individuals with Serious Mental Illness (SMI) under Arizona Revised Statute (A.R.S.) §§ 11-297.

Table 5 – Total Computable Annual DSHP Limits

	Year 1	Year 2	Year 3	Year 4	Year 5
DSHP	\$6,274,400	\$21,137,600	\$27,177,000	\$21,137,600	\$15,098,300

61. DSHP Claiming Protocol.

- a) CMS must approve a DSHP claiming protocol for eligible DSHP expenditures, including identification of fund sources and types of expenditures. The DSHP protocol must be approved by CMS and will be attached to these STCs. The state must comply with the protocol in order to draw down FFP and document expenditures in accordance with the protocol.

- b) In order to claim FFP for DSHP expenditures, the state will provide CMS a summary worksheet that identifies DSHP expenditures by program each quarter.
- c) For all eligible DSHP expenditures, the state will have available for CMS:
 - i. Certification or attestation of expenditures.
 - ii. Actual expenditure data from state financial information system or state client sub-system.
- d) The protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in paragraph 52 below.
- e) The state will claim FFP for DSHP quarterly based on actual expenditures.

1. Prohibited DSHP Expenditures. The following types of expenditures are not permissible DSHP expenditures:

- a) Grant funding to test new models of care
- b) Construction costs (bricks and mortar)
- c) Room and board expenditures
- d) Animal shelters and animal vaccines
- e) School based programs for children
- f) Unspecified projects
- g) Debt relief and restructuring
- h) Costs to close facilities
- i) HIT/HIE expenditures
- j) Services provided to undocumented individuals
- k) Sheltered workshops
- l) Research expenditures
- m) Rent and/or Utility Subsidies that are normally funded by the United States Department of Housing and Urban Development and United States Department of Agriculture (USDA) or other state/local rental assistance programs
- n) Prisons, correctional facilities, services for incarcerated individuals and services provided to individuals who are civilly committed and unable to leave
- o) Revolving capital fund
- p) Expenditures made to meet a maintenance of effort requirement for any federal grant program
- q) Administrative costs
- r) Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans)
- s) Cost of services for which payment was made by Medicare or Medicare Advantage
- t) Funds from other federal grants
- u) Needle-exchange programs
- v) Abortions that would not be allowable if furnished under Medicaid or CHIP
- w) Costs associated with funding federal matching requirements.

62. DSHP Claiming Process.

- a) The state will establish standard documentation of each DSHP’s expenditures, to be specified in the DSHP Protocol.
- b) The state will report all expenditures for DSHP payments to eligible programs on the form CMS-64.9P Waiver under the waiver name “TIP DSHP.” Federal funds must be claimed within two years following the calendar quarter in which the state incurs DSHP expenditures for services received during the performance period described above in paragraph 50(b). Claims cannot be submitted for state expenditures generated from services from programs identified in paragraph 50(b) above incurred after September 30, 2021. Sources of non-federal funding must be permitted by section 1903(w) of the Act and any applicable regulations.

63. Evaluation of the Targeted Investments Program. The state shall submit an update to its 1115 demonstration evaluation design no later than 120 days after the approval of the amendment to implement the Targeted Investments Program and in accordance with Section X, Evaluation of the Demonstration.

64. Sustainability of Physical and Behavioral Health Care Integration and Coordination. Because funding will decrease each year after year 3 and end after year 5, the state must submit a plan for ongoing support for the sustainability of increased behavioral health care integration and care coordination. The state must submit a draft sustainability plan for CMS comment by March 31, 2019. The sustainability plan should include, but is not limited to, the following elements:

- a) The scope of the behavioral health care integration activities that the state wants to maintain including analysis of alternative integration models like Integrated Care models or health homes under sections 1905(t)(1) or 1915(g) of the Act; and
- b) The strategy to secure resources to maintain the integration activities.

65. Reduction in DSHP Expenditures for Failure to Meet Statewide System Transformation Targets. The DSHP will be reduced in the prospective demonstration year if the state does not meet the targets for TI participating providers for the previous year. Reductions in table 6 will be prorated by focus population: 4 percent for criminal justice, 53 percent for adult and 43 percent for child, in which targets described in paragraph 57 are not met.

Table 6 – Total Computable DSHP Reductions for Each Demonstration Year

	Year 1	Year 2	Year 3	Year 4	Year 5
Percentage at Risk	0%	0%	10%	15%	20%
Total Amount at Risk	\$0	\$0	\$2,717,700	\$3,170,640	\$3,019,660

66. Statewide Focus Population Measures. The state will submit revised baselines in the 2017 annual report to CMS to update the baseline in Table 8 below. Table 8

below describes the performance measures and targets that the state is required to meet in the previous year in order for the state to qualify for DSHP funding in Years 3 through 5. The state shall report its progress for these measures each year in the annual report described in paragraph 41.

Table 8 – Statewide Focus Population Measures and Targets

Child Physical and Behavioral Health Integration Measures			
Year of DSHP	Proposed Measure	Numerator and Denominator Definition	Proposed Target
3	Practice has executed an agreement with Health Current and Health Current routinely receives ADT alerts <u>Baseline:</u> to be calculated during Year 1	<u>numerator:</u> An executed agreement with Health Current and Health Current confirmation of practice routine receipt of ADT alerts <u>denominator:</u> Primary care and behavioral health practices participating in the child integration project	5 points over baseline
4	Well-child visits in the third, fourth, fifth and sixth years of life for children with a behavioral health diagnosis (HEDIS, modified) <u>Baseline:</u> To be calculated during Year 1	<u>numerator:</u> AHCCCS members with a BH diagnosis who are age 3-6 years as of the last calendar day of the measurement year, and are attributed to a primary care provider participating in the child integration project, who have at least one well-child visit with any PCP during the measurement year ¹ <u>denominator:</u> AHCCCS members with a BH diagnosis who are age 3–6 years as of the last calendar day of the measurement year and are attributed to a child integration project participating primary care provider	2 points over baseline
5	Well-child visits in the third, fourth, fifth and sixth years of life for children with a behavioral health diagnosis (HEDIS, modified) <u>Baseline:</u> To be calculated during Year 1	<u>numerator:</u> AHCCCS members with a BH diagnosis who are age 3-6 years as of the last calendar day of the measurement year, and are attributed to a primary care provider participating in the child integration project, who have at least one well-child visit with any PCP during the measurement year. <u>denominator:</u> AHCCCS members with a BH diagnosis who are age 3–6 years as of the last calendar day of the measurement year and are attributed to a child	5 points over baseline

¹ Well-care visit as defined in the HEDIS 2017 Well-Care Value Set. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child or be within the Targeted Investment provider entity.

		integration project participating primary care provider	
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Adult Physical and Behavioral Health Integration Measures			
Year of DSHP	Proposed Measure	Numerator and Denominator Definition	Proposed Target
3	Practice has executed an agreement with Health Current and routinely receives ADT alerts <u>Baseline:</u> To be calculated during Year 1	<u>numerator:</u> An executed agreement with Health Current and Health Current confirmation of practice routine receipt of ADT alerts <u>denominator:</u> Adult primary care and behavioral health practices participating in the adult integration project	5 points over baseline
4	Follow-up after hospitalization for mental illness (HEDIS, modified ²) <u>Baseline:</u> To be calculated during Year 1	<u>numerator:</u> AHCCCS members 18 years of age and older at any time during the measurement period who had a follow-up visit with a mental health practitioner within 7 days after a denominator-qualifying discharge, including visits that occur on the date of discharge. ³ <u>denominator:</u> Acute hospital discharges of AHCCCS members 18 years of age and older at any time during the measurement period for treatment of selected mental illness diagnoses ⁴ for members discharged from an adult integration project participating hospital or attributed to an adult integration project participating primary care or behavioral health provider	2 points over baseline
5	Follow-up after hospitalization for mental illness (HEDIS, modified) <u>Baseline:</u> To be calculated during Year 1	<u>numerator:</u> AHCCCS members 18 years of age and older at any time during the measurement period who had a follow-up visit with a mental health practitioner within 7 days after a denominator-qualifying discharge, including visits that occur on the date of discharge. <u>denominator:</u> Acute hospital discharges of AHCCCS members 18 years of age and	4 points over baseline

² Modified to apply only to adults, as the HEDIS specifications include those six years and older in the denominator.

³ The follow-up visit must be with a mental health practitioner as defined by the following NCQA HEDIS value sets: FUH Stand Alone Visits Value Set, (FUH Visits Group 1 Value Set *and* FUH POS Group 1 Value Set), and FUH Visits Group 2 Value Set *and* FUH POS Group 2 Value Set.

