SPECIAL TERMS AND CONDITIONS
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

(AHCCCS) MEDICAID SECTION 1115 DEMONSTRATION

NUMBER: 11-W00275/9
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

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AHCCCS proposes the following amendments to the current Special Terms and Conditions:

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VI. Funding Pools and Payments under the Demonstration.

26. **Safety Net Care Pool (SNCP).** Payments from this pool will assist hospitals and other eligible providers that have high levels of uncompensated care related to medical assistance provided to Medicaid eligibles or to individuals who have no source of third party coverage. In each Demonstration Year (DY), the annual SNCP will be distributed to each provider based on its proportionate share of projected uncompensated care (based on prior period data). Furthermore, payments to each provider in each DY will be subject to a limit computed based on the provider's uncompensated care costs incurred for a 12- month period covered by the DY, except in DY 3 where the limit will be computed based on uncompensated care costs incurred up to December 31, 2013. The total computable amount for the SNCP ~~is $332 million per DY~~ for eligible uncompensated care costs of each group of eligible providers identified in ~~sections A through C of~~ Attachment J ~~(Safety Net Hospital Systems), and $385 million per DY beginning with DY 2 for eligible uncompensated care costs of providers identified in section D of Attachment J (City of Phoenix Hospitals). Any unspent cap amount cannot be transferred to the following DY in order to increase~~is:

- $332 million per DY for Safety Net Hospital Systems (identified in sections A through D of Attachment J),
- beginning with DY 2,
    - $385 million per DY for City of Phoenix Hospitals (Section E of Attachment J),
    - $97 million per DY for City of Mesa Hospitals (Section F of Attachment J), and
    - $135 million per DY for City of Tucson Hospitals (Section G of

Attachment J).
- $16 million per DY for City of Casa Grande Hospitals (Section H of Attachment J).
- $3 million per DY for City of Globe Hospitals (Section I of Attachment J).

Any unspent cap amount cannot be transferred to the following DY in order to increase the annual cap amount.

a) **SNCP Payments.** Funds may be used to assist providers 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 hospitals, clinics, or by other provider types, as agreed upon by CMS and the State and identified in Attachment J. Expenditures must be claimed in accordance with CMS-approved claiming protocols in Attachment I for each provider type. FFP claiming for payments made from the SNCP will begin upon CMS approval of the claiming protocol as identified in sub- paragraph (c). 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 the eligible providers as defined in subparagraph (d), who 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.** The aggregate amount of SNCP payments made to ~~Safety Net Hospital Systems~~ eligible hospitals and their affiliated providers ~~pursuant to sections A through C of Attachment J~~ will not exceed the ~~SNCP amount of~~ following:

- $332 million per DY for Safety Net Hospital Systems (the "Safety Net Hospital System Limit~~"). The aggregate amount of SNCP payments made to the~~")
- $385 million per DY for City of Phoenix High Uncompensated Care Hospitals ~~and their affiliated providers pursuant to section D of Attachment J will not exceed the amount of $385 million per DY~~ (the "Phoenix Hospital Limit~~").~~ ")
- $97 million per DY for City of Mesa High Uncompensated Care Hospitals (the "Mesa Hospital Limit").
- $135 million per DY for City of Tucson High Uncompensated Care Hospitals (the "Tucson Hospital Limit").
- $ 16 million per DY for City of Casa Grande High Uncompensated Care Hospitals (the "Casa Grande Hospital Limit").
- $3 million per DY for City of Globe High Uncompensated Care Hospitals (the

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"Globe Hospital Limit").

The annual 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 period.

The State must submit to CMS for approval and incorporation into Attachment I a claiming protocol for each provider type to provide for the computation of a ~~provider's~~provider's uncompensated care costs. No FFP is available for SNCP payments until the associated claiming protocol is approved by CMS. Such protocols must take into consideration:

i. The cost reporting tool (i.e., the CMS-2552 cost report for hospital providers, and other cost reports for non-hospital providers as approved by CMS) to be used to determine a provider's allowable patient care costs, consistent with Medicare cost principles and OMB Circular A-87, for a specific service period.

ii. A methodology to apportion allowable patient care costs to Section 1905(a) services furnished to Medicaid eligible and uninsured individuals.

iii. An offset of all payments received for the services furnished to Medicaid eligible and uninsured individuals, including all Medicaid payments, third party payments, and payments by or on behalf of the patients, to arrive at the provider's uncompensated care cost.

iv. A carve-out of costs associated with non-emergency services provided to non-qualified aliens, which is a prohibited use of SNCP funds.

v. A payment methodology to allow the State to distribute SNCP payments to providers based on projected uncompensated care costs.

vi. Reconciliations of payments to the provider's uncompensated care cost limits as computed based on the provider's as-filed and finalized cost reports for the actual service period.

The uncompensated care cost limit is computed and SNCP payments are made on a DY basis. To the extent that a provider's cost reporting period does not coincide with the DY, the cost protocol will provide for an allocation of uncompensated care costs to the DY.

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.** The eligible providers for SNCP payments are those identified in Attachment J. The State must seek prior approval from CMS to amend the list of eligible providers. The State must also submit to CMS for review and approval any additional claiming protocol needed due to the expansion of the eligible provider

list.

The State will consider providers which meet the following criteria for SNCP participation:

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

ii. Rural Hospitals which are defined as (a) Arizona hospitals that are not in Pima or Maricopa Counties; or (b) Arizona hospitals that are in counties of 500,000 or fewer persons.

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

iv. Hospitals that qualify for a disproportionate share hospitals (DSH) payment as outlined in Attachment D.

v. City of Phoenix High Uncompensated Care Hospitals which are certain acute care hospitals located within the City of Phoenix as identified in Attachment J.

vi. ~~vi.~~ City of Mesa High Uncompensated Care Hospitals which are certain acute care hospitals located within the City of Mesa as identified in Attachment J.

vii. City of Tucson High Uncompensated Care Hospitals which are certain acute care hospitals located within the City of Tucson as identified in Attachment J.

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viii. City of Casa Grande High Uncompensated Care Hospitals which are certain acute care hospitals located within the City of Casa Grande as identified in Attachment J.

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~~vi.~~ix. City of Globe High Uncompensated Care Hospitals which are certain acute care hospitals located within the City of Globe as identified in Attachment J.

~~vii.~~x. Any provider affiliated with the hospitals outlined in the above subparagraphs (i-ix~~v~~).

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 will be funded by IGTs by eligible governmental entities, which may include IGTs derived from permissible provider taxes levied by a local government. The State will submit to CMS for review and approval all IGT agreements to ensure compliance with Section1903(w)(6)(A) of the Act and Part X of these STCs. Such agreements should specify the amount and source of the IGT money, including funds to provide the non-federal share of expenditures for KidsCare II beneficiaries referenced in subparagraph (i) and AHCCCS coverage for adults referenced in subparagraph (j). 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 reconciliation payments;

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.

h) **SNCP Designated State Health Program (DSHP**). In addition to ~~the $332 million~~ uncompensated care cost payments outlined above, the State may claim FFP for the Trauma and Emergency Services Fund Payments as authorized by Arizona State Proposition 202 for DY 1 and DY 2. The total program amount eligible for FFP cannot exceed $20 million total computable per DY, and expenditures must be claimed in accordance with a CMS-approved claiming protocol. Claiming of FFP cannot begin until the protocol is approved by CMS and incorporated into Attachment I. Any unspent funds cannot be transferred to the following DY in order to increase the annual amount.

i) **Contribution to the KidsCare II Program.** The eligible governmental entities

in subparagraph (f) funding the non-federal share of SNCP payments to Safety Net Hospital Systems identified in sections A through ~~D~~C of Attachment J will provide IGTs to fund the non-federal share of KidsCare II Program expenditures for 21,700 children, estimated at up to $76,991,169 total computable. In addition, the eligible governmental entities in subparagraph (f) funding the non-federal share of SNCP payments to City of Phoenix providers identified in section ~~D~~E of Attachment J will provide IGTs to fund the non-federal share of KidsCare II Program expenditures for an additional 33,191 children estimated at up to $64,361,700 total computable.

j) **Contribution to AHCCCS Coverage Expansion for Certain Adults without Dependent Children**. The eligible governmental entities in subparagraph (f) funding the non-Federal share of SNCP payments to City of Phoenix providers will provide IGTs to fund the non-federal share of AHCCCS expenditures described in 17(b)(iii) for the projected 13,000 adults that will lose Medicaid eligibility under 1931 state plan authority due to lack of a dependent child, estimated at up to $43,063,000 total computable.