⁴ A principal diagnosis of mental illness is defined by the NCQA HEDIS Mental Illness Value Set. Inpatient stay is defined by the Inpatient Stay Value Set, but excludes the Nonacute Inpatient Stay Value Set.

		older at any time during the measurement period for treatment of selected mental illness diagnoses for members discharged from an adult integration project participating hospital or attributed to an adult integration project participating primary care or behavioral health provider	
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Care Coordination Measures for Medicaid Enrolled Released from Criminal Justice Facilities			
Year of DSHP	Proposed Measure	Numerator and Denominator Definition	Proposed Target
3	Practice has executed an agreement with Health Current and routinely receives ADT alerts <u>Baseline</u> : To be calculated during Year 1	<u>numerator</u> : An executed agreement with Health Current and Health Current confirmation of practice routine receipt of ADT alerts <u>denominator</u> : Integrated practices participating in the justice transition	100%
4	Adults access to preventive/ambulatory health services (HEDIS, modified ⁵) <u>Baseline</u> : To be calculated during Year 1	<u>numerator</u> : AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated who had one or more ambulatory or preventive care visits ⁶ during the measurement year <u>denominator</u> : AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated	2 points over baseline
5	Adults access to preventive/ambulatory health services (HEDIS, modified) <u>Baseline</u> : To be calculated during Year 1	<u>numerator</u> : AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated who had one or more ambulatory or preventive care visits during the measurement year <u>denominator</u> : AHCCCS members age 20-44 years during the measurement period	5 points over baseline

⁵ Modified to apply to only those AHCCCS members recently released from a criminal justice facility at which a new integrated clinic has been situated. "Recently released" is defined as excluding those individuals released 60 days prior to end of the measurement period.

⁶ Visits defined by the following NCQA HEDIS measure sets: Ambulatory Visits Value Set and Other Ambulatory Visits Value Set.

		recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated	
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X. EVALUATION OF THE DEMONSTRATION

67. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce, or maintain data and files for the demonstration, a requirement that they make data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 40.

68. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

69. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 calendar days after approval of the demonstration.

Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

- a) All applicable Evaluation Design guidance, including guidance about cost-sharing, and the waiver of retroactive eligibility. Hypotheses for cost-sharing will include (but not be limited to): effects on access to care; and health outcomes. Hypotheses for the waiver of retroactive eligibility will include (but not be limited to): the effects of the waiver on enrollment and eligibility continuity (including for different subgroups of individuals, such as individuals who are healthy, individuals with complex medical needs, prospective applicants, and existing beneficiaries in different care settings (including long-term care settings)). Hypotheses applicable to the demonstration as a whole, and to all key policies referenced above, will include (but will not be limited to): the effects of the demonstration on health outcomes; the financial impact of the demonstration (for example, such as an assessment of medical debt and uncompensated care costs); and the effect of the demonstration on Medicaid program sustainability.
- b) Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD Evaluation Designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a Draft Evaluation Design.
- c) The evaluation design for the demonstration period beginning October 1, 2016 must include research questions, hypotheses, and proposed measures for the the Targeted Investments Program, and the AHCCCS CARE program post-implementation, and a continuation of the state's evaluation of the integration of physical and behavioral health under the RHBAs.

70. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval.

71. Evaluation Questions and Hypotheses. Consistent with attachments B and C (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS's measure sets for eligibility and coverage, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, and/or measures endorsed by National Quality Forum (NQF).

72. Evaluation Budget. A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

73. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

- a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.
- b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
- c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted, should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
- d. The state must submit the final Interim Evaluation Report within 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
- e. The Interim Evaluation Report must comply with Attachment C (Preparing the Evaluation Report) of these STCs.

74. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment C (Preparing the Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

- a) Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.
- b) The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

75. Safety Net Care Pool (SNCP) for Phoenix Children's Hospital. Arizona will conduct an independent evaluation of the use of the SNCP for Phoenix Children's Hospital and submit an evaluation report no later than 90 days after making final payment to PCH. The report will include, but is not limited to the following elements:

- a) A detailed analysis of the SNCP payments for PCH for uncompensated care costs incurred through December 31, 2017.
- b) A comparison of SNCP payments that are attributed to uninsured children and children who are Medicaid beneficiaries.
- c) An analysis of factors that contributed to the necessity of SNCP payments to PCH including, but not limited to:
 - i. Provider and diagnosis payment rates in the state and
 - ii. The number of uninsured and Medicaid eligible children in the state.
- d) An update on the state's progress for proposals and strategies for PCH and Medicaid payment rate reform and the improved impact on Medicaid shortfall and uncompensated care incurred by PCH.

76. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

77. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

78. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

79. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may

choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

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

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

- a) **Tracking Expenditures.** In order to track expenditures under this demonstration, Arizona shall report demonstration expenditures through the Medicaid and state Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the state Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.C through 10.F, as instructed in the state Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below.
- b) **Use of Forms.** For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality cap. The state must complete separate forms for the following categories:
 - i. AFDC/SOBRA
 - ii. SSI
 - iii. Expansion State Adults
 - iv. MED
 - v. ALTCS-DD
 - vi. ALTCS-EPD
 - vii. Payments to IHS and 638 Facilities
 - viii. SNCP
 - ix. DSH and Critical Access Hospital Payments (CAHP)**
 - x. New Adult Group

xi. TIP – DSHP

xii. TIP

**Critical Access Hospital Payments as defined in Attachment E

- c) **Expenditures Subject to the Budget Neutrality Cap.** For purposes of section X, the term “expenditures subject to the budget neutrality cap” shall include all Medicaid expenditures except those as described below, on behalf of the individuals who are enrolled in this demonstration. Expenditures excluded from this demonstration and the budget neutrality cap are Direct Services Claiming program expenditures for Medicaid in the public schools, Breast and Cervical Cancer Treatment program expenditures, Freedom to Work program expenditures, and all administrative expenditures.
- d) **Premium and Cost Sharing Adjustment.** Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration shall be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that the demonstration is properly credited with premium collections, premium collections (both total computable and Federal share) should also be reported on the CMS-64 Narrative.
The state should include these section 1115 premium collections as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.
- e) **Administrative Costs.** Administrative costs shall not be included in the budget neutrality limit. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
- f) **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2- year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS- 64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
- g) **Pharmacy Rebates.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration. The proposed methodology must determine, in a way that reasonably reflects actual rebate-eligible pharmacy utilization, the amounts of rebate that are attributable to pharmacy utilization under the demonstration vs. outside the demonstration, and appropriate subtotals by EG and DY. The methodology (and any subsequent changes to the methodology) must be approved in advance by the CMS Regional Office prior to use. Rebate amounts assigned to the demonstration must be reported on the appropriate Forms CMS-64.9 or 64.9P Waiver, and not on any other CMS-64.9 form (to avoid double-counting). In the absence of an approved methodology, all

pharmacy rebates must be reported on Forms CMS-64.9 or 64.9P Base.

82. Reporting of Member Months. The following describes the reporting of member months in the demonstration. Member months subject to the budget neutrality cap include:

- a) For the purpose of calculating the budget neutrality expenditure cap described in this Agreement, the state shall provide to CMS on a quarterly basis the actual number of eligible member months for:
 - 1) Eligibility Group 1: AFDC / SOBRA
 - 2) Eligibility Group 2: SSI
 - 3) Eligibility Group 3: Expansion State Adults
 - 4) Eligibility Group 4: ALTCS-DD
 - 5) Eligibility Group 5: ALTCS-EPD
 - 6) Eligibility Group 6: New Adult Group
- b) This information shall be provided to CMS 30 days after the end of each quarter as part of the CMS-64 submission, either under the narrative section of the MBES/CBES or as a stand-alone report.
- c) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member months.
- d) For the purposes of this demonstration, the term "demonstration eligibles" refers to all individuals covered by Arizona Medicaid with the exception of individuals in the Freedom to Work and Breast and Cervical Cancer Treatment programs

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

84. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide

FFP at the applicable Federal matching rates for the following, subject to the limits described in this Agreement.

- a) Administrative costs, including those associated with the administration of the demonstration;
- b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c) Net expenditures and prior period adjustments made with dates of service during the operation of the demonstration.

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

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

- a) CMS shall review the sources of the non-Federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b) The state shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendments that impact the financial status of the program.
- c) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid or demonstration payments. This confirmation of Medicaid and demonstration payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid or the demonstration and in which there is no connection to Medicaid or demonstration payments) are not considered returning and/or redirecting a Medicaid or demonstration payment.

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

- a) Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-Federal share of funds under the demonstration.
- b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
 - i. To the extent that Arizona institutes the use of CPEs, the requirements of this term and condition fully apply. The state is subject to any policy guidance or regulation released by CMS regarding the use of CPEs.
 - ii. The disproportionate share hospital (DSH) payment methodology for Arizona State Hospital (ASH) and the Maricopa Medical Center will be cost reimbursement and will utilize CPEs as the funding system. The methodology and the cost identification/reconciliation process, as approved by CMS, are included as an amendment to the DSH methodology in Attachment D.