[RESERVE SPACE for language re contributions to coverage or other policy issues to be discussed.]

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Attachment I
Safety Net Care Pool Claiming Protocol

In accordance with the Special Terms and Conditions (STC) Section VI, this Attachment I serves as the claiming protocol for Arizona's Safety Net Care Pool (SNCP) uncompensated care payments. The protocol provides for the computation of the uncompensated care cost limit for each provider type that is authorized to receive uncompensated care payments in accordance with Section VI and identified in Attachment J. 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 reconciled 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.

~~If~~Except as described below, if a provider is eligible under both section A, B, ~~and/or~~ C and/or D ~~-~~(Safety Net Hospital Systems) and under section ~~D~~E (City of Phoenix Hospitals), Section G (City of Tucson Hospitals) or Section I (City of Globe Hospitals) of Attachment J, payments to the provider will first be credited against the Phoenix Hospital Limit, Tucson Hospital Limit or Globe Hospital Limit, as applicable, described in STC Paragraph ~~25~~26(c), and any remaining eligible uncompensated costs for that provider will be credited against the Safety Net Hospital System Limit described in STC Paragraph ~~25(c).~~26(c). To the extent payment is made to a provider eligible as a Safety Net Hospital System prior to approval of the Tucson or Globe Hospital payments, that payment amount will be credited against the Safety Net Hospital System Limit. Under no circumstances will total SNCP payments to any provider, including payments credited against the Phoenix Hospital Limit, Tucson Hospital Limit, Globe Hospital Limit and ~~the~~ Safety Net Hospital Limit as well as any disproportionate share hospital payments or other supplemental payments, exceed the provider's uncompensated costs, as described in STC Paragraph ~~25~~26(a) and in this Attachment I. In the instance that a provider first receives an allocation from the Phoenix Hospital Limit, Tucson Hospital Limit or Globe Hospital Limit pool, as applicable, the prior period uncompensated care cost data used as the allocation basis from the Safety Net Hospital System Limit pool will be that provider's prior period uncompensated care cost reduced by the Phoenix Hospital Limit, Tucson Hospital Limit or Globe Hospital Limit pool distribution already made to the provider.
~~provider's prior period uncompensated care cost reduced by the Phoenix Hospital Limit pool distribution already made to the provider.~~

Additionally, this Attachment also provides for the claiming protocol for Arizona Designated State Health Program (DSHP) approved for federal matching in accordance with STC Section VI.

Hospital Inpatient and Outpatient Uncompensated Care Costs

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

Interim Computation of Uncompensated Care Costs

SNCP uncompensated care payments will be made to eligible providers and claimed for FFP in quarterly installments per DY (beginning with DY 2 for City of Phoenix, City of Mesa, City of Tucson, City of Casa Grande and City of Globe hospitals). Each DY's SNCP will be distributed based on the provider's proportionate share of projected uncompensated care among all hospitals subject to the same Limit (either the Safety Net Hospital System Limit ~~or~~, the Phoenix Hospital Limit, the Mesa Hospital Limit, the Tucson Hospital Limit, the Casa Grande Hospital Limit or the Globe Hospital Limit), 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. For hospitals eligible pursuant to Section A, Section G, Section H or Section I of Attachment J, the most recent CMS 2552 filed the with hospital's Medicare contractor will be utilized. For hospitals eligible pursuant to Section ~~D~~ E or Section F of Attachment J, any 2552s that overlap the base state fiscal year will be prorated based on the overlapping dates and utilized. The base state fiscal year for such hospitals is 2010.

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
   - For hospitals eligible pursuant to Section A of Attachment J~~,~~ 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. For hospitals eligible pursuant to Section E~~D~~, Section F, Section G, Section H or Section I of Attachment J, the corresponding day totals on Lines (and where applicable subscripted lines) 38 through 47 from Worksheet D-1, Part II. The days from Worksheet D-1 should equal to the days reported on Worksheet S-3 for each routine cost center, except that the Adults & Pediatrics days are adjusted for inclusion of 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.
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- 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 any Phoenix High Uncompensated Care Hospital with a hospital-based inpatient facility located outside of Phoenix, the hospital's Medicaid and uninsured costs will be further adjusted to remove costs related to the non-Phoenix facility. For this purpose, the costs will be adjusted by an estimate of the percentage of costs related to the Phoenix facility. This percentage will be calculated as the ratio of Medicaid revenues of the Phoenix facility to total Medicaid revenues for the Phoenix and non-Phoenix facilities.

8. 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.

9. For hospitals eligible pursuant to Section A ~~of Attachment J~~ (Safety Net Hospital Systems~~),~~), Section G (City of Tucson Hospitals), Section H (City of Casa Grande Hospitals) or Section I (City of Globe Hospitals) of Attachment J, 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. For hospitals eligible pursuant to Section E~~D~~ or F of Attachment J (City of Phoenix Hospitals or City of Mesa Hospitals, respectively), the interim computation of hospital uncompensated care cost limit as described above uses cost reports that overlap the base state fiscal year of 2010.

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 (beginning with DY 2 for City of Phoenix, City of Mesa, City of Tucson, City of Casa Grande, and City of Globe hospitals eligible pursuant to Section E~~D~~, F, G, H and I respectively, of Attachment J), except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a hospital's cost reporting period does not coincide with the DY (or partial DY in DY3), 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 (beginning with DY 2 for City of Phoenix, City of Mesa, City of Tucson, City of Casa Grande, and City of Globe hospitals), except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a hospital's cost reporting period does not coincide with the DY (or partial DY in DY3), 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 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.

Federally Qualified Health Center Lookalike (FQHC-LA) Uncompensated Care Costs

To be eligible for Federal financial participation (FFP), SNCP uncompensated care payments to each individual FQHC-LA cannot exceed the uncompensated care cost limit as computed by the following steps:

Interim Computation of Uncompensated Care Costs

SNCP uncompensated care payments will be made to eligible providers and claimed for FFP in quarterly installments per DY. Each DY's SNCP will be distributed based on the provider's proportionate share of projected uncompensated care, 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 FQHC-LA's interim uncompensated care cost limit begins with the use of each clinic's most recently available average cost per visit used for Medicaid reimbursement, as computed under the FQHC Alternative Payment Methodology in the Arizona State plan Attachment 4.19-B.

   The average cost per visit is derived from FQHC-LA cost reports filed with AHCCCS. (The State plan provides that this average cost per visit is computed based on costs and

visits for two consecutive cost reporting periods.) The State must ensure that the FQHC- LA cost report accounts for only allowable costs related to FQHC health care services, including staff and other healthcare costs and allocable overhead; removes any costs related to non-FQHC services and any overhead allocable to non-reimbursable activities; allows only for costs that are consistent with Medicare and Medicaid cost principles and applicable OMB Circulars; and defines a visit consistent with the State plan definition of an FQHC visit.

2. The average cost per visit is multiplied by the number of uninsured visits pertaining to the most recently available cost reporting period. The number of uninsured FQHC-LA visits must be derived from auditable sources. The result is the facility's uninsured cost.

   Note that for interim computation of uncompensated care costs, Medicaid visits are not included, as these Medicaid visits are reimbursed at the average cost per visit being used to estimate current period actual cost per visit.

3. The uninsured costs computed in Step #2 will be offset by all revenues received by the FQHC-LA for the uninsured services, including but not limited to payments made by or on behalf of patients and any other payments received for uninsured services including applicable grants.

5. The average cost per visit has already been trended to the current period. However, the State can apply trending factors to account for known changes in uninsured utilization 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 FQHC-LA's uninsured costs must be further adjusted to remove costs related to non- emergency services furnished to unqualified aliens. For this purpose, the clinic's uncompensated care costs will be reduced by 12.88.

Interim Reconciliation

Each FQHC-LA's uncompensated care costs must be recomputed based on the actual as-filed cost report for the actual service period. The cost report is filed with AHCCCS covering the federal fiscal year (ending September 30) by April of the following year. SNCP uncompensated care payments made to the FQHC-LA 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 clinic's uncompensated care cost limit, the overpayment will be recouped from the clinic, 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 cost per visit is computed based on allowable FQHC-LA cost and total visits pertaining to the actual service period cost report.