To the extent the state utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the state the amount of such tax revenue (state or local) appropriated to the non-governmental provider used to satisfy demonstration expenditures. The non-governmental provider that incurred the cost must also provide cost documentation to support the state's claim for Federal match.

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

88. Applicability of Fee for Service Upper Payment Limits. If expenditures (excluding fee for service expenditures for American Indian beneficiaries) for inpatient hospital and long-term care facility services, other institutional and non-

institutional services, and drugs provided to AHCCCS fee-for-service beneficiaries equal or exceed 5 percent of the state's total Medical Assistance expenditures, the expenditure authority will be terminated and the state shall submit a demonstration amendment that includes a plan to comply with the administrative requirements of section 1902(a)(30)(A). The state shall submit documentation to CMS on an annual basis that shows the percentage AHCCCS fee-for-service beneficiary expenditures as compared to total Medical Assistance expenditures.

XII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

- 89. Quarterly CHIP Expenditure Reports.** The state shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided to all demonstration populations receiving title XXI funds under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP only for allowable demonstration title XXI expenditures that do not exceed the state's available title XXI funding.
- 90. Tracking CHIP Expenditures.** In order to track title XXI expenditures under this demonstration, the state will report demonstration expenditures, excluding KidsCare II, through the MBES/CBES, following routine CMS-21 reporting instructions. Title XXI demonstration expenditures will be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver identified by the demonstration project number assigned by CMS (including project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). Expenditures for the KidsCare II program will be reported on the CMS-21 with the state plan population in the MBES/CBES. Separate KidsCare II reporting will be provided in the CMS-21 Narrative using a proportion of KidsCare II to the total KidsCare population based on date of payments.
- a) **CHIP Claiming.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.
- b) **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. Arizona must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the state shall provide updated estimates of expenditures for the demonstration population. CMS will make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of

the grant award to the state.

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

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

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

XIII. MONITORING BUDGET NEUTRALITY

93. Monitoring Demonstration Funding Flows. The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame. These reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

- a) Each year, AHCCCS will monitor and ensure that for each contract year, the DES/DDD have provided the appropriate state match necessary to draw down the FMAP for title XIX services provided, respectively, to ALTCS eligible persons. Specifically, AHCCCS and DES/DDD entered into an Intergovernmental Agreement, effective July 1, 1998, whereby DES/DDD transfers to AHCCCS the total amount appropriated for the state match for title XIX ALTCS expenditures. AHCCCS deposits the monies transferred into an Intergovernmental Fund from which AHCCCS has sole disbursement authority.
- b) AHCCCS will report on a comparison of revenues and costs associated with the DES Interagency Agreement, including how any excess revenues are spent. The report will be due by January 15 of each year for the state fiscal year ending the previous June 30.

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

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

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

- a) Eligibility Group 1: AFDC / SOBRA
- b) Eligibility Group 2: SSI
- c) Eligibility Group 3: Expansion State Adults
- d) Eligibility Group 4: ALTCS-DD
- e) Eligibility Group 5: ALTCS-EPD
- f) Eligibility Group 6: New Adult Group
- g) Program Group 1: DSH
- h) Program Group 2: Payments to IHS and Tribal Facilities
- i) Program Group 3: SNCP
- j) Program Group 4: KidsCare II

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

- a) For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each eligibility group described in paragraph 89 as follows:
- i. An annual eligibility group expenditure cap must be calculated as a product of the number of eligible member months reported by the state under paragraph 75 for each eligibility group, times the appropriate estimated per member per month (PM/PM) costs from the table in subparagraph (iii) below.
 - ii. The PM/PM costs in subparagraph (iii) below are net of premiums paid by demonstration eligibles.
 - iii. The PM/PM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility groups subject to the budget neutrality agreement under this demonstration are specified below. The Expansion State Adults population is structured as a “pass-through” or a “hypothetical state plan population”. Therefore, the state may not derive savings from these populations.

Eligibility Group	Trend Rate	DY 6	DY 7	DY 8	DY 9	DY 10
		FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021
AFDC / SOBRA	4.5%	\$749.11	\$782.82	\$818.05	\$854.86	\$893.33
SSI	4.0%	\$1,162.52	\$1,209.02	\$1,257.38	\$1,307.68	\$1,359.99
Expansion State Adults*	NA*	\$719.12	\$728.45	\$755.88	\$775.75	\$796.29
ALTCS - EPD	3.7%	\$6,016.98	\$6,239.61	\$6,470.48	\$6,709.89	\$6,958.16
ALTCS - DD	4.0%	\$6,462.96	\$6,721.48	\$6,990.34	\$7,269.95	\$7,560.75

- iv. The annual budget neutrality expenditure cap for the demonstration as a whole is the sum of DSH allotment, the uncompensated care payments to IHS and tribal facilities, expenditures for the SNCP and KidsCare II program plus the annual expenditure caps for each eligibility group calculated in subparagraph (a)(i) above.
- b) The overall budget neutrality expenditure cap for the 5-year demonstration period is the sum of the annual budget neutrality expenditure caps calculated in subparagraph (a) (iv) above for each of the 5 years. The federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration populations and expenditures described in paragraph 90 during the demonstration period.
- c) Apply the effective FMAP, or enhanced 90 percent match for family planning services, that is determined from the MBES/CBES Schedule C report.

98. Monitoring of New Adult Group Spending and Opportunity to Adjust

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

Eligibility Group	Trend Rate	DY 6	DY 7	DY 8	DY 9	DY 10
		FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021
New Adult Group	3.30%	\$655.13	\$676.75	\$699.08	\$722.15	\$745.98

- a) If the State’s experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the new adult group PMPM limit described above may underestimate the actual costs of medical assistance for the new adult group, the State has the opportunity to submit an adjustment to the PMPM limit, along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to paragraph 7. In order to ensure timely adjustments to the PMPM limit for a demonstration year, the revised projection must be submitted to CMS by no later than the end of the third quarter of the demonstration year for which the adjustment would take effect.
- b) The budget limit for the new adult group is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.
- c) The State will not be allowed to obtain budget neutrality “savings” from this population.
- d) If total FFP reported by the state for the new adult group should exceed the federal share of FFP for the budget limit for the new adult group by more than 3 percent following each demonstration year, the state must submit a corrective action plan to CMS for approval.

99. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. The budget neutrality test for the demonstration extension will incorporate net savings from the immediately prior demonstration period of October 1, 2011 through September 30, 2016, but not from any earlier approval period.

100. Budget Neutrality Savings Phase-Down. Beginning with the demonstration period that begins on October 1, 2016, the net variance between the without-waiver and actual with-waiver costs will be reduced. The reduced variance, calculated as a percentage of the total variance, is used in place of the total variance to determine overall budget neutrality of the demonstration. The formula for calculating the reduced variance is, reduced variance equals total variance times applicable

percentage. The percentages are determined based on how long Medicaid populations have been enrolled in managed care subject to the demonstration. In the case of Arizona, the managed care program will retain 25 percent of the total variance as future savings for the demonstration. Should the state request an extension of its demonstration beyond September 30, 2021, the state must provide actual managed care capitation rate data for AHCCCS enrollees. Budget neutrality will be adjusted again to reflect revised PMPMs based on this data.

101.Exceeding Budget Neutrality. If, at the end of this demonstration period the overall budget neutrality expenditure cap has been exceeded, the excess Federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

Attachment A

Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

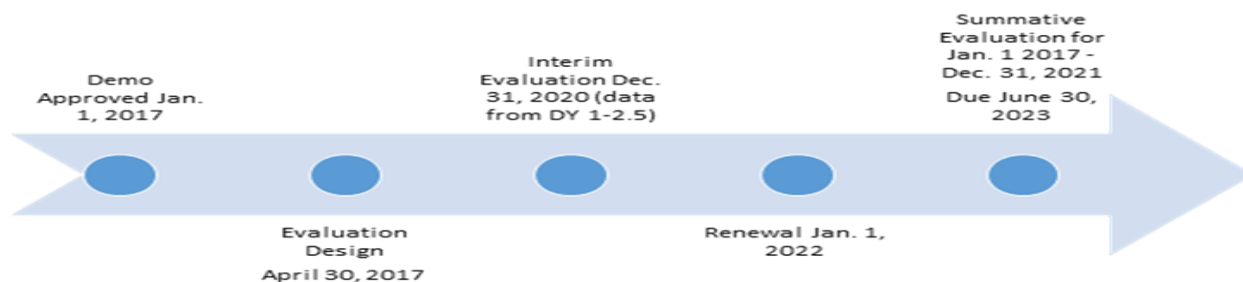
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- A. General Background Information;
- B. Evaluation Questions and Hypotheses;
- C. Methodology;
- D. Methodological Limitations;
- E. Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state’s Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

- 1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- 3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

- 1) Describe how the state’s demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
- 2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when

working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: <https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>.