- Both Medicaid visits and uninsured visits furnished during the service period are applied to the actual cost per visit to determine the clinic's Medicaid and uninsured costs. Medicaid and uninsured visits must be derived from auditable sources, including the State's PMMIS, managed care encounter data, and provider patient accounting records.
- Both Medicaid and uninsured revenues, applicable to actual service period and derived from auditable sources, are offset against Medicaid and uninsured costs to arrive at the clinic's uncompensated care costs.
- 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.

An FQHC-LA's uncompensated care cost limit is determined for the twelve month period in each DY, except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a clinic's cost reporting period does not coincide with the DY (or partial DY in DY3), 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).

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

Final Reconciliation

Each FQHC-LA's uncompensated care costs must be recomputed based on the actual audited cost report for the actual service period. The cost report is audited to ensure costs are allowable consistent with Medicare and Medicaid cost principles and applicable OMB Circulars; and that FQHC services and visits are recognized consistent with the Medicaid State plan. SNCP uncompensated care payments made to the FQHC-LA 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 clinic's uncompensated care cost limit, the overpayment will be recouped from the clinic, 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 cost per visit is computed based on audited allowable FQHC-LA cost and total visits pertaining to the actual service period cost report.
- Both Medicaid visits and uninsured visits furnished during the service period are applied to the audited cost per visit to determine the clinic's Medicaid and uninsured costs. Medicaid and uninsured visits must be derived from the latest available auditable sources, including the State's PMMIS, managed care encounter data, and provider patient accounting records.
- Both Medicaid and uninsured revenues, applicable to actual service period and derived from the latest available auditable sources, are offset against Medicaid and uninsured costs to arrive at the clinic's uncompensated care costs.
- 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.

An FQHC-LA's uncompensated care cost limit is determined for the twelve month period in each DY, except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a clinic's cost reporting period does not coincide with the DY (or partial DY in DY3), 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).
The final reconciliation described above will be performed and completed within eighteen months after the filing of FQHC-LA cost report(s).

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 providers include hospitals that employ and contract for physician services and incur physician professional service costs (whether the professional services are billed by the hospital or by the physicians) and physician practice groups that provide physician services in hospital and other settings and incur the physician professional service costs directly.

Interim Computation of Uncompensated Care Costs

SNCP uncompensated care payments will be made to eligible providers and claimed for FFP in quarterly installments per DY (beginning with DY 2 for City of Phoenix, City of Mesa, City of Tucson, City of Casa Grande, and City of Globe providers eligible pursuant to Section ~~D~~E, Section F, Section G, Section H and Section I, respectively, of Attachment J). Each DY's SNCP will be distributed based on the provider's proportionate share of projected uncompensated care among all providers subject to the same Limit (either the Safety Net Hospital System Limit ~~or~~, the Phoenix Hospital Limit, the Mesa Hospital Limit, the Tucson Hospital Limit, the Casa Grande Hospital Limit or the Globe Hospital Limit), 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 hospitals incurring physician professional service costs

a. The professional component of physician costs are identified from each hospital's CMS 2552 cost report Worksheet A-8-2, Column 4. For providers eligible pursuant to Section C, Section G, Section H or Section Iof Attachment J, the most recent CMS 2552 filed the with hospital's Medicare contractor will be utilized. For providers eligible pursuant to Section D or Section E of Attachment J, any 2552s that overlap the base state fiscal year will be prorated and utilized. For payments made in DY 2 and DY 3, the base state fiscal year is 2010. 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). Registry physicians are excluded from the cost determination for hospitals eligible for payment pursuant to Section ~~D~~E, Section F, Section G, Section H or Section I of Attachment J.);
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 hospital 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 hospital 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. Hospitals eligible for payment pursuant to Section C of Attachment J 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 the hospital incurred its cost (whether salaried or contracted). Where the professional services are not billed by the hospital directly, the hospital must obtain those professional charges from the billing party. If hospitals eligible for payment pursuant to Section ~~D~~E, Section F, Section G, Section H or Section I of Attachment J, cannot identify total billed Medicaid and uninsured professional charges by cost center related to physician services from auditable provider records, total billed departmental charges by cost center are identified from auditable provider records.