- 3) Identify the state's hypotheses about the outcomes of the demonstration:
 - a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
 - b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.
- C. Methodology** – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

- 1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
- 2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
- 3) *Evaluation Period* – Describe the time periods for which data will be included.
- 4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
 - a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
 - b. Qualitative analysis methods may be used, and must be described in detail.
 - c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.

- d. Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
 - e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
 - f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.
- 5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

- 6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
- a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
 - b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
 - c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
 - d. The application of sensitivity analyses, as appropriate, should be considered.
- 7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				

Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

E. Special Methodological Considerations – CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include when the demonstration is considered successful without issues or concerns that would require more regular reporting, such as:

- a. Operating smoothly without administrative changes; and
- b. No or minimal appeals and grievances; and
- c. No state issues with CMS-64 reporting or budget neutrality; and
- d. No Corrective Action Plans (CAP) for the demonstration.

F. Attachments

- 1) **Independent Evaluator.** This includes a discussion of the state’s process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation

design should include a “No Conflict of Interest” statement signed by the independent evaluator.

- 2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.
- 3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment B

Preparing the Evaluation Report

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

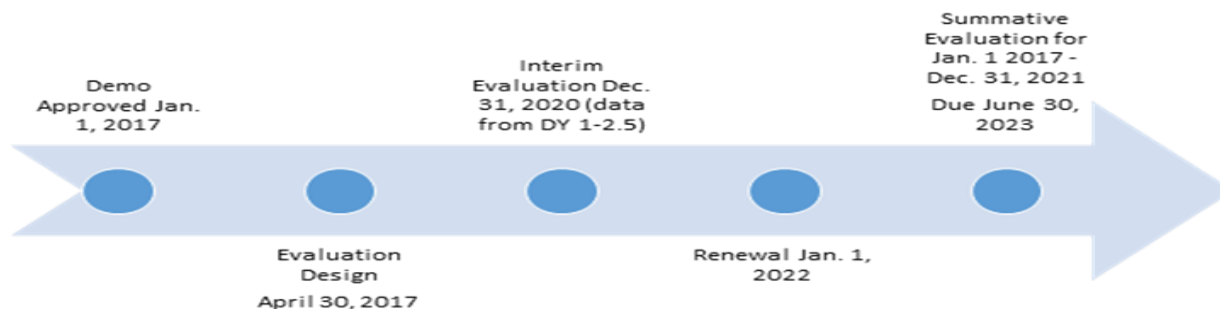
The format for the Interim and Summative Evaluation reports is as follows:

- A. Executive Summary;
- B. General Background Information;
- C. Evaluation Questions and Hypotheses;
- D. Methodology;

- E. Methodological Limitations;
- F. Results;
- G. Conclusions;
- H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
- I. Lessons Learned and Recommendations; and
- J. Attachment(s).

Submission Timelines

There is a specified timeline for the state’s submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state’s website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state’s Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state’s submission must include:

- A. Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
- B. General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
 - 1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential

magnitude of the issue, and why the state selected this course of action to address the issues.

- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- 3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

- 1) Describe how the state’s demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
- 2) Identify the state’s hypotheses about the outcomes of the demonstration;
 - a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
 - b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
 - c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how.

Specifically, this section establishes that the approved Evaluation Design was followed by describing:

- 1) *Evaluation Design* – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
- 2) *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria.
- 3) *Evaluation Period* – Describe the time periods for which data will be collected
- 4) *Evaluation Measures* – What measures are used to evaluate the demonstration, and who are the measure stewards?
- 5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data.
- 6) *Analytic Methods* – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
- 7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations

This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
 - a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives –

In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state’s Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the “opportunities” for future or

revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

- 1) What lessons were learned as a result of the demonstration?
- 2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

- 1) Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C
AHCCCS Disproportionate Share Hospital Program DSH 102

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

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

- Hospital eligibility requirements
- Data on a State Plan Year Basis
- Timing of eligibility determination
- Medicaid Inpatient Utilization Rate (MIUR) calculation (Overall and Group 1 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

<p>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”)</p> <p>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”)</p> <p>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”)</p> <p>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”)</p> <p>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”)</p>	<p>patients</p> <p>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</p> <p>3. The patients of the hospital are predominantly under 18 years of age</p> <p>4. The hospital was in existence on December 22, 1987 but did not offer non-emergency obstetric services as of that date</p>	
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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. This requirement will impact the information collected and submitted by all hospitals that do not have a fiscal year and/or CMS 2552 Report year that runs from 10/1 to 9/30.

In order to make the necessary calculations to determine eligibility and payments on a State Plan Year basis, hospitals that do not have a fiscal/CMS Report year that runs from 10/1 to 9/30 will have to submit cost reports and other data elements for each of the fiscal/CMS Report years that encompass the State Plan Year. For example, for SPY 2008 (10/1/07 to 9/30/08), for a hospital that has a CMS 2552 Report year that runs from 7/1 to 6/30, the hospital will have to submit the CMS 2552 Report and other data elements for the fiscal/CMS Report year that ends on 6/30/08 and the same information for the fiscal/CMS Report year that ends 6/30/09.¹

As discussed later in this Attachment, AHCCCS will extract all Title XIX (Medicaid) claims and encounters from the PMMIS system on the basis of each hospital's CMS 2552 Report year and these data will serve as the basis for all Medicaid days, charges and payments. Similarly, AHCCCS will collect all Medicaid and Non-Title XIX payments (for the Comprehensive Medical and Dental Program, behavioral health services and payments for trauma and emergency departments) on the basis of each hospital's CMS 2552 Report year.

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

initial payments, final payments and data sources, see the discussions that follow.

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

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

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

Timing of Eligibility Determination

The eligibility determination calculations will be performed annually for all hospitals located in the state of Arizona that are registered as providers with AHCCCS 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 the PMMIS system all inpatient and outpatient hospital claims and encounters by date of service for each registered hospital for that hospital's fiscal years that encompass the state plan rate year two years prior to the state plan year of the initial DSH payment.
 - b. Based on the extracted claims and encounters data and data provided by the hospitals, determine for each hospital whether or not that hospital has a Medicaid Inpatient Utilization Rate (MIUR) of at least 1%. For hospitals that qualify under this criteria, determine if the hospital:
 - i. Meets the criteria for Group 1
 - ii. Meets the criteria for Group 1A
 - iii. Meets the criteria for Group 2
 - iv. Meets the criteria for Group 2A
 - v. Meets the criteria for Group 4

- c. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above.
2. The second step of the eligibility process will occur in the state plan rate year two years after the state plan rate year of the initial DSH payment using the same steps above except that the data will be from the actual state plan year(s) 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.

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. In order to find each hospital’s MIUR for the state plan year, AHCCCS will calculate a MIUR separately for each hospital fiscal/CMS Report year that encompasses the relevant State Plan Year and then prorate the results from the two hospital fiscal/CMS Report years as described in the discussion above entitled “Data on a State Plan Year Basis”. AHCCCS will perform this calculation twice. The first calculation will be performed using the state plan year two years prior to the year of the initial DSH payment. The second calculation will encompass 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 year

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 the PMMIS system. 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 clients, including days paid by Medicare, except for Title XIX members between 21 and 65 years of age who is in an Institution for Mental Disease (IMD).

- 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.

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:

$$\text{LIUR} = \frac{\left(\frac{\text{Total Medicaid Patient Services Charges} + \text{Total State and Local Cash Subsidies}}{\text{Total Charges for Patient Services}} \right) + \left(\frac{\text{Total Inpatient Charges Attributable to Charity Care-Cash Subsidies Portion}}{\text{Total Inpatient Charges}} \right)}{2}$$

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

If a hospital has a LIUR that exceeds 25% it will meet the eligibility for Group 2 or 2A. AHCCCS will perform this calculation twice. The first calculation will be performed using the state plan year two years prior to the year of the initial DSH payment. The

second calculation will encompass 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. AHCCCS will account for the amounts of such payments made during the relevant fiscal years. 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 payors or self pay patients that do not qualify for charity care pursuant to the hospital’s charity care policy.
 8. “Cash Subsidies Portion Attributable to Inpatient” means that portion of “Total state and Local Cash Subsidies for Patient Services” that is attributable to inpatient services. 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 payors 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.

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:

$ \begin{aligned} & \textit{Uncompensated Care Costs Incurred Serving Medicaid Recipients} \\ & \qquad \qquad \qquad + \\ & \textit{Uncompensated Care Costs Incurred Servicing the Uninsured} \end{aligned} $
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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 are²:

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 Note: The following discussion applies to hospitals that do not have a per diem ancillary allocation methodology approved by Medicare. For the steps to calculate the OBRA limit

for governmental hospitals that do have such approval, see Exhibit 2 to this Attachment C. Non-governmental hospitals that have such approval should contact AHCCCS for further information.

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

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

The Medicaid Shortfall

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

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

1. The number of Medicaid fee for service (FFS) inpatient hospital days for 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 during the hospital's fiscal/CMS Report years that encompass the state plan year. Supplemental payments (such as GME, Rural Hospital Inpatient Payment and CAH) will be based on the state plan year. During the initial calculation, AHCCCS may use actual data if available as opposed to two years prior payments.

Uninsured Costs

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

procedures as the data included in the cost report.

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

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (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 payor 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 for each fiscal/CMS Report year that encompasses the state plan year. The resulting uninsured costs for each fiscal/CMS Report year will be prorated to derive the state plan year uninsured costs according to the above discussion entitled “Data on a State Plan Year Basis”.

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

1. The number of uninsured inpatient hospital days (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 hospital’s fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital

services. The information collected shall:

- a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,
 - b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)
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 hospital's fiscal/CMS Report years that encompass the state plan year from third parties related to all uninsured inpatient and outpatient hospital services. Payments made by state or local government are not considered a source of third party payment.

The OBRA Limit

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

Group 5 Eligibility Determination

Any Arizona hospital that qualifies for funding in Groups 1, 1A, 2, 2A, or 4 is eligible for funding through Group 5. Group 5 is created to enable DSH-eligible hospitals to get qualifying DSH payments matched via voluntary intergovernmental agreements (IGAs). Per State Medicaid Director Letter #10-010, the state will require the appropriate documentation that the funding has been voluntarily provided. Group 5 DSH payments are on top of the Groups 1, 1A, 2, 2A, and 4 DSH payments, but no individual hospital will receive aggregate DSH payments that exceed its OBRA limit.

Funding for any hospital in Group 5 must be arranged via a voluntary intergovernmental agreement with a political subdivision, tribal government or public university, through certified public expenditures (for governmental hospitals) or an intergovernmental transfer of public funds not derived from impermissible sources, such as impermissible provider-related donations or impermissible health care-related taxes, as a match to draw down DSH payments. Political subdivisions, tribal governments and public universities

will notify AHCCCS of the hospitals designated to receive funds from Pool 5 and of the amount of matching funds that are available through their IGAs or through a certification of public expenditures.

For hospitals that qualify for Group 5, a “LOM” score will be calculated by multiplying the hospital’s LIUR times the hospital’s full OBRA limit, times the hospital’s MIUR.

Example:

Hospital A

OBRA = \$54,734,467, MIUR = 0.3542, LIUR = 0.2946

Group 5 LOM score for Hospital A = $\$54,734,467 \times 0.3542 \times 0.2946 = \underline{\$5,711,394}$

For the first round of distributions, allocations will be provided to hospitals located outside of the Phoenix and Tucson metropolitan statistical areas which have an agreement with a political subdivision, tribal government, or public university for intergovernmental transfer of the non-federal share funding. 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. The total amount of DSH available as a result of the IGAs (Group 5 DSH funds) will be multiplied by each hospital’s LOM percentage of this first round. If any allocation from this round is higher than a hospital’s OBRA limit (remaining after Group 1, 1A, 2, 2A, and 4 DSH distributions) or higher than the matching funds (in total computable) for that hospital, the lower of those two limits will be recorded as the allocation for round one.

The second round of distributions will be open to any hospital that qualifies for funding in Groups 1, 1A, 2, 2A, or 4 which did not participate in round 1 and which has a certificate of public expenditures or an agreement with a political subdivision, tribal government, or public university for intergovernmental transfer of the non-federal share funding. The second round will use the same protocol as the distribution in round 1 with any money remaining in the pool.

If any monies remain in Group 5 after monies have been distributed in rounds 1 and 2 (including monies made available after CMS finalizes the DSH allotment), AHCCCS may issue additional rounds of funding to hospitals which qualified for funding in Groups 1, 1A, 2, 2A, or 4 which have not exceeded their OBRA limit, and which has an agreement with a political subdivision, tribal government, or public university for intergovernmental transfer of the non-federal share funding or a certificate of public expenditure.

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.

All excess IGA funds not used for Group 5 DSH distributions, due to application of the above limits, will be returned to the originating political subdivisions, tribal governments or public universities and will not be retained by AHCCCS for other uses.

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

Aggregate Limits

IMD Limit

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

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

Overall Total Limit

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

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 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 as well as supporting hospital financial reports, as necessary.

The method of extracting and compiling the data from the hospital's financial records shall conform to the instructions for the Form CMS 2552-10. All other non-Medicare Cost Report data and documentation as described on the PFIS cover sheet will be required by such hospitals. EXHIBIT 1 to ATTACHMENT C

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

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

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

The steps to computing the governmentally-operated hospital's OBRA limit are³:

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

state plan year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must 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.

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

The Medicaid Shortfall

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

1. The number of Medicaid fee for service (FFS) inpatient hospital days for each inpatient routine service cost center on the cost report
2. The number of Medicaid managed care inpatient hospital days for each inpatient routine service cost center on the cost report
3. The Medicaid inpatient and outpatient hospital FFS charges 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 Medicaid shortfall will be calculated for each hospital for each fiscal/CMS Report year that encompasses the state plan year. The resulting Medicaid shortfall for each fiscal/CMS Report year will be prorated to derive the state plan year Medicaid shortfall according to the discussion entitled “Data on a State Plan Year Basis”.

The per diem amounts will be calculated by dividing:

- The individual amounts on Worksheet B, Part I Column 24 Lines (and where applicable Subscript Lines) 30 to 35 and Lines 40 to 43
- By
- The corresponding day totals on Line (and where applicable Subscript Line) 1,

Lines 8 through 13 and Lines 16 to 18 (for inpatient hospital subproviders) from Worksheet S-3, Part I, Column 8.

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

The ancillary RCCs will be calculated by dividing:

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

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

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

Uninsured Costs

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

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

guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (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 payor 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 hospital's fiscal/CMS Report years that encompass the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services. The information collected shall:
 - a. Include payments received during the hospital's fiscal/CMS Report years that encompass the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,
 - b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

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

1. The governmentally-operated hospital specific uninsured inpatient and outpatient cost data,
2. The payments made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services, and
3. The uninsured inpatient and outpatient cost.
4. Adjustments to the calculated uninsured inpatient and 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.

EXHIBIT 2 to ATTACHMENT C

AHCCCS

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

Arizona State Hospital (ASH), a governmentally-operated hospital that is an all-inclusive rate provider under Medicare, shall compute, report and certify its OBRA limit as prescribed by this Exhibit. Because ASH only provides inpatient services, the OBRA limit will be 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 the PMMIS system and other agency financial reporting systems to assist ASH in completing required schedules. The information to be provided by AHCCCS will include, but not be limited to:

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

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

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

The inpatient per diem amount will be found by dividing the amounts 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 76 and Lines 90 to 93 (but excluding Subscript Lines 88 to 89) taken from Worksheet

B Part 1 Column 24 dividing the amount determined in step 1 above by the amount determined in step 3 below

2. Summing Line 1 and 28 from Worksheet S-3, Part I, Column 8

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

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

Uninsured Costs

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

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

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (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 each fiscal/CMS Report year that encompasses the state plan year. The resulting uninsured costs for each fiscal/CMS Report year will be prorated to derive the state plan year uninsured costs according to the discussion entitled “Data on a state Plan Year Basis”.

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

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

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

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

EXHIBIT 3 to ATTACHMENT C

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). For SPY 2011, SPY 2012, SPY 2013, SPY 2014, and SPY 2015 the funding will be allocated among six pools (pools 1, 1A, 2, 2A, 4, and 5).

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

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

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

- For SPY 2008, the funding for pools 1, 2, 1A, and 2A and 3 will be \$26,147,700.
- For SPY 2009, the funding for pools 1, 2, 1A, and 2A and 3 will be \$26,147,700.
- For SPY 2010, the funding for pools 1, 2, 1A, and 2A and 3 will be \$500,000.
- For SPY 2011, the funding for pools 1, 2, 1A, and 2A will be \$9,284,800.
- For SPY 2012, the funding for pools 1, 2, 1A, and 2A will be \$9,284,800.
- For SPY 2013, the funding for pools 1, 2, 1A, and 2A will be \$9,284,800.
- For SPY 2014, the funding for pools 1, 2, 1A, and 2A will be \$9,284,800.
- For SPY 2015, the funding for pools 1, 2, 1A, and 2A will be \$9,284,800.