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. If hospitals eligible for payment pursuant to Section ~~D~~E, Section F, Section G, Section H or Section I of Attachment J cannot identify total billed Medicaid and uninsured professional charges for each cost center, a physician cost to departmental charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-d of subsection 1 by the total departmental charges for each cost center as established in paragraph e 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. Hospitals 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 hospitals eligible for payment pursuant to Section ~~D~~E, Section F, Section G, Section H or Section I of Attachment J, if total professional charges for each cost center related to eligible Medicaid and uninsured physician services are unidentifiable using auditable records, total departmental charges for each cost center related to eligible Medicaid and uninsured physician services are identified using auditable records.

For each non-physician practitioner type, the eligible Medicaid and uninsured professional charges are identified using auditable records. Hospitals 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.

2. Steps for physician practice group incurring physician professional service costs

a. The physician compensation costs are identified from the physician practice group's trial balance or other auditable financial records and reported on a CMS-approved physician practice group cost report for the latest available cost reporting period. These professional compensation costs are limited to identifiable and auditable costs that have been incurred by the physician practice group for the professional patient care furnished in all applicable sites of service, including services rendered at non-hospital physician office sites operated by the practice groups and at sites not owned or operated by the practice group for which the practice group bills for and collects payment.

The physician compensation costs are reduced by National Institute of Health (NIH) grants to the extent the research activities component is not removed via physician time studies.

b. On the physician practice group cost report, these physician compensation costs net of NIH grants as applicable, reported by cost centers/departments, are then allocated between clinical and non-clinical activities using a CMS-approved time-study tool. The result of the CMS-approved time study tool is the physician compensation costs pertaining only to clinical, patient care activities. SNCP dollars allocated for physician professional service costs incurred by a physician practice group cannot be claimed for FFP until such a time study tool is approved by CMS. For DYs 1-3, a CMS-approved benchmark RVU methodology can be used in lieu of a CMS-approved time study. The benchmark RVU methodology will determine a direct patient care percentage for each cost center/department based on a ratio of actual direct patient care work RVUs for the period to benchmark RVUs for the department which would have been produced if the physicians were working 100% in direct patient care. Where the physician's compensation is first incurred by another entity and the physician practice group then reimburses the entity for the physician direct patient care costs, the physician clinical costs recognized is the lower of 1) the total physician's total compensation multiplied by the direct ~~paitnet~~patient care percentage; or 2) the amount incurred by the physician practice group in paying for physician direct patient care costs.

c. The physician clinical costs 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 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 physician practice group.

d. The above physician compensation costs must not be duplicative of any costs claimed on the hospital cost reports.

e. Additional costs that can be recognized as professional direct costs are costs for non-capitalized medical supplies and equipment used in the furnishing of direct patient care.

f. Indirect costs incurred by the physician practice group and allocable to the physicians' direct patient care will be also recognized. Where a cognizant agency-approved indirect cost rate is available for the physician practice group, the indirect rate will be applied to the total direct cost, calculated above, based on each center/department's physician compensation costs determined to be eligible for Medicaid reimbursement and identifiable medical supply/equipment costs to arrive at total allowable costs for each cost center If an indirect rate is not available, then actual indirect costs incurred will be identified using auditable financial records including the general ledger. The indirect costs claimed must be allowable under Medicare and Medicaid cost principles and applicable OMB Circulars. The indirect costs may include indirect costs incurred by the physician practice group (including physician group practice clinical support staff salaries and benefits, physician department administrative and office staff salaries and benefits, and other non-salary costs incurred by each physician department) or by its home office as reported on a Medicare-approved home office cost statement and allocated in the cost statement to the physician practice group by approved Medicare allocation methodology. Adjustments to the indirect costs must be made to arrive at allowable indirect costs consistent with the applicable cost principles. The allowable indirect costs must either then be directly assigned or allocated (using accumulated costs as an allocation basis) to each physician department/cost center of the physician practice group.

To determine the additional costs that ~~is~~are allocable to direct patient care, the direct patient care percentage from step 2.b above (resulting from the time study or the time study proxy tool) will be applied the costs identified in steps 2.e and 2.f above at a departmental/cost center level.

g. Total billed professional charges by cost center related to physician services are identified from auditable provider records. Charges must be identified for all professional services for which the physician practice group incurred its cost.