Pool 4 – Governmentally-operated hospitals

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

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

- For SPY 2015, the funding for pool 4 is \$134,420,400.

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

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

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

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

For SPY 2013, funding will be reallocated first to pools 1, 1A, 2, and 2A should the state

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

For SPY 2014, funding will be reallocated first to pools 1, 1A, 2, and 2A should the State make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2014 pool allocation. For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2014 relative weights as described in the "Determination of Payment Amounts" section of this Attachment C. SPY 2014 payments made from reallocated funds will be added to the hospital's original SPY 2014 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2014, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, and 5 until September 30, 2016. A determination will be made by June 30, 2016, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

For SPY 2015, funding will be reallocated first to pools 1, 1A, 2, and 2A should the State make available matching funds. This reallocation to the pools will be based proportionately on the SPY 2015 pool allocation. For each pool, the distribution of the reallocated DSH funding to the hospitals within the pool will be based on each hospital's 2015 relative weights as described in the "Determination of Payment Amounts" section of this Attachment C. SPY 2015 payments made from reallocated funds will be added to the hospital's original SPY 2015 payments with the total SPY payments subject to each hospital's OBRA limit. For SPY 2015, any excess DSH funding in pool 4 not allocated due to OBRA limits may be reallocated to DSH pools 1, 1A, 2, 2A, and 5 until September 30, 2017. A determination will be made by June 30, 2017, by the Administration if any reallocation will occur. AHCCCS shall notify CMS prior to the distribution of any pool 4 reallocated DSH funds.

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

Pool 5 – Voluntary Intergovernmental Agreements

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

- For SPY 2010, the funding for pool 5 is \$26,000,000
- For SPY 2011, the funding for Pool 5 is \$16,000,000.
- For SPY 2012, the funding for Pool 5 is \$25,000,000 + \$2,404,156.73 reallocated from Pool 4 = \$27,404,156.73.
- For SPY 2013, the funding for Pool 5 is \$ is \$34,178,795.
- For SPY 2014, the funding for Pool 5 is the FY 2014 Arizona DSH allotment total computable amount minus \$127,637,400.
- For SPY 2015, the funding for Pool 5 is the FY 2015 Arizona DSH allotment total computable amount minus \$143,705,200.

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

[To Be Placed on Public Hospital Letter Head]

State Plan Year _____

Initial

Final

**CERTIFICATION STATEMENT
DISPROPORTIONATE SHARE HOSPITAL PAYMENT**

As the [insert title] of Maricopa Medical Center, I certify that:

- Maricopa Medical Center has expended local funds in an amount equal to the OBRA Limit(s) indicated below.
- The local funds were not obligated to match other federal funds for any federal program and these funds are not federal funds.
- The attached Maricopa Medical Center OBRA Limit and CPE Schedule is true, accurate and complete to the best of my knowledge and belief and the information presented thereon is either identified and supported in the Hospital's accounting system, has been supplied to me by AHCCCS, or is supported by the attached documentation. I understand that the information presented on the Schedule is subject to audit.
- Maricopa Medical Center and I understand that the Disproportionate Share Hospital Payment received by the hospital will be from Federal funds, that any overpayment of those funds to the hospital will be recovered by AHCCCS, and that any falsification or concealment of a material fact made to receive payment of those funds may be prosecuted under Federal and/or state laws.

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

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

Signature of CEO or CFO

Printed Name

Title

Date

[To Be Placed on Public Hospital Letter Head]

State Plan Year _____

- Initial
- Final

**CERTIFICATION STATEMENT
DISPROPORTIONATE SHARE HOSPITAL PAYMENT**

As the [insert title] of Arizona State Hospital, I certify that:

- Arizona state Hospital has expended state funds in an amount equal to the OBRA Limit(s) indicated below.
- The state funds were not obligated to match other federal funds for any federal program and these funds are not federal funds.
- The attached Arizona State Hospital OBRA Limit and CPE Schedule is true, accurate and complete to the best of my knowledge and belief and the information presented thereon is either identified and supported in the Hospital's accounting system, has been supplied to me by AHCCCS, or is supported by the attached documentation. I understand that the information presented on the Schedule is subject to audit.
- Arizona State Hospital and I understand that the Disproportionate Share Hospital Payment received by the hospital will be from Federal funds, that any overpayment of those funds to the hospital will be recovered by AHCCCS, and that any falsification or concealment of a material fact made to receive payment of those funds may be prosecuted under Federal and/or state laws.

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

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

Signature of CEO or CFO

Printed Name

Title

Date

Attachment D
Reimbursement for Critical Access Hospitals

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

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

- (1) Gather all adjudicated claims/encounters with dates of service from July 1 through June 30 of the prior year for each CAH-designated hospital.
- (2) Sum the AHCCCS payments for inpatient and outpatient services for the year to establish a hospital-specific hospital paid amount.
- (3) Total all AHCCCS payments for inpatient and outpatient services for the year to establish a total paid amount.
- (4) Divide the hospital paid amount by the total paid amount to establish the hospital's utilization percentage.
- (5) Divide the annual CAH appropriation by twelve to get the monthly CAH allocation.
- (6) Multiply each hospital's monthly relative utilization by the monthly CAH allocation to establish each hospital's monthly payment.

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

Attachment E

Safety Net Care Pool Claiming Protocol

In accordance with the special terms and conditions (STC) Section VI, this Attachment E serves as the claiming protocol for Arizona's Safety Net Care Pool (SNCP) for Phoenix Children's Hospital (PCH). The protocol provides for the computation of the uncompensated care cost limit for Phoenix Children's Hospital through December 31, 2017. For each demonstration Year (DY), aggregate uncompensated care payments will be a distribution of the SNCP pool established in Section VI for each DY, and payments to each individual provider cannot exceed the uncompensated care cost limit as determined by this cost claiming protocol for each DY.

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

Under no circumstances will total SNCP payments to PCH (eligible to receive payment for uncompensated care costs incurred through December 31, 2017) exceed the provider's uncompensated costs, as described in paragraph 32 and in this Attachment E.

Hospital Inpatient and Outpatient Uncompensated Care Costs

To be eligible for federal financial participation (FFP), SNCP uncompensated care payments to PCH cannot exceed the uncompensated care costs as computed by the following steps:

Interim Computation of Uncompensated Care Costs

SNCP uncompensated care payments to PCH are limited to uncompensated care costs incurred on or before December 31, 2017. Each DY's SNCP will be distributed based on the provider's projected uncompensated care subject to the PCH Limit described in STC paragraph 32(c), to the extent that sufficient local matching funds are available. This interim computation of uncompensated care costs will be used as the basis for SNCP distribution and will also serve as the uncompensated care cost limit for SNCP payments made to the provider in each demonstration year.

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

Column 24, Lines (and where applicable subscripted lines) 30-43 of CMS 2552-10

by-

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

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

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

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

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

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

For each hospital ancillary cost center, the RCC computed in Step #2 is applied to the

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

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

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

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

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

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

Interim Reconciliation

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

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

A hospital's uncompensated care cost limit is determined for the twelve month period in each DY. Where a hospital's cost reporting period does not coincide with the DY (or partial DY or calendar year if the limits in paragraph 32(c) are stated for a partial DY or a calendar year), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY) based on the number of cost reporting months that overlap with the DY (or partial DY). This is consistent with the methodology for the computation of the OBRA 93 hospital-specific limit for a given DSH State plan rate year.

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

Final Reconciliation

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

The final reconciliation follows the same computation as outlined above in the Interim Computation of Uncompensated Care Costs steps, except that the per diems and RCCs, Medicaid and uninsured days and charges, and payment offset amounts used will pertain to the actual service period (rather than the prior period). Per diems and RCCS will be derived from the audited cost report, and Medicaid and uninsured days, charges and payments will be

updated with the latest available auditable data for the service period. No trending factor will be applied. The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens. The state must ensure that there is no duplication of payments for the same hospital uncompensated care costs under the SNCP and under DSH; SNCP payments must be accounted for in the hospital's OBRA 93 hospital-specific limit.

A hospital's uncompensated care cost limit is determined for the twelve month period in each DY. Where a hospital's cost reporting period does not coincide with the DY (or partial DY or calendar year if the limits in paragraph 27(c) are stated for a partial DY or a calendar year), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY or calendar year) based on the number of cost reporting months that overlap with the DY (or partial DY or calendar year). This is consistent with the methodology for the computation of the OBRA 93 hospital-specific limit for a given DSH State Plan Rate Year.

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

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

Physician Professional Service Uncompensated Care Costs

To be eligible for Federal financial participation (FFP), SNCP uncompensated care payments to each provider cannot exceed the uncompensated care costs as computed by the following steps. The eligible provider is Phoenix Children Hospital, which employs and contracts for physician services and incurs physician professional service costs (whether the professional services are billed by the hospital or by the physicians).

Interim Computation of Uncompensated Care Costs

SNCP uncompensated care payments to PCH are limited to uncompensated care costs incurred on or before December 31, 2017. Each DY's SNCP will be distributed based on the provider's projected uncompensated care subject to the PCH limit as described in STC paragraph 32(c), to the extent that sufficient local matching funds are available. This interim computation of uncompensated care costs will be used as the basis for SNCP distribution and will also serve as the uncompensated care cost limit for SNCP payments made to the provider in each demonstration year.

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

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

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

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

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

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

- the practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medicaid separate from PCH services;
- for all non physician practitioners there must be an identifiable and auditable data source by practitioner type;
- a CMS-approved time study must be employed to allocate practitioner

- compensation between clinical and non-clinical costs; and
- the clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with Medicare cost principles and offset of applicable non-patient care revenues that were not previously offset or accounted for by the application of CMS-approved time study.

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

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

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

1. These costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician professional services;
2. They are directly identified on ws A-8 as adjustments to hospital costs;
3. They are otherwise allowable and auditable provider costs; and
4. They are further adjusted for any non-patient-care activities such as research based on physician time studies.

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

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

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

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

furnished during the period defined by paragraph a of subsection 1.

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

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

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

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

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

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

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

Interim Reconciliation

Each hospital's uncompensated care costs must be recomputed based on the as-filed cost report for the actual service period. The hospital cost report is filed with the Medicare

contractor five months after the close of the cost reporting period. SNCP uncompensated care payments made to the hospital for a DY cannot exceed the recomputed uncompensated care cost limit. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual hospital's uncompensated care cost limit, the overpayment will be recouped, and the federal share will be properly credited to the federal government.

The interim reconciliation follows the same computation as outlined above in the Interim Computation of Uncompensated Care Costs steps, except that the RCCs, Medicaid and uninsured charges, payment offset amounts and any other relevant statistics such as time study or time study proxy data used will pertain to the actual service period (rather than the prior period).

RCCs will be derived from the as-filed cost report; and Medicaid and uninsured charges and payments will be derived from the latest available auditable data for the service period. No trending factor will be applied. The uncompensated care costs must again be adjusted to remove costs related to non-emergency services furnished to unqualified aliens.

A hospital's uncompensated care cost limit is determined for the twelve month period in each DY. Where a hospital's cost reporting period does not coincide with the DY (or partial DY or calendar year if the limits in paragraph 32(c) are stated for a partial DY or a calendar year), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY or calendar year) based on the number of cost reporting months that overlap with the DY (or partial DY or calendar year).

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

Final Reconciliation

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

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

A hospital's uncompensated care cost limit is determined for the twelve month period in each DY. Where a hospital's cost reporting period does not coincide with the DY (or partial DY or calendar year if the limits in paragraph 27(c) are stated for a partial DY or calendar year), the uncompensated care costs computed for a cost reporting period can be allocated to the DY (or partial DY or calendar year) based on the number of cost reporting months that overlap with the DY (or partial DY or calendar year).

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

Attachment F
IHS and 638 Facilities Uncompensated Care Payment Methodology

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

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

Historical Data Methodology

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

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

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

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

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

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

Monthly Payment Calculation – Services

Adult Per Member Per Month Service	\$15.11
Total Number of AI/AN Adults Enrolled with AHCCCS	56,851
May Services Payment	\$859,018.61
Total May Payment to I.H.S and 638 Facilities (Eligibility + Services)	\$3,920,484.61
Facility A - Allocation - 1%	\$39,204.85
Facility B - Allocation - 5%	\$196,024.23

Attachment G
AHCCCS CARE Operational Protocol

Attachment H

Targeted Investments Program DSHP Claiming Protocol

DSHP Claiming Protocol

1. State Documentation of DSHP Expenditures.

Documentation made available by the State for CMS review for quarterly DSHP expenditures will include the agency, program, provider(s), payment amount(s), and relevant provider costs as described below.

2. Offsets.

In accordance with the STC, DSHP expenditures submitted to CMS will not include:

- a. Grant funding to test new models of care
- b. Construction costs (bricks and mortar)
- c. Room and board expenditures
- d. Animal shelters and animal vaccines
- e. School based programs for children
- f. Unspecified projects
- g. Debt relief and restructuring
- h. Costs to close facilities
- i. HIT/HIE expenditures
- j. Services provided to undocumented individuals
- k. Sheltered workshops
- l. Research expenditures
- m. Rent and/or Utility Subsidies that are normally funded by the United States Department of Housing and Urban Development and United States Department of Agriculture (USDA) or other state/local rental assistance programs
- n. Prisons, correctional facilities, services for incarcerated individuals and services provided to individuals who are civilly committed and unable to leave
- o. Revolving capital fund
- p. Expenditures made to meet a maintenance of effort requirement for any federal grant program
- q. Administrative costs
- r. Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans)
- s. Cost of services for which payment was made by Medicare or Medicare Advantage
- t. Funds from other federal grants
- u. Needle-exchange programs
- v. Abortions that would not be allowable if furnished under Medicaid or CHIP
- w. Costs associated with funding federal matching requirements.

To ensure DSHP expenditures do not include costs associated with providing coverage of non-emergency services to undocumented immigrants, the State will reduce actual expenditures by the proportion of the AHCCCS population enrolled in the Emergency Services Program (ESP), which is 6.3%. This adjustment is the undocumented immigrant

offset.

3. Financial Data Reporting.

The Arizona Financial Information System (AFIS) is the accounting system of record for the state of Arizona. Payment voucher information is entered into AFIS by AHCCCS and ADES. All payments made by the state are processed in AFIS. AFIS expenditure data is the basis for identifying the total DSHP expenditure, prior to applying offsets.

For DSHP services to individuals with Serious Mental Illness, AHCCCS' total reportable DSHP expenditures start with the amounts AHCCCS paid the Regional Behavioral Health Authorities (RBHAs) as reported in AFIS. RBHAs provide quarterly financial reports to AHCCCS that identify specific, actual expenditures. These reports are the basis for identifying and calculating offsets as discussed below to reduce the total reportable DSHP expenditures.

For early intervention developmentally disabled DSHP services, ADES' total reportable DSHP expenditures start with the amount of ADES paid to its contracted providers as reported in AFIS. ADES will identify and calculate offsets as discussed below to reduce the total reportable DSHP expenditures.

4. Designated State Health Programs Detail

Services to Individuals with Serious Mental Illness

State Agency: AHCCCS
Program: Services to Individuals with Serious Mental Illness (SMI)
Funding Source: Intergovernmental Agreement (IGA) Funds provided by Maricopa County and Pima County.

Brief Description:

Two counties in Arizona provide funds to AHCCCS via Intergovernmental Agreements (IGAs) to provide services to non-Medicaid individuals with Serious Mental Illness (SMI). AHCCCS contracts with managed care organizations called Regional Behavioral Health Authorities (RBHAs), who contract with providers for case management, peer support and planning, community based supports, medication management services, and other medical services. Funding flows from the counties, to AHCCCS, to RBHAs, and then to providers.

Eligible Population:

The program serves individuals who request behavioral health services, are determined eligible to receive SMI services, and are determined not eligible for Medicaid/CHIP.

An individual is determined eligible to receive SMI services if they have a qualifying SMI diagnosis and functional impairment caused by the diagnosis. Qualifying diagnoses include anxiety, bipolar, major depression, obsessive-compulsive, dissociative, personality, psychotic, and post-traumatic stress disorders. Functional impairment means long-term dysfunction in one of the following domains: (1) inability to live in an independent or

family setting without supervision, (2) risk of serious harm to self or others, (3) dysfunction in role performance, or (4) risk of deterioration. Individuals are evaluated for SMI eligibility by a clinician and receive an initial SMI evaluation and a final SMI eligibility determination.

When an individual requests to receive behavioral health services they are also required to participate in a preliminary financial screening and eligibility process to identify third party payers and determine if they are eligible for Medicaid/CHIP, including submission of an application and completion of the eligibility determination process. If an individual receives an SMI determination, but does not qualify for Medicaid/CHIP, they are eligible to receive services under this program. An individual does not qualify for Medicaid/CHIP if they have household income or assets in excess of the following thresholds, do not meet residency requirements, and/or do not otherwise qualify for categorical eligibility:

Eligibility Criteria:	Income <	Assets >
Children	200% FPL	-
Adults	133% FPL	-
Pregnant Women	156% FPL	-
Long-Term Care	300% FBR	\$2,000
SSI CASH	100% FBR	\$2,000
SSI MAO	100% FPL	-

Funding:

Services provided to non-Title XIX individuals with SMI may be funded by the County IGAs, Mental Health Block Grant, Substance Abuse Block Grant, or State General Fund.