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 2 by the total billed professional charges for each cost center as established in paragraph g of subsection 2.

i. The total professional charges for each cost center related to eligible Medicaid and uninsured physician services are identified using auditable records. The physician practice group must map the claims to their cost centers. Each charge must be mapped to only one cost center 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 2 by the respective cost to charge ratio for the cost center as established in paragraph h of subsection 2.

k. The total Medicaid and uninsured professional service uncompensated care costs are determined by subtracting all revenues received for Medicaid and uninsured physician practitioner services from the Medicaid and uninsured costs as established in paragraph j of subsection 2. 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 uninsured physician amount computed in paragraph k above can be trended to current year to account for cost inflation based on CMS market basket update factor. Furthermore, the State can 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 or physician practice group'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. The physician practice group cost report is filed with the State also five months after the close of the cost reporting period. SNCP uncompensated care payments made to the hospital or the physician practice group 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 or physician practice group'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.

Note that for those hospitals eligible for payment pursuant to Section ~~D~~ E, Section F, Section G, Section H or Section I of Attachment J who were unable to readily identify physician professional charges and instead used departmental charges in Interim Computation of Uncompensated Care Costs steps 1.g-i above, physician professional charges must be used in the computation of uncompensated care cost limit in the Interim Reconciliation here and the Final Reconciliation below.

A hospital's or physician practice group's uncompensated care cost limit is determined for the twelve month period in each DY (beginning with DY 2 for providers eligible pursuant to Section ~~D~~ E, Section F, Section G, Section H or Section I of Attachment J), except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a hospital's or physician practice group's cost reporting period does not coincide with the DY (or partial DY in DY3), 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).

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 or physician practice group'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. The physician practice group's cost report is also audited to ensure costs are allowable consistent with Medicare and Medicaid cost principles and applicable OMB Circulars. SNCP uncompensated care payments made to the hospital or physician practice group 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 or physician practice group'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.

Note that for those hospitals eligible for payment pursuant to Section ~~D~~ E, Section F, Section G, Section H or Section I of Attachment J who were unable to readily identify physician professional charges and instead used departmental charges in Interim Computation of Uncompensated Care Costs steps 1.g-i above, physician professional charges must be used in the computation of uncompensated care cost limit in the Interim Reconciliation above and the Final Reconciliation here.

A hospital's or physician practice group's uncompensated care cost limit is determined for the twelve month period in each DY (beginning with DY 2 for providers eligible pursuant to Section ~~D~~ E, Section F, Section G, Section H or Section I of Attachment J), except for DY 3 in which the uncompensated care cost limit is computed for the three month period ending December 31, 2013. Where a hospital's or physician practice group's cost reporting period does not coincide with the DY (or partial DY in DY3), 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).

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. For the physician practice group-incurred professional service uncompensated care costs, the final reconciliation described above will be performed and completed within eighteen months after the filing of physician practice group cost report(s).

Designated State Health Program (DSHP) - Trauma and Emergency Services Fund

Arizona State Proposition 202 authorizes the use of State tribal gaming revenues for the Trauma and Emergency Services Fund. The fund, administered by AHCCCS, provides payments to Arizona hospitals to offset trauma center readiness costs and emergency services costs.

The fund, as it is currently operated, distributes 90% of available funds to Arizona hospitals that qualify as Level 1 Trauma Centers and 10% of available funds to Arizona hospitals that operate an emergency department. The 90% Level I Trauma Center amount is distributed proportionally to qualifying hospitals based upon each hospital's total of Injury Severity Score times the number of cases at that level. Hospitals report trauma scores and case volume on an Acuity-Adjusted Volume worksheet that uses hospital utilization from a twelve-month period that ends on June 30 of the previous Federal Fiscal Year. The 10% Emergency Department amount is distributed proportionately to qualifying hospitals based on each hospital's emergency department costs, as reported on its Medicare cost report, Worksheet B, Part I, Column 0, Line 61. In DY1, cost report data for the period July 2010 through June 2011 will be used. In DY2, cost report data for the period July 2011 through June 2012 will be used. When a hospital has two cost reports that span this reporting period, data from the two hospital cost reports that span that period will be allocated based upon each cost report's proportion of the reporting period.

Section VI of these STCs allows the Trauma and Emergency Services Fund to be recognized as a DSHP eligible for SNCP claiming in DY 1 and DY 2. The maximum amount per each Demonstration year that would qualify for SNCP claiming is $20 million total computable.