This DSHP reflects only the County IGAs, and so excludes other federal and state sources of funding. Two Arizona counties (Maricopa and Pima) provide approximately \$60 million annually for this state-only program. Funding and associated expenditures are contained within AHCCCS. The counties provide funding to AHCCCS on a monthly basis in accordance with IGAs. These County IGA funds do not serve to meet any maintenance of effort requirement or federal matching requirement for any federal program.

No copayments or fees are charged to this population and so patient payments do not offset the cost of providing services or provide revenue for the program.

In some cases, individuals not eligible for Medicaid/CHIP may have third-party coverage that covers all or a portion of behavioral health services. RBHAs and behavioral health providers are required to determine third party health insurance coverage prior to providing services under this program and are responsible for cost avoiding by coordinating benefits. If third-party liability is identified after services have been provided, RBHAs and providers are responsible for post-payment recovery. All expenditures reported for this program are net of any TPL revenue that is collected.

Eligible Providers:

The State makes monthly installment payments based on the annual contract amount to RBHAs under existing non-Medicaid services contracts. RBHAs contract with behavioral health providers, who provide direct services. On a quarterly basis, RBHAs report back to AHCCCS on the actual services provided in the form of RBHA financial statements. AHCCCS' monthly payments to the RBHAs are reconciled to actual RBHA expenditures.

Documentation and Claiming Process:

Step 1 AHCCCS Division of Business and Finance (DBF) identifies actual expenditures of County IGA funds to RBHAs based on appropriation, fund, and sub-fund account codes as recorded in AFIS. This methodology excludes all federal funds and State General Fund expenditures. The identified amount is the initial, unadjusted DSHP expenditure, which reflects costs incurred by AHCCCS in making payments to the RBHAs specifically for the County IGA program.

Step 2 On a quarterly basis, each RBHA submits a Statement of Activities that reports expenses by funding source, including the County IGA program. AHCCCS Division of Health Care Management (DHCM) reviews the quarterly RBHA financial statements for the period and identifies IGA funds paid to the RBHAs that were not used to provide SMI services and/or were used to provide services that are not permissible as DSHP expenditures, per Section 2. The DSHP expenditure is reduced by these amounts.

The following expenditures are excluded because they are not for SMI services:

- General Mental Health and Substance Abuse Services to non-SMI Adults
- Children's Services to Remanded Juveniles
- Central City Addiction Recovery Center (CCARC) Services

The following expenditures are excluded because they are not DSHP eligible:

- Room and Board Services
- Services provided to residents of an Institution for Mental Diseases (IMD)
- Medicare Part D Prescription Drug Costs
- RBHA Administrative Costs

Step 3 AHCCCS DBF applies the 6.3% undocumented immigrant offset on the DSHP expenditure adjusted by Step 2. The DSHP expenditure is reduced by this amount.

Step 4 AHCCCS prepares a summary schedule that identifies the initial, unadjusted DSHP expenditure in AFIS (Step 1), shows the reductions for funds paid to RBHAs that were not used to provide SMI services and/or were used to

provide services that are not permissible as DSHP expenditures (Step 2), and shows the 6.3% undocumented immigrant offset (Step 3). The final amount is the adjusted, eligible DSHP payment. An example summary schedule is attached.

- Step 5 The State submits a claim to CMS for FFP based on the total computable expenditure incurred by the State in making the eligible DSHP payment.
- Step 6 The State attests expenditures used are correct and verifiable as DSHP allowable.

Process occurs quarterly based on quarterly financial reporting.

Reductions/Offsets for Non-Matchable Expenditure List:

The reportable DSHP expenditures incurred by AHCCCS as reported in AFIS are evaluated for the non-matchable expenditures listed in Section 2 and in the AHCCCS STCs.

Any DSHP expenditures reported from AFIS already exclude expenditures that are funded by federal grants or federal financial participation and other non-state, non-local government funding or revenue sources.

Expenditures for this program are not utilized to meet the state maintenance of effort requirements for the Mental Health Block Grant and Substance Abuse Block Grant, and so do not need to be reduced or offset for this purpose.

The following DSHP ineligible expenditures are offsets/reductions that apply to this program.

- Room and Board Services
- Services provided to residents of an Institution for Mental Diseases (IMD)
- Medicare Part D Prescription Drug Costs
- RBHA Administrative Costs

These are expenditures for services that are not Medicaid-like or for non-medical services. Finally, actual expenditures are reduced by the undocumented immigrant offset amount to exclude costs associated with non-emergency services provided to undocumented immigrants.

Developmentally Disabled Services

State Agency: Arizona Department of Economic Security (ADES)
Program: Division of Developmental Disabilities (DDD)
Funding Source: State General Fund Appropriation

Brief Description:

The Arizona Department of Economic Security (ADES) Division of Developmental Disabilities (DDD) provides state-only early intervention and home and community based services to individuals who are not eligible for Medicaid. Annual funding of approximately \$16.8 million is provided by a state general fund appropriation. DDD directly contracts with independent providers for early intervention services, day treatment, habilitation, residential group homes, occupational therapy, physical therapy, and speech therapy.

Eligible Population:

The target population is primarily children, specifically the early intervention population aged 0 to 3 with, or at risk of, developmental delays. Developmental delays are based on diagnostic criteria in the areas of physical, cognitive, language/communication, social/emotional, and adaptive self-help childhood development. Individuals must be ineligible for Medicaid in order to receive state-only services. Children are ineligible for Medicaid primarily due to household income or assets in excess of established limits. Some individuals may have other insurance, in which cases state-only funding may function as the payer of last resort.

Funding:

The source of non-federal revenue is an annual state general fund appropriation. DDD exchanges a file with AHCCCS to identify individuals who are Medicaid-eligible and for whom Medicaid should pay for services, and providers must bill Medicaid first. For individuals with third party coverage, providers must bill insurance first and DDD requires documentation of the denial of those claims in order to process a state-only payment. All expenditures for this program are net of costs that were avoided or revenues recovered.

IDEA Part C is not a funding source for this program. However, ADES DDD reports these state-only expenditures to the Arizona Department of Education in order to demonstrate compliance with state Maintenance of Effort requirements for IDEA Part C.

Eligible Providers:

ADES DDD contracts with independent providers for early intervention services, day treatment, habilitation, residential group homes, occupational therapy, physical therapy, and speech therapy.

Documentation and Claiming Process:

Step 1 ADES submits data summary table to AHCCCS that identifies actual expenditures based on appropriation, fund, and sub-fund account codes as recorded in AFIS. This amount is the initial, unadjusted DSHP expenditure. These identified expenditures are expenditures incurred by ADES in making medical service payments to contracted providers for the DDD program.

- Step 2 ADES submits data summary table to AHCCCS that identifies actual expenditures based on service category to AHCCCS, including identification of the amount of expenditures for Room and Board services. The DSHP expenditure is reduced by this amount.
- Step 3 ADES submits data summary table to AHCCCS that identifies state expenditures reported as Maintenance of Effort (MOE) for the IDEA Part C federal grant. The DSHP expenditure is reduced by this amount. MOE is calculated once annually and offset is applied in a single quarter.
- Step 4 AHCCCS applies the 6.3% undocumented immigrant offset on the DSHP expenditure as adjusted by Step 2 and Step 3. The DSHP expenditure is reduced by this amount.
- Step 5 AHCCCS prepares a summary schedule that identifies the initial, unadjusted DSHP expenditure in AFIS (Step 1), shows the reduction for Room and Board expenditures (Step 2), shows the reduction for IDEA Part C MOE (Step 3), and shows the 6.3% undocumented immigrant offset (Step 4). The final amount is the adjusted, eligible DSHP payment.
- Step 6 The State submits a claim to CMS for FFP based on the total computable expenditure incurred by the State in making the eligible DSHP payment.
- Step 7 The State attests expenditures used are correct and verifiable as DSHP allowable.

Reductions/Offsets for Non-Matchable Expenditure List:

Any DSHP expenditures reported from AFIS already exclude expenditures that are funded by federal grants or federal financial participation and other non-state, non-local government funding or revenue sources.

Actual expenditures are reduced by Room and Board expenditures. These are the only expenditures for services that are not Medicaid-like. The expenditures reported in AFIS do not include any payments made by ADES for non-medical services.

Actual expenditures are reduced by the expenditures reported as MOE for the IDEA Part C grant program. Process occurs quarterly and IDEA Part C MOE offset is calculated annually and applied to a single quarter.

Finally, actual expenditures are reduced by the undocumented immigrant offset amount to exclude costs associated with services provided to undocumented immigrants.

Attachment J
Monitoring Protocol