For each demonstration year, the State should document its computation and distribution of its Trauma and Emergency Services Fund payments to each qualifying hospital. Upon distribution of payments to the hospitals, the State would be allowed to claim FFP of the actual paid amounts as part of the SNCP claims, subject to the $20 million total computable limit. The State should include a schedule of the payment amounts made to each qualifying hospital in its annual DY SNCP reporting to CMS. ….

Attachment J
Participating Providers in the SNCP

A. Hospital Uncompensated Care Cost Payments

- Phoenix Children's Hospital
- University Medical Center
- University Physicians Healthcare Hospital at Kino Campus
- Maricopa Medical Center
- Little Colorado Medical Center (Winslow Memorial Hospital) - effective DYs 2 and 3 only
- Southeast Arizona Medical Center - effective DYs 2 and 3 only
- White Mountain Regional Medical Center - effective DYs 2 and 3 only
- Copper Queen Hospital - effective DYs 2 and 3 only
- Cobre Valley Community Hospital
- Benson Hospital
- La Paz Regional Hospital

B. Federally Qualified Health Center Lookalike (FQHC-LA) Uncompensated Care Cost Payments

Avondale Family Health Center
950 E. Van Buren, Avondale 85323
623.344.6800

El Mirage Family Health Center
12428 W. Thunderbird, El Mirage 85335
623.344.6500

Glendale Family Health Center
5141 W. Lamar St., Glendale 85301
623.344.6700

Maryvale Family Health Center
4011 N. 51st Ave., Phoenix 85031
623.344.6900

Chandler Family Health Center
811 S. Hamilton, Chandler 85225
480.344.6100

Guadalupe Family Health Center
5825 E. Calle Guadalupe, Guadalupe 85283
480.344.6000

Mesa Family Health Center
59 S. Hibbert, Mesa 85210
480.344.6200

Comprehensive Healthcare Center
2525 E. Roosevelt St., Phoenix 85008
602.344.1015

McDowell Healthcare Center
1144 E. McDowell Rd., Phoenix 85006
602.344.6550

7th Avenue Family Health Center
1205 S. 7th Ave., Phoenix 85007
602.344.6600

South Central Family Health Center
33 W. Tamarisk St., Phoenix 85041
602.344.6400

Sunnyslope Family Health Center
934 W. Hatcher, Phoenix 85021
602.344.6300

7th Avenue Walk In Clinic
1201 S. 7th
Ave. Phoenix
85007
Phone: (602) 344-6655

C. Physician Professional Service Uncompensated Care Cost Payments
- Phoenix Children's Hospital
- Maricopa Medical Center
- University Physician's Healthcare

D. Non-Physician Practitioner Professional Service Uncompensated Care Cost Payments - effective DYs 2 and 3
- Maricopa Medical Center

~~D~~E. City of Phoenix High Uncompensated Care Hospital Cost Payments: Hospital and Physician Professional Service Costs
- Banner Estrella Medical Center
- Banner Good Samaritan Medical Center
- John C Lincoln-Deer Valley Hospital
- John C. Lincoln North Mountain Hospital
- Maryvale Hospital Medical Center- Paradise Valley Hospital
- Phoenix Baptist Hospital
- Phoenix Children's Hospital
- St Joseph's Hospital-Phoenix
- St Luke's Medical Center

F. City of Mesa High Uncompensated Care Hospital Cost Payments: Hospital and Physician Professional Service Costs
- Banner Desert Medical Center
- Banner Baywood Medical Center
- Banner Baywood Heart Hospital
- Mountain Vista Medical Center

G. City of Tucson High Uncompensated Care Payments: Hospital and Physician Professional Service Costs

- Tucson Medical Center
- Carondelet St. Mary's Hospital
- Carondelet St. Joseph's Hospital
- The University of Arizona Medical Center - University Campus (formerly University Medical Center)
- The University of Arizona Medical Center - South Campus (formerly University Physicians Healthcare Hospital at Kino Campus)

H. City of Casa Grande High Uncompensated Care Payments: Hospital and Physician Professional Service Costs

- Casa Grande Regional Medical Center

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I. City of Globe High Uncompensated Care Payments: Hospital and Physician Professional Service Costs

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- Cobre Valley Community Hospital

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